

BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 OF PA-DE HEALTH AND WELFARE FUND

Summary of Material Modifications | Coronavirus Disease 2019 (COVID-19)

Dear Participant:

This notice, referred to as a Summary of Material Modifications (SMM), announces temporary changes to your plan of benefits to respond to the current Coronavirus Disease 2019 (COVID-19) public health threat. To ensure that participants are protected during this difficult time, effective immediately, the Board of Trustees has resolved to improve the plan of benefits as follows:

1. 100% Coverage for COVID-19 Diagnostic Testing.

Your Health and Welfare Fund will completely cover the testing necessary to diagnose COVID-19, regardless of the setting in which such testing occurs. This means that such testing will be covered without any out-of-pocket cost to you, irrespective of whether the testing occurs in your physician's office, an emergency room, urgent care center, or other facility.

100% coverage will apply for testing incurred on both an in-network and out-of-network basis, without regard to any prior authorization requirements that would otherwise apply but for those based on medical necessity.

2. Extended Eligibility

In light of the shutting down of many job sites in recent days, the Trustees have voted to make sure that all those who were eligible for benefits and working in covered employment during March 2020, will continue to be eligible for benefits until such time as this public health crisis ceases to severely curtail employment.

Accordingly, all Employees who were eligible for benefits and working in covered employment or certified as having been available for work during March 2020 will remain in coverage by using any hours bank available. In the event that an Employee does not have an hours bank sufficient to maintain coverage for the months of April, May and June, such Employee will be permitted to borrow against future hours bank credits, up to a maximum of 100 hours for each of the benefits months of April, May, and June 2020.

Thereafter, the Trustees will consider whether further extensions are warranted based on the facts and circumstances prevailing at that time.

Conclusion

The Trustees are treating this public health threat with the utmost urgency and will continue to respond accordingly to ensure that all impacted individuals have access to the care and medications they require. In the meantime, the Trustees encourage all participants to take all possible precautionary measures recommended by the Centers for Disease Control (CDC) to protect themselves and their families. As always, if you have any questions regarding this notice, or the benefits offered by the Fund, please feel free to contact the Fund Office at 215-856-9663.

Very truly yours,

The Board of Trustees

(over)

Disclosure of the Plan's "Grandfathered" Status

The Trustees believe that the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan may preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. Questions about 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 Fund Office at Bricklayers Benefit Plans, 2704 Black Lake Place Philadelphia, PA 19154 or by phone at 215-856-9663.

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH & WELFARE FUND
SUMMARY OF MATERIAL MODIFICATIONS**

This notice contains important changes to your Health and Welfare Benefits and should be kept with your Summary Plan Description for future reference.

Telemedicine is being offered as a benefit through your Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare coverage. **This change is effective January 1, 2020.** Telemedicine visits will have no cost sharing applied. These benefits are provided through MDLive. You will be receiving detailed information how to sign up for this benefit in the near future.

GRANDFATHER PLAN DISCLOSURE

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 plan administrator, Maria Morris, 2704 Black Lake Place, Philadelphia, PA 19154, 215-856-9663. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If there are any questions concerning this change and its application, such should be directed to Maria Morris, Fund Administrator, at (215) 856-9663 or can be submitted in writing to the Fund Office located 2704 Black Lake Place, Philadelphia, PA 19154.

Board of Trustees
Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund

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Effective May 1, 2021, the Fund's pharmacy benefit manager will change from Express Scripts to Sav-Rx Prescription Services. Your benefits will not change. You will receive a new identification card which will be used to fill prescriptions beginning on May 1, 2021. You can contact Sav-Rx with any questions by calling 1-866-91-BRICK (1-866-912-7425). Agents are available 24 hours a day, 7 days a week, 365 days a year.

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1. Changes to Dental Benefits

Effective January 1, 2023, there are several changes to the current dental plan.

1. The annual plan maximum has been increased from \$1,000 per person to \$1,500 per person.
2. Any claims paid for diagnostic and preventive care will not be applied towards the annual plan maximum.
3. Implants will be covered with a 45% coinsurance requirement. The Plan will pay for 55% of the cost for implants up to the annual plan maximum.

Any claims incurred from January 1, 2023 through March 1, 2023 will be reprocessed according to the new plan design. If you believe that you are due a reimbursement, please contact your dental provider to confirm the claim has been adjusted.

2. Changes to Urgent Care Benefit

Effective May 1, 2023, the copayment for urgent care will be reduced from \$70 to \$20 per visit.

3. No Surprises Act

Under the No Surprises Act, you will not be subject to surprise or balance billing when you receive the following types of care:

- Emergency care; or
- Treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center.

Balance Billing (sometimes called “surprise 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 the Plan's network.

“Out-of-network” describes providers and facilities that haven’t signed a provider agreement with Independence Blue Cross. Out-of-network providers may be permitted to bill you for the difference between what the 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 the Plan’s in-network cost-sharing amount (such as deductibles, 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 balance 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 the 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 the 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). The Plan will pay out-of-network providers and facilities directly.
- The Plan will:
 - 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 the Plan 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 under the Plan.

No Surprises Act Claims – Appeal Rights

Should you have a claim denied for coverage or payment in the manner described above for emergency services or non-emergency services performed at an in-network facility by an out-of-network provider, you may appeal the matter to the Board of Trustees.

If the Board of Trustees denies your claim appeal involving a claim covered by the No Surprises Act, you may elect to have that adverse appeal determination reviewed by an External Third-Party Review.

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During the period of the Public Health Emergency, coverage for COVID-19 related testing, treatment and vaccinations was required to be provided with no member cost sharing. The Public Health Emergency will end on May 11, 2023. Effective May 12, 2023, coverage will revert back to the standard level in place prior to the Public Health Emergency. These changes are listed below:

1. Testing provided by a medical professional will be subject to the applicable copayment based on place of service, both in-network and out-of-network.
2. Over the counter testing kits will no longer be covered under the Plan.
3. Coverage for COVID-19 vaccinations will be covered in the same manner as all other vaccinations.
4. Coverage for antiviral treatment of COVID-19 will be covered in the same manner as all other antiviral prescription treatments.

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