PLUMBERS' WELFARE FUND
LOCAL 130, U.A.

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June 17, 2022

IMPORTANT PLAN CHANGES

Summary of Material Modifications

Dear Active Participant:

The Trustees' goal is to provide you with comprehensive and affordable coverage while ensuring that all provisions of the Plumbers' Welfare Fund, Local 130, U.A. ("Plan") comply with federal law. This Summary of Material Modification ("SMM") explains the changes to the Plan Document and Summary Plan Description in order to comply with the No Surprises Act and other related provisions as incorporated in the Consolidated Appropriations Act of 2021. The No Surprises Act requires significant changes to the Plan and offers many protections to participants, including protections to participants to prevent "surprise billings" in an emergency situation or when a Non-PPO Provider treats a participant at a PPO facility without the participant's express consent or when a participant uses a Non-PPO Air Ambulance provider.

As always, you are encouraged to use PPO facilities and PPO providers whenever possible. An explanation of your rights under the No Surprises Act related to "surprise billings" is enclosed with this SMM. Please review these changes carefully and contact the Fund Office with any questions. The changes described in this SMM shall apply June 1, 2022 as required under the No Surprises Act.

Note: The changes described here apply only to the medical benefits (including prescription drug benefits, to the extent relevant) offered under the Plan and not to the dental, vision, disability, life insurance, or HRA benefits.

Coverage of Emergency Services and Certain Non-Emergency Services Provided by PPO and Non-PPO Providers

For claims incurred on or after June 1, 2022, the following additional rules apply as required under the No Surprises Act.

Changes to Emergency Services under the No Surprises Act

The Plan will cover Emergency Services provided at a Non-PPO facility or by a Non-PPO Provider in the same manner as PPO Emergency Services and without pre-authorization. Additionally, the Plan will not impose more restrictive administrative requirements on Non-PPO Emergency Services than requirements for Emergency Services received at a PPO facility or provider

Accordingly, the Plan has been revised as follows:

1. **New Definition of Emergency.** The definition of Emergency Medical Condition in the Plan is replaced with the following definition of "Emergency" to read as follows:

   - **Emergency** means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

     If symptoms exist that reasonable may be interpreted as an Emergency, that condition will be considered an Emergency even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of a heart attack is not made. Likewise, if you are taken for treatment to the nearest hospital or trauma center by the police, fire department, or ambulance under circumstances beyond your control, this too will be treated as an Emergency.

2. **Revised Definition of Emergency Services.** The definition of Emergency Services is revised to read as follows:

   - **Emergency Services** means outpatient and inpatient services provided with respect to an Emergency and include treatment provided by and within the capabilities of the emergency department of a Hospital (including a Hospital outpatient department) or an independent, freestanding emergency department that provides Emergency Services and is geographically separate and licensed separately from a Hospital under applicable state law, including an appropriate medical screening examination and ancillary services routinely available to the emergency department to evaluate such Emergency and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services include treatment of an Emergency by an urgent care clinic or facility if such urgent care clinic or facility is permitted by applicable state licensure laws to provide such services.

3. **Coverage for Emergency Services.** The category "Emergency Room Care" is re-designated as "Emergency Services" in the Summary of Benefits chart and applies to "Emergency Services" more generally, and Emergency Services provided by both PPO and Non-PPO Providers will be subject to a $150 co-payment and covered at 100% for the first $1,000 and 80% for amounts in excess of $1,000 without application of the deductible; the

co-payment will apply to the annual out-of-pocket maximum applicable to PPO providers (even if provided by a Non-PPO provider) and will be waived if you are admitted to the Hospital. With respect to Non-PPO providers, the Plan's payment will be based on the Recognized Amount (as defined). If you are admitted to the Hospital as a result of an Emergency, as in the past, you are required to call the Utilization Review Provider within 24 hours of the admission.

4. **Coverage for Post-stabilization Services.** Post-stabilization services provided by Non-PPO providers and facilities will generally be considered Emergency Services for purposes of applying the payment rules with respect to Emergency Services as set forth in the Schedule of Benefits unless certain conditions are met. Post-stabilization services include outpatient observation or an inpatient or outpatient stay that is related to the Emergency or with respect to the visit in which other Emergency Services are furnished.

   Post-stabilization services at a Non-PPO facility or from a Non-PPO Provider are not considered Emergency Services for payment purposes if:

   (i) the attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO Provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition,

   (ii) the Non-PPO facility or provider furnishing such services provides adequate notice to the patient as required by federal law (including notice that the provider is a Non-PPO provider with respect to the Plan, the estimated charges for treatment and any advance limitations that the Plan may put on the treatment, of the names of any PPO providers at the facility who are able to provide treatment, and notice that the patient may elect to be referred to one of the PPO providers listed); and

   (iii) receives informed consent from the patient to continue treatment despite the greater cost, in compliance with applicable law.

