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February 2022

TO: All Participants and their Dependents, including COBRA beneficiaries, of Operating Engineers Health and Welfare Trust Fund for Utah ("Plan")

FROM: Board of Trustees
Operating Engineers Health and Welfare Trust Fund for Utah

The information described in this document is **very important** to you and your dependents. Please read it carefully.

SUMMARY OF MATERIAL MODIFICATIONS TO THE INDEMNITY MEDICAL PLAN:
IMPROVEMENTS TO BENEFITS FOR CERTAIN SERVICES FROM NON-CONTRACT PROVIDERS
Effective January 1, 2022

The No Surprises Act was signed into law in December 2020. This federal law protects patients who receive Emergency Services at a Hospital or an Independent Freestanding Emergency Department and Air Ambulance Services. This law also protects patients who receive non-emergency services from a Non-Participating Provider at a participating (i.e., in-network) facility.[1] Effective January 1, 2022, Employees and Dependents receiving these services will only be responsible for paying their in-network Cost-sharing requirement and cannot be Balance Billed by the Provider or facility for these services.

Effective January 1, 2022, the Fund is implementing a number of improvements to the Plan to comply with the No Surprises Act as discussed below. Capitalized terms are defined in the section labeled "NEW/REVISED DEFINITIONS OF THE PLAN" or in the SPD.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care Provider furnishing the Emergency Services is a Participating Provider or a participating emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirements or limitations on out-of-network Emergency Services that are more restrictive than the requirements or limitations that apply to Emergency Services received from Participating Providers and participating emergency facilities;

[1] The federal law does not apply for non-emergency services from a Non-Participating Provider at a participating facility if the Non-Participating Provider meets certain notice and consent requirements for such services.

- At 80% of the Allowed Charges when received from either a Participating or Non-Participating Provider (the Employee or Dependent is responsible for payment of 20% Coinsurance up to the Coinsurance maximum). Non-PPO ground ambulance services are payable at 60% of the Allowed Charge.
- By calculating the Cost-sharing requirement for Emergency Services provided by a Non-Participating Provider or facility as if the total amount charged for the services was equal to the Recognized Amount for the services; and
- By counting any Cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any PPO Deductible or PPO Out-of-Pocket Maximums applied under the Plan (and the PPO Deductible and PPO Out-of-Pocket Maximums are applied) in the same manner as if the Cost-sharing payments were made with respect to Emergency Services furnished by a Participating Provider or a Participating emergency facility.

In general, you cannot be Balance Billed for these items or services. The Cost-sharing amount for Emergency Services from Non-Participating Providers will be based on the lesser of billed charges from the Provider or the Qualified Payment Amount ("QPA").

Non-Emergency Items or Services from a Non-Participating Provider at a Participating Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-Participating Provider at a PPO facility, the items or services are covered by the Plan:

- 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 Participating Provider;
- By calculating the Cost-sharing requirement as if the total amount that would have been charged for the items and services by a Participating Provider was equal to the Recognized Amount for the items and services;
- By counting any Cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the Plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such Cost-sharing payments were made with respect to items and services furnished by a Participating Provider; and
- In general, you cannot be Balance Billed for these items or services.

Non-emergency items or services performed by a Non-Participating Provider at a Participating facility will be covered based on the Plan's definition of Allowed Charge and forgo the financial protections of the No Surprises Act if:

1. At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice that the Provider is a Non-Participating Provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any Participating Providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the Participating Providers listed; and
2. The participant or dependent gives informed consent to continued treatment by the Non-Participating Provider, acknowledging that the participant or beneficiary understands that

continued treatment by the Non-Participating Provider may result in greater cost to the participant or beneficiary.

