Office and Professional Employees Locals 30 & 537
Health & Welfare Trust Fund

Administered By: Benefit Programs Administration

Telephone • (800) 386-4350 • (562) 463-5065 • Facsimile (562) 908-7568 • www.opeiufunds.org

To: All Participants and their Dependents Who Are Eligible for Major Medical Health and Welfare Active Plan Benefits, including COBRA Beneficiaries

Summary of Material Modifications

December 15, 2021

PARTICIPANT NOTICE

This Participant notice will advise you of certain material modifications (plan changes) that have been made to the OPEIU Locals 30 & 537 Health and Welfare Fund (the Plan). This information is **very important** for you and your eligible dependents. Please take the time to read it carefully.

These changes become effective with the plan year beginning on February 1, 2022.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you may be protected from surprise billing or balance billing. Some out of network providers that you see in an in-network hospital can ask you to sign a consent form and if you do, they may bill you.

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, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care 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.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services 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 may include services you get after you're in stable condition, unless the treating doctor says that you can be moved, 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 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 <u>never</u> 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.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- 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 (based on the median rate of contracted providers) 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 Benefit Programs Administration at (562) 463-5065 or toll free at (800) 386-4350.

You may also go to the following website for a description of the federal balance billing protections and contact information for the applicable federal and state agencies:

https://www.cms.gov/nosurprises/consumers

Starting January 1, 2022, the federal government phone number for information and complaints will be (800) 985-3059.

Independent External Review

The Plan's existing appeals procedures include the right to seek an independent external review of an adverse benefit determination that involves medical judgment or a rescission of coverage. Effective with the plan year beginning on February 1, 2022, the right to independent external review also applies to adverse determinations with respect to out-of-network emergency services, nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. For example, a patient could ask for external review if the Plan decided that pre-stabilization

emergency treatment in an out-of-network emergency room did not qualify as "emergency services" under the No Surprises Act and thus imposed greater cost sharing on the patient.

External reviews are initiated by contacting: Benefit Programs Administration at 562-463-5065 or toll free at (800) 386-4350

Identification Cards

You will be issued a new ID card from Aetna after their systems are updated at the end of the first quarter of 2022. The ID cards will contain the following medical deductible and out of pocket information:

- Maximum out-of-pocket limit for the plan year starting February 1, 2022: $4,300 person/ $8,600 family for Network Medical Providers
- In-network deductible for the plan year starting February 1, 2022: $350 person/ $1,050 family
- Out-of-network deductible for the plan year starting February 1, 2022: $700person/ $2,100 family
- Contact information regarding in-network hospitals and urgent care facilities: (888) 632-3862 or www.aetna.com

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If you have questions, please contact the Trust office at:

Benefit Programs Administration
1200 Wilshire Blvd, Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5065 or toll free at (800) 386-4350

Sincerely,
THE BOARD OF TRUSTEES