# PLAN SUMMARIES OF MATERIAL MODIFICATION

# 2021-2024


MASSACHUSETTS
LABORERS' BENEFIT FUNDS

# MASSACHUSETTS LABORERS' HEALTH & WELFARE FUND

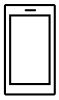
P.O. Box 1501, 1400 District Avenue, Suite 200
Burlington, Massachusetts 01803
Telephone (781) 272-1000 • Toll Free (800) 342-3792 • Fax (781) 238-0703 • claims@mlbf.org


## Important Information Regarding Changes to your Health Plan

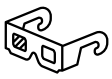
**Si necesita esta información en español, comuníquese con la Oficina del Fondo al 721-272-1000**

**Effective July 1, 2021,** the following benefit changes will be implemented:

**Oncology Utilization Management**: In order to ensure that our members are receiving the best and most appropriate care for their cancer diagnosis, any NEW treatment plan for cancer care, including chemotherapy and radiation treatment will require prior authorization from The Telligen Cancer Care program. If you or a covered family member are struggling with a cancer diagnosis, contact Telligen to receive support and guidance from a dedicated Oncology nurse. You can reach the Telligen Cancer Care Program at 1-833-226-7275.



**Telehealth Copayments:** All Non-covid related medical and behavioral health care received via telehealth will now be paid the same as an office visit. Deductible, coinsurance, and copayments will apply to these services the same as if the services were received in the office. Telehealth visits with WellConnection providers will continue to have no out of pocket cost. WellConnection can be accessed through the Blue Cross/Blue Shield of Massachusetts "MyBlue" app. Download the My Blue app and access 24/7 virtual care at no cost to you.



**Safety Glasses:** You can now receive prescription safety glasses through your Davis Vision benefits. Safety Glasses are available in addition to your regular prescription glasses once every 2 years for members only. The vision benefit is available once every two years only. You can not receive the safety glasses separately if you have already received your regular exam and glasses. All services must be obtained at the same time from a participating Davis provider.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Trust Agreement No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan.

MASSACHUSETTS
# LABORERS' HEALTH & WELFARE FUND

July 2021

**Important information regarding changes to your Prescription Drug Plan**

As you know, Express Scripts (ESI) is the Fund's Pharmacy Benefit Manager (PBM). Beginning July 1, 2021, the Fund is partnering with Express Scripts and Save On SP, LLC (**SaveonSP),** to help you and the Fund save money on specialty medications. This notice describes the SaveonSP program and serves as a Summary of Material Modification to the Fund's Summary Plan Description (SPD).

**SaveonSP Program General Overview**

The SaveonSP program saves you and the Fund money on certain specialty medications through use of manufacturer copayment assistance programs. If you are prescribed a specialty drug that is part of the SaveonSP program and you enroll and participate, your cost share will be paid through the drug manufacturer's copay assistance program and you will pay nothing ($0).

If you are prescribed a specialty drug that is part of the SaveonSP program and you do not participate in the program, the specialty drug will be subject to an increased cost share as listed on the SaveonSP program's current *Non-Essential Health Benefit Specialty Drug List*, and the cost share will not count towards your out-of-pocket maximum.

**Enrollment in the Program**

If you are currently taking (or prescribed in the future) a medication on the program's *Non-Essential Health Benefit Specialty Drug List*, copy available via the Fund Office, you will be contacted by SaveonSP about enrolling in the program. If you don't hear from SaveonSP you can call SaveonSP at 1-800-683-1074 or call the Fund Office.

**Important: Enrollment in the program is voluntary, but if you do not enroll, your cost share for any participating specialty drug will increase significantly.** Specifically, if you choose not to enroll and participate in the SaveonSP program, you will be charged the full Co-payment listed on the SaveonSP program's current Non- Essential Health Benefit Specialty Drug List for a participating specialty drug. The Co-payment amount can be significant and will not count towards your out-of-pocket maximum. However, if you enroll in the SaveonSP program, your full cost share for the participating specialty drug will be paid through the drug manufacturer's copay assistance program and you will pay nothing.

