Washington-Idaho Operating Engineers-Employers Health & Security Trust Fund

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Administered by
Welfare & Pension Administration Service, Inc.

March 19, 2021

TO: All Participants and Eligible Dependents
Washington-Idaho Operating Engineers-Employers Health and Security Trust Fund

RE: Dialysis Benefit Changes and Gene and Cellular Therapy Coverage-
Effective January 1, 2021

This is a Summary of Material Modification ("SMM") describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description Booklet.

The Board of Trustees of the Washington-Idaho Operating Engineers-Employers Health & Security Trust Fund (the "Plan") has made recent changes to the benefits available under the Plan. For the Dialysis Benefit, this notice updates and replaces the benefit provision previously described in a Summary of Material Modification dated October 2015, effective June 1, 2015. All provisions of the existing Summary Plan Description and Plan not modified or amended herein remain in full force and effect.

As always, we encourage you to use a PPO Participating Provider to receive the highest level of benefits. PPO Providers have agreed to accept the PPO allowed amount as payment in full, and cannot bill you for charges beyond your deductible, co-insurance and co-pays. Unlike PPO Providers, Non-PPO Providers may also balance bill you for their billed charges in excess of the Usual and Customary Charge allowed by the Plan.

DIALYSIS BENEFIT

If you or your covered dependent is receiving outpatient dialysis treatment for any reason, **the following benefits will apply for dialysis services and supplies received on or after January 1, 2021** (please note, benefits for inpatient dialysis treatment are provided under the Inpatient Hospital Services provisions of the Plan):

A. Initial Outpatient Treatment Period – The first 120 days of your dialysis treatment:

- Benefits for network and non-network providers will be paid subject to the medical deductible and coinsurance provisions of the Plan. Benefits for network providers will be based on the provider's network contracted rate and benefits for non-network providers will be based on the Usual and Customary Charge as defined by the Plan.

B. Supplemental Outpatient Treatment Period – If you continue to require dialysis beyond the Initial Outpatient Treatment Period:

- Benefits for dialysis services and supplies received from a network provider will be paid at 100% of the network contracted rate and will not be subject to the medical deductible or coinsurance provisions of the Plan.
- Benefits for dialysis services and supplies received from a non-network provider will be paid at 150% of the current Medicare Allowed Amount and will not be subject to the medical deductible or coinsurance provisions of the Plan. Please note, you will be responsible for any billed charges above 150% of the Medicare Allowed Amount (see Additional Information below).
- Under the Plan's Coordination of Benefits (COB) provisions, for both network and non-network providers, when Medicare is the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare Parts A and B, regardless of whether you are enrolled under both of these parts.

Additional Information

If you are receiving dialysis, your diagnosis may make you eligible for Medicare coverage. Although you are not obligated by the Plan to apply for Medicare Part A and/or Part B, it is important to note that **enrolling in Medicare coverage may protect you from balance billing by providers of dialysis services**.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, Members are required to provide the Administration office with the first date of eligibility for Medicare Coverage. In addition, **it is highly recommended that members requiring dialysis treatment contact the Trust's medical management vendor, Innovative Care Management (ICM) at (800) 862-3338.** The ICM Case Management nurse can assist you in understanding your care options and how services will be covered by the Plan and/or Medicare.

For purposes of this benefit, the Medicare Allowed Amount is the amount that a Medicare contracted provider agrees to accept as full payment for the covered service.

For purposes of this benefit, a network provider is defined as a provider who has a contract with Premera Blue Cross in Washington, Premera Blue Cross Blue Shield of Alaska or a local Blue Cross and/or Blue Shield licensee in other areas that are part of the BlueCard Program.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of dialysis services. The contract may allow for a payment arrangement for dialysis services different than outlined above.

GENE AND CELLULAR THERAPY

Effective January 1, 2021, the Plan will cover medically necessary Gene and Cellular Therapy services from an approved facility and/or provider. Benefits are subject to all applicable Plan terms, including deductibles, coinsurance, annual out-of-pocket maximums, and general Plan limitations and exclusions. To be covered, Gene and Cellular Therapy services must be provided by a facility or provider that is in the Plan's PPO network or has otherwise been approved by the Plan.

Gene and Cellular Therapy services require pre-certification under the Plan's Utilization Management Program as outlined in the Plan's Summary Plan Description. Pre-certification of Gene and Cellular Therapy services is required regardless of whether an inpatient hospital stay is necessary. To pre-certify services, you or your provider should contact the Plan's Utilization Management Program,

Innovative Care Management (ICM), at (800) 862-3338. The pre-certification requirement does not apply to widely available mRNA based vaccines authorized by the FDA, such as vaccines for COVID-19.

Gene and Cellular Therapy includes gene and cellular based therapy techniques that modify and/or use a person's genes or cells to treat or cure disease. Gene Therapy, as defined by the Plan, includes medically necessary gene and cellular based therapies provided by an approved Physician, Hospital or other Provider. These therapies may include, but are not limited to:

- Cellular immunotherapies;
- Genetically modified oncolytic viral therapy;
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions;
- All human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
    - o Luxturna® (Voretigene neparvovec)
    - o Zolgensma® (Onasemnogene abeparvovec-xioi)
    - o Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9;
- Oligonucleotide-based therapies. Examples include:
    - o Antisense. An example is Spinraza (Nusinersen)
    - o siRNA
    - o mRNA
    - o microRNA therapies

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (800) 351-6480, option 1. Please also refer to the Trust website for additional notices: www.wa-idengineerstrustfunds.com.

Grandfathered Plan

The Board of Trustees believe the Washington-Idaho Operating Engineers-Employers Health and Security Trust Fund Health Benefit Plan (the "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 at: Board of Trustees, WA-ID Operating Engineers-Employers Health and Security Trust c/o WPAS, Inc., PO Box 34203, Seattle, WA 98124-1203, or by phone at 1-800-351-6480. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families. This Website has a table summarizing which protections do and do not apply to grandfathered health plans.

Board of Trustees
Washington-Idaho Operating Engineers-Employers Health and Security Trust Fund

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