**FOOD EMPLOYERS LABOR RELATIONS ASSOCIATION AND UNITED FOOD AND COMMERCIAL WORKERS VEBA FUND**

**FELRA & UFCW ACTIVE HEALTH AND WELFARE PLAN**
**Plans I, X, XX, and XXX**

# SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund ("Fund") is pleased to inform you of the following improvement made to your coverage under the FELRA & UFCW Active Health and Welfare Plan ("Plan") Plans I, X, XX, and XXX, effective January 1, 2022. These changes to your Plan are designed to comply with the No Surprises Act of 2021, which was enacted to shield patients from the negative financial impacts of unexpected balance billing by non-network providers for certain medical claims such as those relating to emergency medical care. Please keep this document with your Summary Plan Description ("SPD").

1. **The following new definitions are added under the "Definitions" section of the SPDs:**

**ANCILLARY SERVICES.** With respect to an in-network *Health Care Facility*, (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

**CONTINUING CARE PATIENT.** An individual who is: (1) receiving a course of treatment for a *Serious and Complex Condition*; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

**EMERGENCY SERVICES**. Any of the following, with respect to an *Emergency Medical Condition*:

- 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*;
- 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

- 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:
    - The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;
    - 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
    - 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.

**HEALTH CARE FACILITY**. For non-*Emergency Services,* a: (1) hospital; (2) hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

**INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT**. A facility that is geographically separate and distinct from a *Hospital* under applicable state law and provides, and is licensed under state law to provide, *Emergency Services*.

**NO SURPRISES ACT.** The No Surprises Act enacted under the federal Consolidated Appropriations Act of 2021.

**NO SURPRISES SERVICES.** The following services, to the extent covered under the Plan: (1) out-of-network *Emergency Services*; (2) out-of-network air ambulance services; (3) non-emergency *Ancillary Services* (such as anesthesiology, pathology, radiology, neonatology and diagnostic services and other services defined as ancillary under the *No Surprises Act* and its implementing regulations) when performed by out-of-network providers at in-network *Health Care Facilities*; and (4) other out-of-network non-*Emergency Services* performed by an out-of-network provider at in-network *Health Care Facilities* with respect to which the provider does not comply with federal *Notice and Consent* requirements.

**NOTICE AND CONSENT.** With respect to out-of-network services provided at an in-network *Health Care Facility*, *Notice and Consent* means: (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and (2) you give informed consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued treatment by the out-of-network

provider may result in greater cost to you.

**SERIOUS AND COMPLEX CONDITION.** A condition, (1) in the case of an acute illness, that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

**2. The definitions of "Co-Payment or Co-Insurance" and "Medical Emergency" under the "Definitions" Section of the SPDs are deleted and replaced with the following:**

**CO-PAYMENT OR CO-INSURANCE.** The out-of-pocket amount of the *Allowable Charge* that a participant or dependent is responsible for paying when receiving benefits after paying any applicable *Deductible* amount for that year. Effective January 1, 2022, the *Co-insurance* or *Co-payment* applicable to *No Surprises Services* is based on the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider.

**EMERGENCY MEDICAL CONDITION**. A medical condition, including a mental health condition or substance use disorder, manifesting itself 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: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

3. **All references in the SPDs to the "Usual, Customary, and Reasonable charge" or the "UCR charge" are deleted and replaced with the "Allowable Charge," and the definition of "Usual, Customary, and Reasonable or UCR" under the "Definitions Section of the SPDs is deleted and replaced with the following:**

**ALLOWABLE CHARGE.** The fee, as determined by the *Fund*, that is the lowest of: (1) the health care provider's actual charge; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the maximum amount that the Fund has determined it will pay for the service or supply; or (4) the amount that is reasonable and customary for the locality in which incurred. Notwithstanding the above, for CareFirst in-network claims, the *Allowable Charge* is the CareFirst allowed amount.

4. **The first sentence under "Hospitalization" in the SPDs' "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" is deleted and replaced with the following:**

**All emergency *Inpatient Hospital* stays must be certified within 24 hours of admission and all non-emergency *Inpatient* stays must be pre-certified with Conifer Health Solutions, to the extent consistent with applicable law.**

5. **The last sentence under "Hospitalization" in the Plan I SPD's "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" is deleted.**

6. **The last sentence under "Hospitalization" in the Plan X, XX and XXX SPDs' "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" is deleted and replaced with the following:**

> **You must use an in-network CareFirst PPO provider (with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*).**

7. **The last sentence under "Medical" in the Plan I SPD's "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" is deleted and replaced with the following:**

> **You must use LabCorp or Quest facilities** in order to be covered for laboratory services, except that laboratory services performed by out-of-network providers at in-network facilities also are covered.

