Warehouse Employees Union Local No. 730
Health & Welfare Trust Fund

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Summary of Material Modifications

December 2021

The Board of Trustees of the Warehouse Employees Union Local No. 730 Health & Welfare Fund ("Fund") is pleased to announce that it has amended the Summary Plan Description ("SPD") to comply with the No Surprises Act, included in the Consolidated Appropriations Act, 2021. Please keep this document with your SPD and your Summary of Benefits and Coverage ("SBC").

Effective January 1, 2022, the SPD will be modified as follows:

1. **First Change**

The following notice is inserted on page 32 of the SPD:

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "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 your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your 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 your plan's in-network cost-sharing amount (such as 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 balanced 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 your 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 <u>never</u> 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 your 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). Your health plan will pay out-of-network providers and facilities directly.

- The Fund will generally:

    - 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 it 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.

Beginning January 1, 2022, if you believe you've been wrongly billed, you may contact the Department of Health and Human Services (HHS) at 1-800-985-3059 or the Fund Office.

Visit https://www.cms.gov/nosurprises/consumers or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws for more information about your rights under federal law.

2. **Second Change**

The following language is inserted on page 50 of the SPD:

Continuing Care Patients

If a participating provider leaves the Cigna HealthCare network, a Continuing Care Patient who is receiving care with that provider will receive notification of such change in network status and the Continuing Care Patient and may continue to receive such care at the same in-network co-payment for up to 90 days after the later of the provider leaving the network or being notified of such change.

A Continuing Care Patient is an individual who is: (1) undergoing a course of treatment for a "serious and complex condition," defined as (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 life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time; (2) undergoing a course of institutional or inpatient care; (3) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; or (4) determined to be terminally ill and receiving treatment for such illness.

3. **Third Change**

The following language is inserted on page 100 of the SPD:

7. You may request external review for any adverse benefit determination relating to a No Surprises Service. You must file a request for external review of a denial of No Surprises Services claims within four months of the date you received the final adverse benefit determination. The Plan will refer your appeal to an Independent Review Organization (IRO). You will receive a decision from the IRO within 45 days of the IRO's receipt of your request for review.

4. **Fourth Change**

The following definition as it appears on page 87 of the SPD is amended to read:

EMERGENCY MEDICAL CONDITION/SERVICES. An 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 includes: (1) an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; (2) 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); and (3) services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until: (a) The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation; (b) The patient 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 such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and (c) The patient gives informed consent to continued treatment by the nonparticipating provider, acknowledging that she or he understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

5. **Fifth Change**

The definition of “Usual, Customary, & Reasonable Charges” as it appears on page 89 of the SPD is deleted, the following definition of “Maximum Allowed Amount” is inserted, and all references to “Usual, Customary, & Reasonable Charges” or to “UCR” are changed to “Maximum Allowable Amount”:

Maximum Allowed Amount – The charge that is used to calculate payment of your benefits. The Maximum Allowed Amount depends on the type of health care provider that furnishes a covered service to you, and on the type of service provided.

Except for No Surprises Services, for Cigna HealthCare providers, the Maximum Allowed Amount is based on the provisions of that provider's network payment agreement. You pay your copayment and/or coinsurance if it applies. For all out of network providers, the Maximum Allowed Amount is based on the usual, customary and reasonable fees for the provider's geographic region. You pay the deductible and coinsurance and any amount above the allowed amount

For No Surprises Services, the Maximum Allowed Amount is the "Qualifying Payment Amount" ("QPA"), as defined under regulations to the No Surprises Act, and is based on the median of the in-network rates payable for the same or similar service in the same geographic region, adjusted for inflation.

6. **Sixth Change**

The following definition is inserted in the "Definitions" section on page 88 of the SPD:

NO SURPRISES SERVICES. "No Surprises Services" means the following services: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) ancillary services as defined under the No Surprises Act and its implementing regulations (including anesthesiology, pathology, radiology, and diagnostic services) when performed by out-of-network providers at in-network facilities; and (4) services to treat a condition that is not an Emergency Illness performed by an out-of-network provider at in-network facilities for which the provider does not comply with the notice and consent requirements under the No Surprises Act and its implementing regulations.

Sincerely,

Board of Trustees