**Specialty Drugs Exclusive Pharmacy Reminder**

PO Box 1501
1400 District Avenue
Suite 200
Burlington, MA 01803

(781) 272-1000
(800) 342-3792

(781) 238-0703

claims@mlbf.org

mlbf.org

Accredo, ESI's partner specialty pharmacy, is the Fund's exclusive Specialty Network and Specialty drugs must be obtained through Accredo. Prior authorization is required for most Specialty drugs. If a drug for which prior authorization is required is obtained without prior authorization the claim is treated as an out-of-network claim.

If you obtain a specialty drug from an out-of-network pharmacy, including your physician's office or hospital, the plan will only cover the prescription if there has been prior authorization based on a determination that the prescription could not reasonably be filled at a network pharmacy. When you purchase a specialty medication from an out-of-network provider with prior authorization, the allowed amount will be the amount that would have been covered if the medication had been purchased through Accredo. Costs above the allowed amount are not applied to your out-of-pocket maximum.

Covered Individuals receiving Specialty medications at a facility such as a nursing home or convalescence home should call the Fund Office. If you have any further questions or concerns, please contact the Fund Office at 800-342-3792.

Sincerely,

Board of Trustees

MASSACHUSETTS LABORERS' HEALTH & WELFARE FUND
P.O. Box 1501, 1400 District Avenue, Suite 200
Burlington, Massachusetts 01803
Telephone (781) 272-1000 • Toll Free (800) 342-3792 • Fax (781) 238-0703 • claims@mlbf.org

**Important Information Regarding Dependent Eligibility**

**Si necesita esta información en español, comuníquese con la Oficina del Fondo al 721-272-1000**

**RE: Coverage for Ex-Spouses**

In an effort to ensure that Plan assets are being used for Participants and their beneficiaries only, The Board of Trustees has made a change to the way that an ex-spouse can be covered by the Plan.

## Effective 01/01/2022 Coverage will only be continued for an ex-spouse of a Plan Participant in accordance with federal COBRA regulations.

COBRA allows for 36 months of coverage from the date of divorce. The current monthly COBRA premium will apply. Ex-spouses currently covered under the plan can only elect COBRA continuation coverage for the remainder of the 36 months from the date of divorce.

Ex-spouses currently covered under the plan that are no longer eligible for COBRA continuation coverage (date of divorce was greater than 36 months ago) will no longer be eligible dependents under the Plan and will need to look elsewhere for coverage. Coverage may be available through their own employer, Medicaid, or the Health Insurance Marketplace at www. Healthcare.gov.

All covered ex-spouses that are qualified for COBRA continuation coverage should receive an election packet with additional information on how to continue coverage and what the costs are.

If you have any questions regarding this information, please feel free to contact the Eligibility Department at 781-272-1000.

Sincerely,
The Board of Trustees

MASSACHUSETTS LABORERS' HEALTH & WELFARE FUND
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Burlington, Massachusetts 01803
Telephone (781) 272-1000 • Toll Free (800) 342-3792 • Fax (781) 238-0703 • claims@mlbf.org

**Date:** December 2022

**To:** Massachusetts Laborers' Health and Welfare Fund Participants, including COBRA Beneficiaries

**From:** The Board of Trustees

**Re:** Summary of Material Modification (SMM) to the Health and Welfare Fund

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**This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

## IMPROVEMENTS TO BENEFITS FOR CERTAIN SERVICES FROM OUT-OF-NETWORK PROVIDERS
## Effective January 1, 2022

The No Surprises Act (NSA) was signed into law in December 2020. The NSA protects patients who receive emergency services at a hospital or at an independent freestanding emergency department and from air ambulances. In addition, the NSA protects patients who receive non-emergency services from an Out-of-Network Provider at an in-network Health Care Facility. Effective January 1, 2022, participants receiving these services will only be responsible for paying their in-network cost-sharing and cannot be balance billed by the provider or facility for these services.

The Board of Trustees is pleased to announce that, effective January 1, 2022, the Fund is implementing several improvements to the Plan to comply with the NSA as discussed below. Capitalized terms are defined in the section labeled "NEW/REVISED DEFINITIONS OF THE PLAN" at the end of this SMM.

### 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 an in-network provider or an in-network emergency facility, as applicable, with respect to the services;

- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and in-network emergency facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by an in-network provider or an in-network emergency facility;
- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost-sharing payments made by the participant with respect to out-of-network Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network 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 an in-network provider or an in-network emergency facility.