8. **The last three sentences under "Medical" in the Plan X, XX and XXX SPDs' "Schedule of Benefits for Full Time Participants" and "Schedule of Benefits for Part Time Participants" are deleted and replaced with the following:**

> **You must use a CareFirst PPO participating provider (with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*). You must pre-certify all non- emergency *Inpatient Hospital* stays with Conifer Health Solutions. You must use LabCorp or Quest facilities** in order to be covered for laboratory services, except that laboratory services performed by out-of-network providers at in-network facilities also are covered.

9. **The "Use Participating Doctors" Subsection under the "Consumer Tips" Section of the Plans X, XX, and XXX SPDs is deleted and replaced with the following:**

> **Use Participating Doctors**
> When you need to see a doctor or go to a *Hospital* or other facility, you must use a CareFirst provider to have coverage, with the exception of (1) *No Surprises Services* and emergency *Ambulance Service*. To locate a CareFirst provider, contact CareFirst at the number listed on your ID card.

10. **The first two paragraphs of the "CareFirst PPO" Section of the Plans X, XX, and XXX SPDs are deleted and replaced with the following:**

> CareFirst PPO is a network of *Hospitals*, *Physicians*, and other health care providers which offers medical and *Hospital* services at discounted rates that are generally lower than usual provider fees. **You must use a CareFirst provider to have coverage for *Hospital*,**

**medical, or surgical benefits under the *Fund*** (with the exception of: (1) *No Surprises Services* and (2) emergency *Ambulance Service*)**.**

**Exceptions**
You are covered for *No Surprises Services* provided by non-PPO network providers. You are also covered for out-of-network emergency *Ambulance Service*.

11. **The following paragraph is added to the SPDs' "CareFirst PPO" Section:**

**Provider Directory**
The provider directory listing those providers that are in-network because they participate in CareFirst's network will be updated at least every ninety (90) days and will be available through the Fund's website. If you receive services from a provider that you thought was in-network, based on inaccurate information in a current provider directory, then the services provided by that out-of-network provider will be covered as if the provider was in-network.

12. **The last paragraph of the SPDs' "CareFirst PPO" Section is deleted and replaced with the following:**

**Important: For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the *Hospital* or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations generally will not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.**

13. **The following is added to the beginning of the "Comprehensive Medical Benefits" Section of the SPDs:**

Notwithstanding anything in this Section to the contrary, no prior authorization requirement will apply to *Emergency Services*.

14. **The following new sections are added under the "Comprehensive Medical Benefits" Section of the SPDs:**

**Air Ambulance Services**
Under applicable law, the cost-sharing requirement applicable to out-of-network air ambulance services must be no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider. In general, you cannot be balance billed for these air ambulance services.

**Continuing Care Patients**
If an in-network provider leaves the CareFirst network, a *Continuing Care Patient* who is

receiving care with that provider will be notified, and may elect to continue to receive such care at the same in-network *Co-Payment* and *Co-Insurance* rate for up to 90 days after the provider leaves the network.

15. **The "You Must Use a CareFirst Provider" Subsection of the Plan X, XX and XXX SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

**You Must Use a CareFirst Provider**
Medical benefits will be covered for active participants in Plans X, XX, and XXX ***only if services are performed by an in-network provider,*** with the exception of: (1) *No Surprises Services* and (2) emergency *Ambulance Service*. When you need to use a provider (whether a *Hospital*, *Physician*, or other health care provider), be sure they are in the CareFirst network. Otherwise, your claim will be denied unless it fits into one of the specific exceptions mentioned above.

16. **The "Payment of Benefits" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

**Payment of Benefits**
When the professional services described below are rendered by a *Physician*, physician's assistant, nurse practitioner or certified surgical assistant, the Plan will provide benefit payment at the percentage shown in your Schedule of Benefits, up to the *Allowable Charge*. The annual *Deductible* applies, except as may otherwise be provided here or under applicable law. Payment by the *Fund* will constitute full and final payment, except as may otherwise be provided or limited here or under applicable law. Charges made in excess of these amounts are the responsibility of the patient, **except** in the case of No Surprises Services. Your only financial responsibility for any *No Surprises Service* is any applicable *Deductible*, *Co-Insurance* and/or *Co-Payment* amount, up to the lesser of the median of the in-network rates payable for the same or similar service in the same geographic region, which may also be referred to as the "Qualifying Payment Amount" ("QPA"), or the amount billed by the provider. You will not be responsible for any other amount relating to *No Surprises Services*, even if the provider does not accept the *Allowable Charge*.

