Mid Central Operating Engineers
Health and Welfare Fund
PO Box 9605
Terre Haute, IN 47807

Announcing Important Plan Improvements

Date: August 2022

To: Active Employees, Non-Medicare-Eligible Retirees, and Their Eligible Dependents Participating in the Mid Central Operating Engineers Health and Welfare Fund

From: The Board of Trustees

As the Board of Trustees of the Mid Central Operating Engineers Health and Welfare Fund (the Fund or the Plan), effective August 1, 2022, the Plan must comply with the No Surprises Act.

The No Surprises Act requires significant changes to the Plan and offers many protections to Participants, including protections to Participants in an emergency situation or when a non-PPO provider treats a Participant at a PPO facility without the Participant's express consent or when a Participant uses a non-PPO Air Ambulance provider.

You are still encouraged to use PPO facilities and PPO providers whenever possible. Please review these changes carefully.

Coverage of Emergency Services and certain Non-Emergency Services received at PPO Facilities

Effective August 1, 2022, this Plan will comply with the federal No Surprises Act. The No Surprises Act requires that the Plan be amended as follows:

1. The Plan will cover Emergency Services provided at a non-PPO facility or by a non-PPO health care provider in the same manner as PPO Emergency Services. This means the following with respect to how Emergency Services are covered.

    a. You will pay the same cost-sharing whether you receive covered Emergency Services from a non-PPO facility or provider or a PPO facility or provider. In general, you cannot be balance billed for covered Emergency Services. Your cost-sharing will be based on the Recognized Amount payable for these services.

    b. Any cost-sharing payments you make with respect to non-PPO Emergency Services will count toward your PPO deductible and PPO out-of-pocket maximum in the same manner as those received from a PPO provider.

    c. The Plan will not impose prior authorization requirements for Emergency Services and will not impose more restrictive administrative requirements on non-PPO Emergency Services than on PPO Emergency Services.

2. If you receive non-emergency items or services that are otherwise covered by the Plan from a non-PPO provider who is working at a PPO facility, those non-emergency items or services will be covered by the Plan as follows:

a. The non-emergency items or services received from a non-PPO provider working at a PPO facility will be covered 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 a participating provider.

b. In general, you cannot be balance billed for these non-emergency items or services. Your cost-sharing will be based on the Recognized Amount payable for these services.

c. Any cost-sharing payments you make with respect to covered non-Emergency Services will count toward your PPO deductible and PPO out-of-pocket maximum in the same manner as those received from a PPO provider.

3. In certain circumstances, you can be billed by a non-PPO provider who works at a PPO facility. This can occur if you are notified by the non-PPO provider that they do not participate with the Plan. The provider must give you a notice stating certain information required by federal law, including that the provider is a nonparticipating 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 participating providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed. If you give informed consent to be treated by the non-PPO provider, then the plan will pay for these services at the non-PPO rate, and the provider can bill you for the balance directly. This rule does not apply to services provided by hospital-based providers for Ancillary Services, such as anesthesiologists and radiologists.

4. 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.

5. Emergency Services means the following:

   a. 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

   b. 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).

   c. Emergency Services 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 beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation.

6. The Recognized Amount on which your cost sharing amount is based will be the lessor of billed charges from the provider or the Qualifying Payment Amount, which means the plan's median PPO rate.

Ancillary Services

You will pay the same cost-sharing for covered Ancillary Services received at a non-PPO facility or Independent Freestanding Emergency Department or by a non-PPO provider at a PPO Health Care Facility or a PPO facility or provider.

In general, you cannot be balance billed for covered Ancillary Services.

Your cost sharing amount will be based on the Recognized Amount.

Any cost sharing amount you pay with respect to covered Ancillary Services will count toward your deductible and out-of-pocket maximum.

Ancillary Services include emergency medicine, anesthesiology, pathology, radiology, and neonatology, services provided by assistant surgeons, hospitalists, and intensivists, diagnostic services, such as radiology and laboratory services, and items and services provided by a non-PPO provider if there is no PPO provider who can furnish such item or service at such PPO facility.

Air Ambulance Services

Cost-sharing for air ambulance services (medial transport by fixed wing airplane or rotary wing helicopter) will be the same whether the provider is a PPO provider or non-PPO provider.

Cost-sharing will be calculated based on the lesser of the billed charge or the Qualifying Payment Amount, and any cost-sharing amounts will count toward your PPO deductible and PPO out-of-pocket maximum.

Continuing Coverage with a Provider who leaves the Plan's Network

Effective August 1, 2022, if you are a Continuing Care Patient and the Plan terminates its contract with your PPO provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

1. Notify you in a timely manner of the Plan's termination of its contracts with the PPO provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and

2. Allow you ninety (90) days of continued coverage at PPO cost sharing to allow for a transition of care to a PPO provider.

3. You are a Continuing Care Patient with respect to a provider or facility if you are:

    a. undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;

    b. undergoing a course of institutional or inpatient care from the provider or facility;

    c. 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;

    d. pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

    e. determined to be terminally ill and receiving treatment for such illness from such provider or facility.

External Review of Claims Subject to the No Surprises Act

Effective August 1, 2022, if your initial claim for benefits related to an Emergency Service, non-Emergency Service provided by a PPO provider at a PPO 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.

Grandfathered Notice

The Plan's Trustees believe this 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 the protections that apply and that do not apply to a grandfathered health plan and what might cause a plan to lose grandfathered health plan status can be directed to the Plan Administrator at 812-232-4384. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Final Notes

If you have questions about the changes announced in this SMM or your Plan benefits in general, contact the Fund Office at (812) 234-4384.

This information only highlights certain features of the Mid Central Operating Engineers Health and Welfare Fund. 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.

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