The participant's cost-sharing amount for Emergency Services from Out-of-Network Providers will be based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

**Non-Emergency Items or Services from an Out of-Network Provider at an In-Network Health Care 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 an Out-of-Network Provider at an in-network Health Care 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 an in-network provider.
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services were equal to the Recognized Amount for the items and services.
- By counting any cost-sharing payments made by the participant 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 an in-network provider.
- Non-emergency items or services performed by an Out-of-Network Provider at an in-network Health Care Facility will not be covered if:

    ✓ 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 is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Plan, of the estimated charges for the treatment and any advance limitations that the Plan may put on the treatment, of the names of any in-network providers at the facility who are able to treat the participant, and that the participant may elect to be referred to one of the in-network providers listed; and

- ✓ The participant gives informed consent to continued treatment by the Out-of-Network Provider, acknowledging that the participant understands that continued treatment by the Out-of-Network Provider may result in greater cost to the participant.

- The notice and consent exception 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 Out-of-Network 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 an in-network provider,
  - ✓ With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and
  - ✓ With cost-sharing counted toward any in-network deductible and in-network out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an in-network provider.

The participant's cost-sharing amount for Non-emergency Services performed at an in-network Health Care Facility by Out-of-Network providers will be based on the lessor of billed charges from the provider or the QPA.

**Air Ambulance Services**

If a participant receives Air Ambulance services that are otherwise covered by the Plan from an Out-of-Network Provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from an Out-of-Network 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 an in-network provider.
- In general, a participant cannot be balance billed for these items or services. Participant cost-sharing will be calculated as if the total amount that would have been charged for the services by an in-network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments a participant makes with respect to covered Air Ambulance services will count toward the in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider.

**External Review**

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by an Out-of-Network Provider at an in-network Health Care Facility, and/or Air Ambulance service, as covered under the NSA, is eligible for External Review.

**Continuity of Coverage**

If a participant is a Continuing Care Patient, and the network contract with the in-network provider or facility terminates, or the participant's benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan:

1. The participant will be notified in a timely manner of the contract termination and of the participant's right to elect continued transitional care from the provider or facility; and
2. The participant will be allowed up to ninety (90) days of continued coverage at in-network cost-sharing to allow for a transition of care to an in-network provider.

**Incorrect Provider Directory Information**

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.

The provider directory will be updated and verified at least every ninety (90) days. If a participant obtains and relies upon incorrect provider directory information about whether a provider is an in-network provider from the Plan or its administrators, the Plan will apply the in-network cost-sharing to the claim, even if the provider was an Out-of-Network Provider.

**Complaint Process**

If a participant believes they've been wrongly billed, or otherwise has a complaint under the No Surprises Act, the participant may contact the Fund Office or file the complaint at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing or call 1-800-985-359.

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

**Air Ambulance** means medical transport 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, for patients.

**Ancillary services** are, with respect to an in-network 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 federal regulation; and
- Items and services provided by an Out-of-Network Provider if there is no in-network provider who can furnish such item or service at such facility.

**Cost-sharing** means the amount a participant 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 Out-of-Network providers, or the cost of items or services that are not covered under the Plan.

**Cost-sharing Amount** for Emergency and certain Non-emergency Services at an in-network Health Care

Facility performed by an Out-of-Network Provider, and air ambulance services from an Out-of-Network Provider will be based on the Recognized Amount.

**Continuing Care Patient** means an individual who, with respect to a provider or facility.

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;

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

3. 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;

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

5. 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** 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 an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant is able to travel using nonmedical transportation or nonemergency medical transportation; or

- The participant is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on treatment, of the names of any in-network providers at the facility who are able to treat the participant, and that the participant may elect to be referred to one of the in-network providers listed; and

- The participant gives informed consent to continued treatment by the Out-of-Network Provider, acknowledging that the participant understands that continued treatment by the Out-of-Network Provider may result in greater cost to the participant.

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

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. 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 federal No Surprises Act (Public Law 116-260, Division BB).

**Out-of-Network Health Care 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 the Plan, with respect to the furnishing of an item or service under the Plan or coverage respectively.