The notice and consent exception for non-emergency items or services provided by a Non-Participating Provider at a participating facility does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Participating Provider satisfied the notice and consent criteria, and therefore these services 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 Participating Provider;
- With the Cost-sharing requirement calculated as if the total amount that would have been charged for such items and services by a Participating Provider was equal to the Recognized Amount for the items and services;
- With Cost-sharing for items and services so furnished counted toward any in-network Deductible and in-network Out-of-Pocket Maximums, as if such Cost-sharing payments were made for items and services furnished by a Participating Provider; and
- In general, you cannot be Balance Billed for these items or services.

The Cost-sharing Amount for non-emergency services at participating facilities by Non-Participating Providers will based on the Recognized Amount, which is, generally, the lesser of the billed charges from the Non-Participating Provider or the QPA (i.e., the Plan's median of contracted rates for the item or service in that location).

Air Ambulance Services

If you receive Air Ambulance Services from a Non-Participating Provider that are otherwise covered by the Plan, those services will be covered by the Plan as follows:

- The Air Ambulance Services received from a Non-Participating Provider will be covered with a Cost-sharing requirement that is no greater than the Cost-sharing requirement that would apply if the services had been furnished by a Participating Provider;
- With the Cost-sharing requirement for the services calculated as if the total amount that would have been charged for the services by a Participating Provider of Air Ambulance Services was equal to the lesser of the QPA or the billed amount for the services;
- Any Cost-sharing payments you make with respect to covered Air Ambulance Services will count toward you PPO Deductible and PPO Out-of-Pocket Maximum in the same manner as if those services were received from a Participating Provider; and
- In general, you cannot be Balance Billed for these items or services.

Payments to Non-Participating Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Participating Facilities by Non-Participating Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-Participating Provider or Air Ambulance Service Provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the Cost-sharing Amount under the Plan, and the Provider or facility is prohibited from billing the participant or dependent in excess of the required Cost-sharing Amount.

The Plan will pay a total Plan payment directly to the Non-Participating Provider that is equal to the amount of the Out-of-Network Rate for the services that exceeds the Cost-sharing Amount for the same services, less any initial payment amount.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Participating Provider or facility terminates, or your benefits under the Plan are terminated because of a change in terms of the Providers' and/or facilities' participation in the Plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the Provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at the Participating Cost-sharing Amount to allow for a transition of care to a Participating Provider.

Incorrect Participating Provider Information

A list of Participating Providers is available to you without charge on the website (www.anthem.com) 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 or an organization contracting on its behalf.

If you obtain and rely upon incorrect information provided by the Plan about whether a Provider is a Participating Provider from the Plan or its administrators, the Plan will apply the PPO Cost-sharing Amount to your claim, even if the Provider was a Non-Participating Provider when the service were received.

Complaint Process

If you believe that you've been billed incorrectly, or otherwise have a complaint under the No Surprises Act, you may contact the Trust Fund Office for assistance.

EXTERNAL REVIEW OF CERTAIN COVERAGE DETERMINATIONS
Effective January 1, 2022

Chapter 15 of the 2018 SPD concerning Claims and Appeals is amended. The following section is added to Chapter 15:

External Review of Emergency Services, Air Ambulance Services, and Services Provided by Non-Participating Providers at Participating Facilities

This External Review process is intended to comply with the No Surprises Act and Affordable Care Act (ACA) External Review requirements. If your initial claim for benefits related to an Emergency Service, non-emergency service provided by a Non-Participating Provider at a participating facility, and/or Air Ambulances Service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination.

For purposes of this section, references to the "Claimant" include the Employee and any covered Dependent(s), and the Employee's and covered Dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s). Further, with respect to this section, an independent review organization (IRO) means an entity that conducts independent external

reviews of Adverse Benefit Determinations in accordance with the Plan's External Review provision outlined in this section and current federal external review regulations.

If an appeal of a No Surprises Service health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied, the Claimant may request further External Review by an independent review organization if the denial fits any of the parameters described below:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment;
- The denial is due to a rescission of coverage (i.e., any cancellation or discontinuance of coverage that has a retroactive effect), regardless of whether the rescission has any effect on any particular benefit at that time; and/ or
- An adverse benefit determination that involves whether the Plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act.