Changes to Non-Emergency Services from Non-PPO Providers at PPO Facilities under the No Surprises Act

1. **New Definition of Recognized Amount**:

   - **Recognized Amount** means with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility— an (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the lesser of the billed amount by the provider or facility or the amount that is the qualifying payment amount (as determined in accordance with federal regulations § 2590.716–6).

2. **New Definition of Ancillary Services**:

   - **Ancillary Services** mean emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items

and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no network provider who can furnish such item or service at such facility.

3. **Coverage of Non-PPO Provider at a PPO facility.** If you receive non-Emergency items or services that are otherwise covered by the Plan from a Non-PPO Provider who is working at a PPO facility, those non-Emergency items or services will be covered by the Plan as follows:

   - The non-Emergency items or services received from a Non-PPO Provider working at a PPO facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO Provider. In other words, the coinsurance percentage and any co-payments applicable to such services will be the same as if the services were furnished by a PPO Provider (see also the enclosed notice entitled "Your Rights and Protections Against Surprise Medical Bills" for additional information about your protections against balanced billing).

   - If applicable your coinsurance will be based on the Recognized Amount (as defined in the section above). Any cost-sharing payments you make with respect to covered non-Emergency services will count toward your PPO (in-network) deductible and PPO (in-network) out-of-pocket maximum in the same manner as those received from a PPO Provider.
   - **Note Important Exception:** An exception applies with respect to certain Non-PPO Providers who have provided notice to the patient and received informed consent with respect to the non-network billing practices in compliance with applicable law. If the exception applies, the applicable Non-PPO coinsurance rate will be applied to the Reasonable and Customary Charge, and the Non-PPO deductible and out-of-pocket maximum will apply.

Air Ambulance Services

Effective June 1, 2022, the co-insurance rate that you pay for Medically Necessary air ambulance (medial transport by fixed wing airplane or rotary wing helicopter) services will be the same whether the provider is a PPO or Non-PPO provider. Any co-insurance payments you make with respect to covered Air Ambulance services will count toward your in-network (PPO) deductible and out-of-pocket maximum, regardless of whether received from a PPO or non- PPO provider.

Provider Directories and Services or Supplies Obtained from Non-PPO Provider Believed to be a PPO Provider

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan's PPO network.

If you obtain from the Plan and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider is a non-PPO provider. In other words, benefits will be paid as if the provider were, in fact, a PPO provider, subject to application of the PPO coinsurance rates, copayments, benefit maximums, deductibles and out-of-pocket maximums.

Continuing Coverage with a PPO Provider who leaves the Plan's PPO Network

If you are a "Continuing Care Patient" and the Plan's medical network terminates its contract with your PPO provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan (but not in cases involving provider fraud or the provider's failure to meet quality of care standards), the Plan will:

- Notify you in a timely manner of the Plan's termination of its contracts with the PPO provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and

- Allow you ninety (90) days of continued coverage with benefits paid on the same terms and conditions under the Plan as if the provider or facility had remained in the PPO in order to allow time for you to transition your care to a PPO provider.

You are a Continuing Care Patient with respect to a provider or facility if you are:

- undergoing a course of treatment for a "serious and complex condition" from the provider or facility;

- undergoing a course of institutional or inpatient care from the provider or facility;

- scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

- pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

- determined to be "terminally ill" and receiving treatment for such illness from such provider or facility.

For purposes of Continuing Care Patients, an individual has a "serious and complex condition" if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. An individual is "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is six months or less.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a Non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for external review as set forth in Section 16.14 of the Plan.

Should you have any questions concerning this SMM, please contact the Fund Office at (312) 226-5000.

Sincerely,

Board of Trustees
Plumbers' Welfare Fund, Local 130 U.A.

This announcement, which serves as a Summary of Material Modification ("SMM"), contains only highlights of recent changes to the Plan. In order to understand this announcement in context, please refer to your Plan Document and Summary Plan Description ("SPD"). If there is a discrepancy between the wording here and the Plan Document and SPD, the Plan Document and SPD will govern, except to the extent expressly modified in this SMM. The Trustees reserve the right to amend, modify, or terminate the Plan at any time. Please file this SMM together with your SPD.

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"**Surprise billing**" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Employee Benefits Security Administration at 1-866-444-3272. You may also call this number or contact the EBSA *electronically at* www.askebsa.dol.gov *for technical assistance or to make a complaint.*

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.