**Out-of-Network Provider** means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

**Out-of-Network Rate** with respect to 1) Emergency Services provided by an out of-network provider, facility, or Independent Freestanding Emergency Department, 2) non-emergency services furnished by an Out-of-network provider at an In-network Health Care Facility, and 3) Air Ambulance Services by an out-of network provider, the term "Out-of-Network Rate" means one of the following in order of priority:

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

**Qualifying Payment Amount (QPA)** means the amount calculated using the methodology described in 29 CFR 716-6(c).

**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 (QPA)

For air ambulance services furnished by Out-of-Network providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

**Serious and Complex Condition** means with respect to a participant, dependent, 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 –

    - ✓ life-threatening, degenerative, potentially disabling, or congenital; and
    - ✓ requires specialized medical care over a prolonged period of time.

**Termination** includes, with respect to the Continuation of Care benefit, 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 Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, you may call the Fund Office at (781) 272-1000 or (800) 342-3792.

**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 these Plan changes, please contact the Fund Office.**

*In accordance with ERISA reporting requirements, this announcement serves as your Summary of Material Modifications to the Plan.* It is intended to be a brief summary of the plan change. It cannot describe each and every Plan provision that may be relevant to your situation. You should always refer to your plan Rules and Regulations for the full details of your Plan. You should keep all Important Plan Benefit Change announcements with your Summary Plan Description so it contains up-to-date information. Receipt of this announcement does not validate your eligibility under the Plan. You should always call the Fund Office to verify your eligibility prior to any service.

# MASSACHUSETTS LABORERS' HEALTH & WELFARE FUND

P.O. Box 1501, 1400 District Avenue, Suite 200
Burlington, Massachusetts 01803
Telephone (781) 272-1000 • Toll Free (800) 342-3792 • Fax (781) 238-0703 • claims@mlbf.org


**This notice contains important information regarding your health care benefits**

Date: February 20, 2022

To: Participants of the Massachusetts Laborers' Health and Welfare Fund

From: The Board of Trustees

RE: At-Home COVID Test Kits

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The Massachusetts Laborers' Health & Welfare Fund has partnered with Express Scripts, to cover FDA-approved over the counter COVID-19 testing kits with no out of pocket costs and no prescription required effective January 15, 2022.

Each covered family member may purchase up to eight (8) tests per month (multi test packs count as multiple tests). These tests must be for personal use and may not be used for employment purposes.

**How to get free at-home tests:**

**Federal Government:** With the help of the United States Postal Service, households can request four (4) tests to be delivered for free. To learn more and order at-home tests, visit www.covidtests.gov.

**Retail Pharmacy:** Present your Express Scripts ID card at any participating pharmacy counter (not the regular checkout lane). Your tests will be processed with a $0 copay.

**Mail Order Pharmacy**: Log in or register at Express-scripts.com and click on the "Order At-home COVID-19 tests" quick link. Due to limited supplies, your tests make take 4 weeks to arrive.

**Non- Participating retailer**: You can submit a claim for reimbursement for FDA approved tests purchased on-line or in store to Express Scripts. Reimbursement will be capped at $12/per test.

You can find a detailed description of how Express Scripts will be administering this benefit, as well as a reimbursement form at www.mlbf.org, or by visiting the Express Scripts COVID-19 Resource center at www.express-scripts.com/covid-19/resource-center.

If you have any questions regarding the information in this notice, please contact the Fund Office.

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The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan documents are at the Fund Office and may be inspected by you free of charge during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and/or factual, arising under the Plan.

# MASSACHUSETTS LABORERS' HEALTH & WELFARE FUND

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**Important Information Regarding Changes to your Health Plan**

**Effective April 6, 2023,** the following benefit changes will be implemented:

**Improvement to your Vision Plan:** You are now able to split the benefits for your eye examination and eyeglasses (or contact lenses). You are no longer required to receive your exam and materials on the same date and from the same provider. This allows added flexibility if, for instance, your optometrist carries a limited selection of frames. By way of reminder, the vision benefit is still available once every 24 months for patients 19 and over, and once every 12 months for patients up to age 19. All services must be obtained from a participating Davis provider.

