SUMMARY OF MATERIAL MODIFICATIONS

ELECTRICAL WORKERS HEALTH AND WELFARE FUND

EFFECTIVE JANUARY 1, 2022

The Summary Plan Description for the Electrical Workers Health and Welfare Fund is hereby amended effective January 1, 2022, as follows:

1. **Part I, Health Benefits, at page 5 is amended to read as follows:**

PART I
HEALTH BENEFITS

The following sections of Part I of this Plan describe the health benefits covered under the Plan, subject to the Plan's terms, conditions, and exclusions.

Preferred Provider Organization (PPO)

To help manage certain health care expenses, the Plan contains a cost management feature – the Preferred Provider Organization (PPO) network. A PPO is a network of Physicians and Hospitals that have agreed to charge negotiated rates. When you use a network provider (or preferred provider), you save money for yourself and the Plan because the network provider has agreed to charge a discounted dollar amount.

The PPO may have agreements with network providers that may include financial incentives to promote the delivery of health care in a cost-efficient and effective manner; however, your coinsurance and deductible amounts will not be changed by any subsequent adjustments to the negotiated rate.

If you use an out-of-network provider for certain non-emergency items or services, the out-of-network provider's charges can exceed the Reasonable and Customary Charges and you will have to pay the difference between what the Plan would pay and the full amount charged for the item or service (called balance billing).

However, you are protected from balance billing in the following circumstances:

1) Emergency Services

If you have an Emergency Medical Condition and receive Emergency Services from an out-of-network provider or facility, you are protected from balance billing and you will not pay more than the in-network cost-sharing amount. This protection may apply to services you receive after you are in stable condition, however, you can waive your protections against balance billing for post-stabilization services if you give written consent to the provider.

If you have any questions regarding the Plan's network providers, please contact the Fund Office. You can also access an updated list of in-network providers at bluecrossmnonline.com

2) Out-of-Network Providers at In-Network Facilities

If you receive services from an in-network hospital or ambulatory surgical center and providers within that facility are out-of-network, you are protected from balance billing and you will not pay more than the in-network cost-sharing amount. You can waive your protections against balance billing if you give written consent to the provider, however, you cannot waive your protections against balance billing for the following out-of-network services at an in-network facility: anesthesiology, pathology, radiology, neonatology, and diagnostic services, including radiology and laboratory services.

Continuity of Care following Termination of Provider's In-Network Status

If the treating provider for a Continuing Care Patient loses their status as an in-network provider, the Plan will provide notice to the Continuing Care Patient and they will have the opportunity to elect to continue to receive services from that provider for up to 90 days under the terms that were applicable to that provider prior to termination of its in-network status, to allow for a transition of care to an in-network provider.

If you have any questions regarding the Plan's preferred, in-network providers, please contact the Fund Office.

Identification Card

When you or a member of your family enter a hospital, or are treated by a doctor, present your identification card. The hospital or doctor will then verify your eligibility for Plan benefits through the Fund Office.

When you purchase prescription drugs at a participating pharmacy, present your identification card so you can enjoy the discounts the Fund has negotiated on your behalf. If you need help locating a participating pharmacy, you can call the Fund Office.

2. **Part I, Health Benefits, Section One, Definitions, is amended to add the following definitions:**

Continuing Care Patient:

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

a. is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;

b. is undergoing a course of institutional or inpatient care from the provider or facility;

c. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

e. 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.

Emergency Medical Condition:

The term emergency medical condition means a medical condition manifesting itself 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 a condition including:

a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

b. serious impairment to bodily functions, or

c. serious dysfunction of any bodily organ or part.

This definition includes mental health conditions and substance use disorders.

Emergency services:

The term emergency services includes:

a. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department, to evaluate whether an Emergency Medical Condition exists; and

b. Such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department.

Independent Freestanding Emergency Department:

An independent freestanding emergency department is a health care facility that provides emergency services, and is geographically separate and distinct from a hospital, and separately licensed as such by a state.

Serious and Complex Condition:

Serious and Complex Condition means:

a. 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; or

b. in the case of a chronic illness or condition, a condition that is—

i. is life-threatening, degenerative, potentially disabling, or congenital; and

ii. requires specialized medical care over a prolonged period of time.

3. Part I, Health Benefits, Section Three, III. Major Medical, paragraph B(6) is amended as follows:

B. <u>Eligible Expenses</u>: All necessary and reasonable charges for medical care rendered while under the care of a licensed physician are covered under this Major Medical Benefit, including:

…

6. Charges for ambulance services. You may be balance billed if you receive ground ambulance services from an out-of-network provider. However, if you receive air ambulance services from an out-of-network provider, you will not pay more than the in-network cost-sharing amount. The term "air ambulance" means medical transport by a rotary-wing or fixed-wing air ambulance.