PATIENT PROTECTIONS
Effective January 1, 2022

The Plan does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any Participating or Non-Participating Provider; however, payment by the Plan may be less for the use of a Non-Participating Provider.

You do not need prior authorization from the Fund, Anthem Blue Cross, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem Blue Cross at (800) 274-7767.

NEW/REVISED DEFINITIONS OF THE PLAN
Effective January 1, 2022

To implement the protections of the No Surprises Act, effective January 1, 2022, the Fund is adopting the following new/revised definitions of terms in the Plan.

Air Ambulance Service means medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605.

The definition of "Allowable Medical Expense(s) or Allowed Charge" at page 121 of the 2018 SPD (Chapter 18 – Glossary) is repealed and replaced with the following:

Allowed Charge/Allowed Amount/Allowable Charge means:

1. For Emergency Services provided by Non-Participating Providers, for Non-Emergency Services provided by a Non-Participating Provider at a participating facility, and for Air Ambulance Services, the Out-of-Network Rate, as defined below**.**

2. For all other services, the lesser of:
   a. The dollar amount this Plan has determined it will allow for covered Medically Necessary services or supplies provided by Non-Participating Providers as determined by the Plan's Preferred Provider Organization (PPO) based on appropriate and reasonable charges for the services in the geographical area where the services are provided. With respect to Non-Participating Hospitals or facilities within the PPO service area for items and services other than Emergency Services, the allowed charge will be the negotiated contract rate of the PPO Hospital or facility that is geographically nearest to the Hospital or Facility where treatment was received. The Plan's Allowed Charge is not based on or intended to be reflective of fees that have traditionally been described as usual and customary (U&C); usual, customary, and reasonable (UCR); or any other traditional term. Non-Participating Providers' bills often exceed the Plan's Allowed Charge, and in such cases the Plan's benefits will be based on the Allowed Charge, not the Non-Participating Provider's billed rate. When the patient has not had a reasonable opportunity to select a Participating Provider, the Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the Allowed Charge for the submitted claim.

   b. The Non-Participating Provider's actual billed charge.

3. When using Non-Participating Providers, except for No Surprises Act Services, the Participant or Dependent is responsible for any difference between the actual billed charge and the Plan's Allowed Charge (a practice called "balance billing"), in addition to any Copayment and percentage coinsurance required by the Plan.

Ancillary Services are, with respect to a PPO health care facility:

- Items and services related to 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 subject to exceptions specified by the Secretary;
- Items and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and
- Items and services provided by a Non-Participating Provider if there is no Participating Provider who can furnish such item or service at such facility.

Balance Billing. A bill from a health care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the Provider actually charged (the billed charges). Amounts associated with Balance Billing are not covered by this Plan, even if the Plan's Coinsurance Maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's Coinsurance Maximum and may result in balance billing to you. **Non-Participating Providers commonly engage in balance billing.** This means a Plan participant may be billed for any balance that may be due in addition

to the amount payable by the Plan. **Generally, you can avoid Balance Billing by using Participating Providers**.

Pursuant to the No Surprises Act, you may not be Balance Billed for Emergency Services, Air Ambulance Services, and, unless appropriate notice and consent criteria are met, Non-Emergency Services performed by Non-Participating Providers at a participating facility. For these No Surprises Services, Cost-sharing payments shall count toward any in-network Deductible and in-network Out-of-Pocket Maximum.

Continuing Care Patient means an individual who, with respect to a Provider or facility—

- Is undergoing a course of treatment for a Serious and Complex Condition from the Provider or facility;
- Is undergoing a course of institutional or inpatient care from the Provider or facility;
- Is 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;
- Is pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or
- Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such Provider or facility.

Cost-sharing means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the Plan. Cost sharing generally includes Copayments, Coinsurance, and amounts paid towards Deductibles, but does not include amounts paid towards premiums, Balance Billing by Non-Participating Providers, or the cost of items or services that are not covered under the Plan.