**Improvement to Genetic Testing benefit:** The Board of Trustees has removed the $2,500 annual maximum for genetic testing. By way of reminder, the genetic testing must still be FDA approved and medically necessary, and the results of the test(s) must directly impact clinical decision making. All tests need to meet Cigna Medical Coverage Policy Criteria. Prior authorization from Cigna is required for many genetic tests. Your ordering physician should contact Cigna at 1-855-274-8383 to determine if authorization is required.

**Effective May 12, 2023,** the following benefit change will be implemented:

**Over the Counter Covid-19 Tests**: Due to the end of the Covid emergency period, the Fund will no longer provide coverage for over-the-counter Covid tests. The Fund will still provide coverage for medically necessary tests ordered by a physician and administered at an in-network laboratory.

If you have any questions regarding these changes, please call the Fund office at 781-272-1000, ext. 202.

Para servicios de traducción, comuníquese con la oficina del Fondo al 781-272-1000, extensión 205.
Para serviços de tradução, entre em contato com o escritório do Fundo pelo telefone 781-272-1000, ramal 205.
Código SMM

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Trust Agreement No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan.

MASSACHUSETTS

# LABORERS' HEALTH & WELFARE FUND

**Important Information Regarding Changes to your Health Plan**

**This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

**Effective January 1, 2024,** the following changes to your health benefits will be implemented:

**Applied Behavior Analysis (ABA):** The limit on coverage of ABA services for autism spectrum disorder to individuals under age 18 has been removed. Medically necessary in-network services with prior authorization from HMC Healthworks (Uprise Health) will be covered regardless of patient age. There is no coverage for out-of-network services. For authorization, or to locate a provider, contact HMC at 1-800-522-6763.

**Treatment for Gender Dysphoria:** The Board of Trustees has removed the exclusion for services related to surgery to treat gender dysphoria. All medically necessary treatment for gender dysphoria will be covered in accordance with Cigna's Medical Coverage Policy guidelines. There is no coverage for out-of-network services. To locate a provider, register and log on to MyCigna.com.

**Habilitative Therapy**: All coverage for outpatient habilitative physical and occupational therapy was previously subject to a combined benefit maximum of 60 visits per calendar year. The visit limit will now be waived for medically necessary treatment of a mental health or substance use disorder. The visit limit remains for treatment of any other medical diagnosis. There is no coverage for out-of-network services. To locate a provider, register and log on to MyCigna.com.

**Prescription Medication**: The Board has eliminated all internal authorization requirements for medications to treat substance use disorder. For all prescription medications, the Fund will follow Express Scripts prior authorization policies. Contact Express Scripts at 800-467-2006 with any questions.

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**Biofeedback**: Outpatient biofeedback was previously included with homeopathy, naturopathy, oriental medicine, and massage therapy, in the combined benefit maximum of 40 visits per calendar year. Outpatient biofeedback is no longer subject to any visit limit. There is no coverage for out-of-network services. To locate a provider, register and log on to MyCigna.com.

**Nutritional Counseling**: The 12-visit calendar year maximum for medical nutritional counseling has been removed. Medically necessary nutritional counseling visits will be covered with no visit limit. There is no coverage for out-of-network services. To locate a provider, register and log on to MyCigna.com.

**Out-of-Network Emergency Transportation**: Coverage for out-of-network emergency medical ground transportation will no longer be limited to the reasonable and customary amount. Coverage will be provided at 80% of billed charges. Members will still be responsible for 20% coinsurance. Coverage is not provided for non-emergency transport.

**Enhancements to Dental Benefits:** The following enhancements will be made to your Delta Dental benefits:

- Coverage of medically necessary bone grafts at excision/implant site has been added to your dental benefit. This is a major restorative procedure covered at 50% of the allowed amount (applies to Plan A coverage only).
- The frequency of coverage for medically necessary periodontal cleanings has been changed from once every three months to four times per calendar year.
- The limitation on coverage of fluoride treatments to individuals up to age 19 will be eliminated, and fluoride treatments will now be covered under the preventive benefit with no age limit.
- The age limit for preventive sealants has been increased from age 15 to age 19.

If you have any questions regarding these changes, please call the Fund office at 781-272-1000, ext. 202.