4. Part I, Health Benefits, Section Three, V. Wellness/Preventive Care Benefits, paragraphs 1-3, are amended as follows:

1. Covered Preventive Services For All Adults

- Abdominal aortic aneurysm one-time screening for men between 65-75 who have ever smoked
- Diabetes (Type 2) screening for adults aged 35-70 who are overweight or obese
- Low-dose aspirin use to prevent cardiovascular disease and colorectal cancer for adults aged 50-59 with a high cardiovascular risk
- Colorectal cancer screening for adults aged 45-75 (may include fecal occult blood testing, sigmoidoscopy, colonoscopy or virtual colonoscopy)
- Depression screening
- Annual preventive eye exam
- Falls prevention exercise interventions for community-dwelling adults aged 65 years and over

- Healthy diet behavioral counseling interventions for adults with hypertension or elevated blood pressure, dyslipidemia, or those who have mixed or multiple risk factors (*e.g.*, metabolic syndrome or an estimated 10-year cardiovascular disease risk of 7.5% or greater).
- Hepatitis B virus screening in persons at high risk for infection
- Hepatitis C virus screening in adults aged 18-79
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- High blood pressure screening for adults age 18 or older
- Latent tuberculosis screening in populations at increased risk
- Lung cancer annual screening for adults 50-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Obesity screening (BMI of 30 or higher) and for those determined obese, intensive multicomponent behavioral interventions
- Preexposure prophylaxis (PrEP) medication for the prevention of HIV infection for persons at high risk, including required testing and screening before and during use of PrEP medication, and adherence counseling.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Skin cancer prevention behavioral counseling for young adults and parents of young children about minimizing exposure to UV radiation to reduce risk for skin cancer for persons aged 6 months to 24 years with fair skin types
- Low to moderate dose statin medication for the prevention of cardiovascular disease for adults ages 40 – 75 with certain risk factors
- Syphilis screening for adults at higher risk
- Tobacco use screening, behavioral interventions, and Food and Drug Administration-approved pharmacotherapy for cessation (up to two cessation attempts per year)

2. Covered Preventive Services For Pregnant Women Or Women Who May Become Pregnant

- Asymptomatic bacteriuria screening using urine culture
- Breastfeeding: Comprehensive lactation support services from a trained provider, including counseling, education, and breastfeeding equipment, during pregnancy and the postpartum period (breastfeeding equipment requires prior authorization and is subject to specific restrictions, contact the Fund office for information)
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women at 24 weeks of gestation or after

- Healthy weight and weight gain—behavioral counseling interventions for pregnant women
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening
- Preeclampsia screening throughout pregnancy and low-dose aspirin as preventive medication after 12 weeks gestation in women at high risk for preeclampsia
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening for all pregnant women
- Tobacco use screening and behavioral interventions for cessation

3. Covered Preventive Services For Children

- Alcohol, tobacco, and drug use assessments for adolescents
- Anemia risk assessment or screening, as appropriate
- Autism screening for children at 18 and 24 months
- Behavioral assessments throughout childhood
- Bilirubin concentration screening for newborns
- Blood pressure screening throughout childhood
- Blood screening for newborns
- Cervical dysplasia screening for sexually active females
- Depression screening for adolescents beginning routinely at age 12
- Developmental screening throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Annual preventive eye exam
- Fluoride varnish for all infants and children as soon as teeth are present to age 5
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing and vision screening for all children
- Height, weight and body mass index (BMI) measurements throughout childhood
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at high risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Lead screening for children at risk of exposure
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits

- Obesity screening in children age 6 and older and up to three office visits a year for counseling and behavioral interventions
- Oral fluoride supplements for children without fluoride in their water source
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling for sexually active adolescents
- Skin cancer prevention behavioral counseling for adolescents
- Tobacco use interventions, including education and brief counseling, to prevent initiation of tobacco use (including e-cigarette products, *i.e.*, vaping)
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for children under age 5 to detect amblyopia or its risk factors

4. Part I, Health Benefits, Section Six, I. Benefit Appeals Procedure, subsection C, Claims Appeal Procedure, paragraph 2(b)(v) is amended as follows:

b. Preliminary Review:

Within five (5) business days following the date of receipt of your External Review request the Trustees, or the Fund Office as its designee, must complete a preliminary review of the request to determine whether it is eligible for External Review. In order to be eligible for External Review the following factors must be met:

…

v. Your adverse benefit determination or final adverse benefit determination involves medical judgment (including, but not limited to, determinations of medical necessity, appropriateness, or experimental or investigational nature of the treatment), a rescission of coverage, or consideration of whether the Plan is complying with the protections against surprise balance billing and cost-sharing protections related to Emergency Services, a Continuing Care Patient, and/or out-of-network care at an in-network facility.