The **Cost-sharing Amount** for Emergency and Non-emergency Services at Participating Facilities performed by Non-Participating Providers, and Air Ambulance Services from Non-Participating Providers will be based on the Recognized Amount.

The definition of "Emergency Medical Condition" at page 123 of the SPD (Chapter 18-Glossary; Version: 2018) is repealed and replaced with the following:

Emergency Medical Condition 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.

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-Participating Provider or Non-Participating Emergency Facility (regardless of the department of the hospital in which such items or services are furnished) also include post-stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services were furnished until:

1. The attending emergency physician or treating Provider determines that the patient is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and
2. The patient or their authorized representative is supplied with a written notice of the following:
    a. The Provider is a Non-Participating Provider with respect to the Plan,
    b. An estimate of the charges for treatment and any advance limitations that the Plan may put on treatment,
    c. The names of any Participating Providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the Participating Providers listed; and
    d. The patient or their authorized representative gives informed voluntary consent to continued treatment by the Non-Participating Provider, acknowledging that the patient (or their authorized representative) understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or beneficiary.

Health Care Facility (for non-emergency services) is each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent Freestanding Emergency Department is a Health Care Facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

No Surprises Act means the No Surprises Act (Public Law 116-260, Division BB).

No Surprises Services means the following, to the extent covered under the Plan:

- Emergency Services by a Non-Participating Provider or facility;
- Air Ambulance Services by a Non-Participating Provider;
- Non-emergency ancillary services for anesthesiology, pathology, radiology, and diagnostics, when performed by a Non-Participating Provider at a participating facility; and
- Other non-emergency services performed by a Non-Participating Provider at a participating health care facility for which the Non-Participating Provider does not meet the federal notice and consent requirements required under the No Surprises Act.

Non-Participating Emergency Facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the Plan or coverage respectively.

Out-of-Network Rate. With respect to Emergency Services provided by a Non-PPO Provider, non-emergency services furnished by a Non-Participating Provider at a participating facility, and Air Ambulance Services by a Non-Participating Provider, **Out-of-Network Rate** means, in order of priority, one of the following:

1. If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
2. Applicable state law;
3. The amount negotiated by the parties; or
4. The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

Out-of-Pocket Maximum or Limit. The No Surprises Act modifies the Maximum Coinsurance, an Out-of-Pocket Limit, provided in Chapter 4 of the 2018 SPD for Emergency Services, non-emergency services furnished by a Non-Participating Provider at a PPO facility, and Air Ambulance Services. Any Cost-sharing payments (e.g., copayments, *coinsurance*, and deductible) made by the participant or beneficiary are counted towards any in-network deductible or Out-of-Pocket Limit.

Preferred Provider Organization (PPO), also known as a participating provider organization, is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. The providers contract with the network to provide health care services and items at a reduced rate to the plan's participants. The Plan's PPO is Anthem Blue Cross.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the Plan or issuer for the item or service in the area.

Recognized Amount means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by Non-Participating Providers, the **Recognized Amount** is the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

Serious and Complex Condition means with respect to a participant, beneficiary, or enrollee under the Plan one of the following:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
2. In the case of a chronic illness or condition, a condition that is—
    a. Is life-threatening, degenerative, potentially disabling, or congenital; and
    b. Requires specialized medical care over a prolonged period of time.

In the context of Continuity of Care, **Termination** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Please keep this important notice with your Summary Plan Description/Plan Document for easy reference to all Plan provisions. If you have any questions, please contact the Trust Fund Office at the numbers listed above. You may also call the Fringe Benefits office at (800) 532-2105.

Sincerely,

Board of Trustees
Operating Engineers Health and Welfare Trust Fund of Utah

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Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Fund Office.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.

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This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at 510-433-4422 or Toll Free at 800-251-5014. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/agencies/ebsa/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.