Para servicios de traducción, comuníquese con la oficina del Fondo al 781-272-1000, extensión 205. Código SMM 2024
Para serviços de tradução, entre em contato com o escritório do Fundo pelo telefone 781-272-1000, ramal 205. Código SMM 2024

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*In accordance with ERISA reporting requirements, this announcement serves as your Summary of Material Modifications to the Plan.* It is intended to be a brief summary of the plan change. It cannot describe each and every Plan provision that may be relevant to your situation. You should always refer to your plan Rules and Regulations for the full details of your Plan. You should keep all Important Plan Benefit Change announcements with your Summary Plan Description, so it contains up-to-date information. Receipt of this announcement does not validate your eligibility under the Plan. You should always call the Fund Office to verify your eligibility prior to any service.

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# LABORERS' HEALTH & WELFARE FUND

**Date:** October 01, 2023

**To:** Massachusetts Laborers' Health and Welfare Fund Participants

**From:** The Board of Trustees

**Re:** Summary of Modification (SMM) to the Health and Welfare Fund

**This information is** important **to you and your dependents.** Please take the time to read it carefully.

A new eligibility rule is being added to the Plan's Summary Plan Description effective January 1, 2024.

***If you are a bargaining unit member of the Massachusetts and Northern New England Laborers' District Council (i.e., a Laborer), this change will not affect your eligibility. You are simply receiving notice of this plan change as required by law.***

**Eligibility for Non-Bargained Employees of Contributing Employers**

Beginning January 1, 2024, coverage under the Plan will be available to certain employees of contributing employers who are not covered by a collective bargaining agreement with the Massachusetts and Northern New England Laborers' District Council.

Non-bargained employees of contributing employers will be eligible for coverage if:

- You work for a contributing employer that contributes to the Fund under a Participation Agreement covering non-bargained employees;
- You work at least 30 hours per week;
- You work in the Fund's geographic jurisdiction (Maine, New Hampshire, Vermont, and/or Massachusetts);
- Your employer submits an application for coverage that is approved by the Trustees

If you are eligible, your spouse and/or dependent(s) may also be eligible for coverage under the existing dependent eligibility rules of the Fund. You must provide enrollment documents for your eligible dependents within 90 days of your effective date of coverage.

The following additional rules apply for non-bargained employees:

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- Your coverage will begin on the first day of the month after a completed enrollment form is received from your employer and approved by the Fund.
- Your coverage will terminate on the first day of the month following the earliest of:
    - Your death;
    - Your termination of employment;
    - The participation agreement between your employer and the Fund is terminated; and/or
    - Your employer's collective bargaining agreement with Massachusetts and Northern New England Laborers' District Council terminates.
- Please note that the Fund may terminate coverage of your employer from this program if it fails to make any contributions owed to the Fund as required under a binding participation agreement and/or collective bargaining agreement.
- Your coverage includes:
    - Medical benefits;
    - Prescription drug benefits;
    - Member Assistance Program;
    - Dental benefits; and
    - Vision care benefits.
- Your coverage **does not** include weekly accident and sickness benefits, life insurance benefits, accidental death and dismemberment benefits, or retiree benefits.
- You may **opt out** of coverage if you have proof of coverage elsewhere. If you opt out, you will be permitted to enroll by providing documentation to the Fund of a qualifying event under the Plan within thirty (30) days of such qualifying event, or by decision of the Fund Trustees, which decision the Trustees may make in their sole discretion.

The Trustees reserve the discretion to change or eliminate the terms of coverage for non-bargained employees at any time. This may include declining to cover an otherwise eligible individual and/or terminating coverage of an otherwise eligible individual, at any time and in the Trustees' sole discretion.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, you may call the Fund Office at (781) 272-1000 or (800) 342-3792.

**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 these Plan changes, please contact the Fund Office.**

*In accordance with ERISA reporting requirements, this announcement serves as your Summary of Material Modifications to the Plan.* It is intended to be a brief summary of the plan change. It cannot describe each and every Plan provision that may be relevant to your situation. You should always refer to your plan Rules and Regulations for the full details of your Plan. You should keep all Important Plan Benefit Change announcements with your Summary Plan Description so it contains up-to-date information. Receipt of this announcement does not validate your eligibility under the Plan. You should always call the Fund Office to verify your eligibility prior to any service.