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Wisconsin Laborer's Health Fund
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ANNOUNCING IMPORTANT CHANGES TO THE PLAN

Date: December 2022

To: Active Employees, Non-Medicare-Eligible Retired Employees, and Their Eligible Dependents Participating in the Wisconsin Laborers' Health Fund

From: The Board of Trustees

As the Board of Trustees of the Wisconsin Laborers' Health Fund (the Fund or Plan), we are pleased to announce new changes to the Plan. This letter provides a summary of 5 changes to the Plan. In the near future, you will receive more detailed information on these changes. This notice also updates the summary of benefits and coverage for the coverage period September 1, 2022, to August 31, 2023. Please file this letter with your Plan-related documents for easy reference.

Change Number 1: DOT Physical Exam Coverage – effective August 29, 2022

The Plan now covers Department of Transportation physical exams as a preventive care service. This means the Regular Plan will cover 100% of the exam, when provided by an in-network provider, without application of your deductible. The Bare Bones Plan will cover the DOT physical exam as a preventive service by an in-network provider at 30% coinsurance after the deductible is met through December 31, 2022. Beginning January 1, 2023, the Bare Bones Plan will cover 100% of the exam, consistent with other preventive care changes (see Change Number 3 below for more information).

Change Number 2: No Surprises Act – effective September 1, 2022

The No Surprises Act includes rules to protect you from surprise balance billing (balance bills are what non-network providers or facilities can charge you even if after you pay your deductible, copayment or coinsurance – also known as your "cost-sharing" amounts). Under these new rules, non-network providers can no longer send you these surprise balance bills in the following situations:

- Emergency services (not including ground ambulance services) from a non-network provider, facility, or air ambulance. This includes services you receive after you are in stable condition. An "emergency medical condition" means a medical condition so severe that a prudent layperson could reasonably expect that the absence of immediate medical attention to result in serious impairment to bodily functions or placing your health in serious jeopardy.
- When you receive certain services, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon services, hospitalist services, or intensivist services, from a non-network provider at a network hospital or ambulatory surgical center.

When balance billing is not allowed:

- You will pay only network cost-sharing amounts.
- Your cost-sharing amounts will be based on what the Fund would pay for the services had they been provided by a network provider.
- What you pay will count toward your network deductible and out-of-pocket limit.
- If the Fund denies a claim for a service protected from balance billing, you can submit the claim for external review at the end of the Fund's appeal process. Any such request for external review must

be received by the Fund Office no later than four months following the date your appeal was denied by the Trustees.

Non-network providers can ask you to give up your balance billing protections for post-stabilization services and other services you may receive from a non-network provider at a network hospital or ambulatory surgical center.

In addition to the balance billing protection, the No Surprises Act also provides the following protections for you:

- If a network provider or facility leaves the Anthem network, you may be able to receive care as if the provider or facility was still a network provider for up to 90 days so that you have time to transition to a network provider. You will have this option if you are inpatient, scheduled for nonelective surgery, or receiving care for a pregnancy, serious and complex condition, or terminal illness when your provider or facility leaves the Anthem network.
- If you can show that you received inaccurate information from Anthem that a provider was a network provider, then you will pay network cost-sharing for that claim. However, note that the non-network provider may still balance bill you for that claim.

Change Number 3: Affordable Care Act Changes – effective January 1, 2023

The Plan has considered itself to be a "grandfathered" health plan for purposes of Affordable Care Act compliance since March 2010. This means that the Plan has been complying with some, but not all, Affordable Care Act requirements. Effective as of January 1, 2023, the Trustees have decided to treat the Plan as "non-grandfathered," which means that the Plan will comply with all applicable Affordable Care Act requirements. For example, effective January 1, 2023:

- The out-of-pocket maximum for the Regular Plan and Retiree Plan is $4,500 per person or family for in-network providers and $10,000 per person or family for out-of-network providers. The out-of-pocket maximum for the Bare Bones Plan is $6,600 per person and $13,200 per family for in-network providers and $25,000 per person or family for out-of-network providers. Covered medical expenses, including copayments, deductibles and organ transplant expenses, are applied to the out-of-pocket maximum.
- Your prescription drug copayments will now count toward a separate prescription drug out-of-pocket maximum. For the Regular Plan and Retiree Plan, the prescription drug out-of-pocket maximum is $4,600 per person and $13,700 per family. For the Bare Bones Plan, the prescription drug out-of-pocket is $2,500 per person and $5,000 per family. Only prescription drug copayments will count toward the prescription drug out-of-pocket maximum.
- Preventive services for the Bare Bones Plan are now covered at 100% when provided by in-network providers. Additionally, the Plan covers all preventive services with an A or B recommendation from the United States Preventive Task Force, services described in guidelines from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Health Resources and Services Administration guidelines for children and women. For more information on what preventive care services are covered, you can visit www.healthcare.gov.
- If your appeal for health benefits is denied for reasons involving medical judgment (for example, medical necessity or experimental/investigational reasons), you may be able to request an external review from an independent review organization. Any request for external review must be received by the Fund Office within four months from the date of the notice from the Trustees that your appeal is denied.

Additionally, the out-of-network mental health and substance use disorder inpatient treatment coinsurance is changed to the standard out-of-network coinsurance. This means that you will pay 40% coinsurance for these services.

Change Number 4: Prescription Drug Provider Changes – effective January 1, 2023

Also effective January 1, 2023, the Plan's prescription drugs will be provided through Express Scripts (or "ESI"). **You will be receiving new ID cards** with the updated prescription drug information soon. For the most part, your prescription drug coverage is not changing. **Your copays are not changing.** You will continue to pay:

30 day supply – retail pharmacy (including Walgreens)	You pay:
• Generic Prescription	$8
• Formulary Brand Name Prescription*	$25
• Non-formulary Brand Name Prescription*	$40
31-90 day supply – mail order or Walgreens	
• Generic Prescription	$16
• Formulary Brand Name Prescription*	$50
• Non-formulary Brand Name Prescription*	$80
* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.	

A few changes that will be implemented include:

- 90-day fills of long-term maintenance (non-specialty) medications will be available through Walgreens or the ESI Mail Order Pharmacy. As a reminder, you can obtain 1 initial fill and 2 refills of a 30-day supply but then you must obtain 90-day supply.
- Preventive care medications are covered at 100%.
- The Plan no longer uses the "high impact advocacy program."

Call ESI at 888-208-4492, go online at www.express-scripts.com, or download the Express Scripts mobile app for more information and to confirm drug coverage.

Change Number 5: Retiree Health Coverage Changes – effective January 1, 2023

If you are a non-bargained Employee, you no longer need to begin drawing your Social Security benefits to enroll in retiree health coverage. You may purchase retiree coverage through the Health Fund if you have been eligible for Health Fund benefits for the four-year period immediately before your retirement.

Questions?

If you have questions about the changes described in this letter or would like more information about Plan eligibility or the Fund's health benefits in general, contact the Fund Office at the address and telephone number shown at the top of this Notice.