IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS AND NOTICE TO PARTICIPANTS

(Plan No. 501; I.D. 16-0776208)

February 17, 2023

Dear Participant,

The following information describes modifications to the benefits provided by the Iron Workers District Council of Western New York and Vicinity Welfare Fund ("Fund"), effective July 1, 2022.

The section titled **DEFINITIONS,** beginning on page 13, is revised to add new terms as follows:

Ancillary Services
With respect to a participating healthcare 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.

Emergency Services

(1) With respect to an Emergency Medical Condition, a medical screening examination (as required under EMTALA or as would be required under EMTALA if it applied to an Independent Freestanding Emergency Department) which is within the capability of a Hospital (or Independent Freestanding Emergency Department), including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital (or Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished). Excellus determines whether a facility qualifies as an Independent Freestanding Emergency Department.

(2) Emergency Services also include post-stabilization services unless the following conditions are met:

   a. The attending emergency physician or treating provider has determined that you are able to travel using nonmedical transportation or non-emergency medical transportation to an available In-Network Provider or Facility located within a reasonable travel distance, taking into account your medical condition and any other relevant factor,

   b. If the Provider is an Out-of-Network Provider, (a) the Provider gives you notice that the services rendered will be performed by an Out-of-Network Provider, and you consent to waive your rights under the surprise bill requirements, and (b) you or your authorized representative are in a condition to provide informed, voluntary consent; and

c. The Provider satisfies any additional applicable laws and requirements, including, without limitation, those provided in guidance issued by the Department of Health and Human Services.

Health Care Facility (for Non-Emergency Services)

(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

A health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable state law.

In-Network Provider

A Facility, Professional Provider, or a Provider of additional health services who has a contract with EBCBS or another Blue Cross or Blue Shield plan to provide services to you at a discounted rate. In-network providers have agreed to accept the discounted rate as payment in full for services covered under the Plan. A list of In-Network Providers is included in a provider directory and is available at www.excellusbcbs.com or upon request by calling the customer service number on your identification card. The list may be revised from time to time. The In-Network Provider directory will give you the following information about In-Network Providers:

(1) Name, address, and telephone number;

(2) Specialty;

(3) Board certification (if applicable);

(4) Languages spoken; and

(5) Whether the In-Network Provider is accepting new patients.

You are only responsible for any In-Network Provider Copayment, Deductible, or Coinsurance that would apply to the covered services, and you will not be responsible for paying for any Out-of-Network charges that exceed your In-Network Provider Copayment, Deductible, or Coinsurance if you receive covered services from a provider who is not an In-Network Provider because you reasonably relied on incorrect information the Plan or EBCBS provided about whether the provider was an In-Network Provider in the following situations:

(1) The provider is listed as an In-Network Provider in the online provider directory;

(2) The paper provider directory listing the provider as an In-Network Provider is incorrect as of the date of publication;

(3) You were given written notice that the provider is an In-Network Provider in response to your telephone request for network status information about the provider or
(4) You are not provided with written notice within one business day of your telephone request for network status information."

II.

The section titled **DEFINITIONS** is revised to delete the definition of the term **Emergency** appearing on page 18 in its entirety and replace it with the following:

Emergency Medical Condition
A medical condition 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 a condition described in the Emergency Medical Treatment and Active Labor Act ("EMTALA"), including (1) placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

III.

The **SCHEDULE OF MEDICAL BENEFITS** section is amended to add a new paragraph immediately following the **Medically Necessary** paragraph on page 39, as follows:

"**No Surprises Act"**
Notwithstanding anything contrary in this Summary Plan Description, the Plan will comply with applicable requirements of the "No Surprises Act."

IV.

The **SCHEDULE OF MEDICAL BENEFITS** is amended on pages 53 and 54 so that the "Out-of-Network" columns for the subsections below are revised to read as follows, with new language in bold italics:

Benefit Description	Out-of-Network
Emergency Room Facility	
Facility Emergency Room Visit	Covered in full; subject to in-network deductible ***in accordance with the No Surprises Act***
Emergency Room Professional	
Physician Emergency Room Visit	20% coinsurance, subject to an in-network deductible ***in accordance with the No Surprises Act***
Transportation	
Prehospital Emergency Transportation – Ground or Water	Covered in full; subject to in-network deductible ***in accordance with the No Surprises Act***
Air Ambulance	100% of the Centers for Medicare and Medicaid Services Provider fee schedule, unadjusted for geographic locality, or the Provider's charge, if less and Air Ambulance life-sustaining oxygen support will be covered at the lesser of either the provider's billed charges, or the Excellus in-network rate or, if none, the equivalent Excellus in-network rate***, unless the No Surprises Act mandates other reimbursement/cost-share.***

V.

A new section titled "**NO SURPRISES ACT BENEFITS"** is inserted after the section **PREVENTIVE SERVICES**, which begins on page 55, as follows:

Protection From Surprise Medical Bills

1. **Your rights and protections against surprise medical bills.** When you receive Emergency Services (defined under the "Definitions" Section) from an out-of-network provider or are treated for certain non-emergency Services by an out-of-network provider at an in-network hospital, Independent Free Standing Emergency Department, or ambulatory surgical center, you are protected from surprise billing or balance billing.

2. **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, or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare 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.

3. **You are protected from balance billing for:**

   - **Emergency services and air ambulances.** If you have an emergency medical condition and get emergency services or air ambulance 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 services such as 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 never 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.

4. **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.

- Your health plan generally must:

    - 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.

If you believe you've been wrongly billed, you may contact Excellus BlueCross BlueShield at the customer service phone number on the back of your card. Visit www.cms.gov/nosurprises or call 1-800-985-3059 for more information about your rights under federal law.

Transitional Care

You or Your Dependents have the option of requesting extended care from Your current healthcare provider or facility if the provider or facility is no longer working with Your Health Plan and is no longer considered In-Network. The In-Network benefit level may continue for up to 90 days or until You no longer meet the criteria below, whichever is earlier, despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents must have been and must continue to be, under a treatment plan by a provider or facility that was a member of the participating Network. You must also be one of the following:

- An individual undergoing a course of treatment for a serious and complex condition that is either:

    - An acute Illness is a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.

    - 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.

- An individual undergoing Inpatient or institutional care.

- An individual scheduled for non-elective surgical care, including necessary postoperative care.

- An individual who is pregnant and being treated.

- An individual who is terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card.

VI.

The section titled **External Appeals Procedures,** beginning on page 95, is amended to add the following sentence to the end of the first paragraph:

> "The following external review procedures also apply to coverage decisions that involve a determination whether the Plan is complying with the surprise billing and cost-sharing protections contained in the No Surprises Act."

As always, if you have any questions regarding these benefit modifications, please get in touch with the Fund Office at (585) 424-3510.

Sincerely,

Board of Trustees

The Board of Trustees