17. **The "Hospital Services" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

**Hospital Services**
***Conifer Health Solutions pre-authorization is required for all Hospital admissions,*** **except that there is no prior authorization requirement for *Emergency Services***. Contact Conifer Health Solutions at (833) 778-9806.

18. **The third paragraph under the "Diagnostic X-Ray and Laboratory Services" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

**Important:** **For laboratory services to be covered, you must use either LabCorp or Quest Diagnostic Laboratories for all laboratory services (except those performed when you are an *Inpatient* in the Hospital or by out-of-network providers at in-network facilities). Lab services performed in your doctor's office or other locations generally will not be covered. To find the nearest LabCorp location, call (888) 522-2677 or log onto their website at www.labcorp.com/psc/index.html. To find the nearest Quest location, call (800) 377-7220 or go to their website at www.questdiagnostics.com/appointment.**

19. **The second, third, and fourth paragraphs under the "Inpatient Medical Services" Subsection of the Plan X, XX and XXX SPDs' "Comprehensive Medical Benefits" Section are deleted.**

20. **The "Outpatient Emergency Care" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

**Outpatient Emergency Care**
Benefits are available to you or your eligible dependents for care received within 72 hours of an *Accidental Injury*, by a *Physician*, wherever it is performed, and for *Outpatient Emergency Services*.

21. **The first two paragraphs of the "Outpatient Lab Work" Subsection of the Plan I SPD's "Comprehensive Medical Benefits" Section are deleted and replaced with the following:**

Outpatient laboratory and x-ray services are covered as a Comprehensive Medical Benefit at 80% up to the *Allowable Charge*, after satisfying the *Deductible*. ***You must use either a Quest Diagnostics ("Quest") or Laboratory Corporation ("LabCorp") facility for all outpatient laboratory services in order for such services to be covered by the Plan (except for laboratory services provided by out-of-network providers at in-network facilities).***

Be sure your doctor knows **before lab work is performed** that you generally will only be covered for services if the bill comes to the Fund directly from either a LabCorp or Quest facility. Even if your doctor has a contract with LabCorp to perform lab work or x-ray services in his/her office, tell him/her that generally ***only lab work performed at a Quest or LabCorp facility will be covered.*** Your Plan generally will not pay for lab work performed and billed from your doctor's office.

22. **The "Outpatient Treatment" Subsection of the SPDs' "Comprehensive Medical Benefits" Section is deleted and replaced with the following:**

**Outpatient Treatment**
*Outpatient Hospital* treatment will be covered when the treatment is for:
1. The performance by a *Physician* of minor surgical procedures required for treatment and not solely for diagnosis,
2. care rendered within 72 hours after a non-occupational *Accidental Injury*, or

3. *Emergency Services*.

Benefits for coverage of *Outpatient* radiation and radioactive isotope therapy will be provided when performed in the *Outpatient* department of a *Hospital* and billed as a *Hospital* service.

23. **In the "Conifer Health Solutions" (formerly "Carewise Health") Section of the SPDs, the last bullet point under "2. Emergency Admission (Requires Certification within 48 Hours of Admission)" is deleted and replaced with the following:**

- Emergency room visits do not require certification and *Emergency Services* do not require prior authorization.

24. **In the first numbered list under the SPDs' "Claims Filing and Review Procedure" Section, the first sentence of number 6. is deleted and replaced with the following:**

**You must use a CareFirst PPO participating provider** (with the exception of (1) *No Surprises Services* and (2) emergency *Ambulance Service*).

25. **The following is added to the end of the "Claims Review – Types of Claims," "4. Post-Service Claim" Subsection of the SPDs' "Claims Filing and Review Procedure" Section:**

Notwithstanding the above, providers of *No Surprises Services* will receive payment, or a denial, of a *Post-Service Claim* for *No Surprises Services* within 30 days of the Fund's receipt of all information necessary to adjudicate the claim.

26. **The second sentence under the "External Review of Claims for Uninsured Benefit – Comprehensive Medical and Prescription Drug" Subsection of the SPDs' "Claims Filing and Review Procedure" Section is deleted and replaced with the following:**

External review is limited to claims: (a) relating to a *No Surprises Service;* (b) involving medical judgment (e.g., lack of *Medical Necessity*, or a determination that a claim is *Experimental* or cosmetic); or (c) involving a retroactive rescission of coverage.