Central Illinois Carpenters Health & Welfare Trust Fund

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IMPORTANT INFORMATION ABOUT YOUR BENEFITS

January 2022

Dear Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Fund") to change benefits from time to time when the financial soundness of the Fund requires, and at other times to comply with changes to the Federal law. This Summary of Material Modifications ("SMM") advises you of changes to the Fund's plan of benefits in order to comply with the No Surprises Act (the "NSA"), effective January 1, 2022. Accordingly, please retain a copy of this SMM with your Plan Description booklet.

The NSA was signed into law in December 2020 and generally protects patients from "balance billing" for Out-of-Network emergency services or facilities, Out-of-Network air ambulance services, and certain non-emergency services performed by an Out-of-Network provider at an In-Network facility (collectively "No Surprise Services").

As described in more detail below, Participants and Dependents receiving No Surprise Services will generally only be responsible for paying their In-Network cost sharing. You are still encouraged to use In-Network facilities and participating providers whenever possible. Additionally, this SMM describes other changes required by the NSA, including expanded emergency services and continuity of care provisions.

Consequently, the following changes are made to the Fund's plan of benefits effective January 1, 2022:

EMERGENCY SERVICES

The NSA requires emergency services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. 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;

3. 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;

4. 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 In-Network emergency facility;

5. 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;

6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider.

NON-EMERGENCY SERVICES PERFORMED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY

The No Surprises Act requires non-emergency services performed by an Out-of-Network Provider at an In-Network Health Care Facility to be covered as follows:

1. 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;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the recognized amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on your Out-of-Network coverage (meaning your Out-of-Network cost sharing will apply) if:

a. 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

b. 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.

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.

PAYMENTS TO OUT-OF-NETWORK PROVIDERS AND FACILITIES

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at In-Network Facilities by out-of-network Providers, and Air Ambulance Services

within 30 calendar days of receiving a clean claim from the out-of-network provider. The 30 day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the Participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

CONTINUITY OF COVERAGE

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your 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. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and

2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

INCORRECT PROVIDER INFORMATION

A list of in-network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. 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.

If you obtain and rely upon incorrect information about whether a provider is in-network from the Plan or its administrators, the Plan will apply in-network cost-sharing to your claim, even if the provider was out-of-network at the time the service was rendered.

COMPLAINT PROCESS

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office at 866-732-1919 or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

EXTERNAL REVIEW OF CERTAIN COVERAGE DETERMINATIONS

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by an out-of-network provider at an in-network facility, and/or Air Ambulances service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

NEW DEFINITIONS

Due to the nature of the changes required by the NSA, the Fund has adopted the following definitions, which will assist you in fully understanding the changes required by the NSA:

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 a 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 the Secretary; 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 or Dependent 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.

The **Cost Sharing Amount** for Emergency and Non-emergency Services at In-Network Facilities performed by Out-of-Network Providers, and air ambulance services from Out-of-Network providers 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 an 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 or Dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The Participant or Dependent 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 your treatment and any advance limitations that the Plan may put on your treatment, of 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
- The Participant or Dependent gives informed consent to continued treatment by the out-of-network provider, acknowledging that the Participant or Dependent understands that continued treatment by the out-of-network provider may result in greater cost to the Participant or Dependent.

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/Non-PPO emergency 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 a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the Plan or coverage respectively.

Out-of-Network/Non-PPO 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 items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

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.

In the context of Continuity of Care, **Termination** includes, with respect to a contract, 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.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits, or the content of the Summary Plan Description document, contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.