WISCONSIN ELECTRICAL EMPLOYEES BENEFIT FUNDS

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NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION-WISCONSIN CHAPTER

December 2021

Re: Update on Health Plan Changes Required by Federal Legislation for 2022

This letter is intended to provide you an overview of key changes in the Plan's coverages required under a recently enacted Federal statute, the No Surprises Act (which Congress passed as part of the Consolidated Appropriations Act) and to update information in the summary of benefits and coverage you received for the 2022 plan year. These changes will be reflected in the updated Plan summary plan description that you will receive later this year; in the meantime, please refer to this overview for information regarding the changes or contact the Fund Office if you have questions. Information regarding the No Surprises Act is also posted on the Fund's website. All of these changes are effective January 1, 2022.

Balance Billing and Cost-Sharing Protections

Out-of-network providers and facilities (that is, providers and facilities that do not participate in the Plan's Anthem network) can no longer send you surprise balance bills in certain situations. "Balance bills" are what out-of-network providers or facilities can charge you even after you pay your Plan deductible or coinsurance (called your Plan "cost-sharing").

You are protected from balance billing for:

- Emergency services (not including ground ambulance services) from an out-of-network provider, facility, or air ambulance. This includes services you receive after you are in stable condition.

- Certain services from out-of-network providers at in-network hospitals or ambulatory surgical centers. Even if you receive services from a hospital or ambulatory surgical center that is part of the Anthem network (i.e., "in-network"), certain providers there may be out-of-network. Beginning in 2022, you can't be balanced billed by out-of-network providers for the following services received at an in-network hospital or ambulatory surgical center: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon services, hospitalist services, or intensivist services.

When balance billing is not allowed, you also have the following protections:

- You will pay only in-network cost-sharing amounts under the Plan.

- The Plan will base your cost-sharing amount on what it would pay in-network.

- What you pay will count toward your in-network deductible and out-of-pocket limit.

- If the Plan denies a claim for a service protected from balance billing, you can submit the claim for external review at the end of the Plan's appeal process.

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Don't accidentally give up your protections against balance billing!
Read any consents you are given before you receive health care.

Out-of-network providers can ask you to give up your balance billing protections for post-stabilization services and other services you may receive at an in-network hospitals or ambulatory surgical centers from an out-of-network providers.

If A Provider or Facility Leaves Anthem's Network

If an in-network provider or facility leaves the Anthem network, you may be able to receive care as if the provider or facility was still in-network for up to 90 days so that you have time to transition to an in-network provider. You will have this option if you are inpatient, scheduled for nonelective surgery, or receiving care for a pregnancy, serious and complex condition, or terminal illness when your provider or facility becomes out-of-network.

If Anthem Gives Incorrect Advice About a Provider's Network Status

If you can show that you received inaccurate information from Anthem that a provider was in-network on a particular claim, then you will pay in-network cost-sharing for that claim. The out-of-network provider **may** still balance bill you for that claim.

Vision Benefit Increase: Effective January 1, 2022, the Plan will increase the Adult Vision Benefit from $300 up to $400 maximum payable per eligible person per calendar year, no deductible or co-pay, for eye exam, lenses, frames, contact lenses, tinting, coating, bi-focal, tri-focal etc. (must be prescription).

Prescription Drug Out-of-Pocket

The prescription drug out-of-pocket shown in the 2022 summary of benefits and coverage is not correct. For the 2022 plan year, the most you will pay out-of-pocket for prescription drugs under the Plan is $7,200/person or $12,900/family.

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