LOCAL 282
Welfare, Pension, Annuity, & Job Training Trust Funds
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**VERY IMPORTANT NOTICE TO PARTICIPANTS AND DEPENDENTS COVERED BY THE**

**Local 282 Welfare Trust Fund**

**Important Information Regarding Your Health Benefits**

*This document is a Summary of Material Modifications ("SMM") intended to notify you of an important change made to the plan of benefits of the Local 282 Welfare Trust Fund (the "Fund"). You should take the time to read this SMM carefully and keep it with the copy of the Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office at (516) 488-2822 or (718)-343-3322.*

May 2022

**Re: Local 282 Welfare Trust Fund – Medical Benefits Changes Under the No Surprises Act Effective March 1, 2022 (Plans A, C, and D) and Changes Regarding Over-the-Counter COVID-19 Tests**

Dear Participant:

This Summary of Material Modifications ("SMM") advises you of changes to certain medical benefits under the Local 282 Welfare Trust Fund (the "Fund"), as required by the Employee Retirement Income Security Act of 1974 ("ERISA"). This SMM also serves as an amendment to the Fund's Summary Plan Description and Plan Document.

This SMM describes two changes: changes pursuant to the No Surprises Act ("NSA") and changes related to purchases of over-the-counter COVID-19 tests.

## NO SURPRISES ACT

### Effective Date of Changes

As explained below, these changes are effective March 1, 2022 (the start of the 2022-2023 Plan Year) in order to comply with the NSA requirements.

### Applicable Plans of Benefits

These changes only apply to certain medical benefits for Active Employees and Dependents in Plans A, C, and D. These changes do not apply to any other non-medical or retiree-only medical benefits provided under the Fund.

### Defined Terms

Capitalized terms used below are defined at the end of this SMM, or, if not, in the SPD.

### Background

As explained in the SPD, if you use an Out-of-Network provider, the provider can charge you whatever they want and can bill you for the difference between the amount they bill and what the Fund pays, which is referred to as

the Maximum Allowable charge. This is called balance billing, and the differences can be very significant. In addition, unlike with In-Network providers, the Fund only covers a percent of the Maximum Allowable charge and will not pay any of the charges until the you have satisfied the Deductible.

The NSA was signed into law in December 2020. As explained below, the law requires health plans to cover certain Out-of-Network claims with the same participant cost-sharing as for In-Network claims, including Emergency Services at hospitals and certain independent freestanding emergency departments, Out-of-Network Air Ambulance Services, continuing care for up to 90 days by a provider who leaves the network, and certain Non-Emergency Services performed by an Out-of-Network provider at an In-Network facility (collectively "No Surprise Services"). In addition, providers are not permitted to balance bill you for these services.

Pursuant to the NSA, we have amended and added definitions and terms in the SPD as set forth below in the Definitions section.

You are still encouraged to use In-Network facilities and In-Network providers whenever possible. Please review these changes carefully and contact the Fund Office with any questions that you may have.

**NSA Requirements**

Air Ambulance Services

The NSA requires Air Ambulance Services (to the extent covered by the Fund) to be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network provider. In general, you cannot be balance billed for these Air Ambulance Services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network provider of Air Ambulance Services were equal to the lesser of the Qualifying Payment Amount ("QPA") or the billed amount for the services.

Any cost-sharing payments you make with respect to covered Air Ambulance Services will count toward your In-Network deductible (as applicable) and In-Network out-of-pocket maximum in the same manner as those received from an In-Network provider. Please note the Fund currently does not have an In-Network deductible.

Continuing Care Patients

If you are a Continuing Care Patient and the Fund terminates its In-Network contract with an In-Network provider or facility (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud), or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Fund, the Fund will do the following:

1. Notify you in a timely manner of the Fund's termination of its In-Network contract with the In-Network provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and

2. Allow you up to ninety (90) days of continued coverage at the In-Network cost sharing rate to allow for a transition of care to an In-Network provider or facility (provided you otherwise remain eligible for Fund coverage and continue to meet the definition of Continuing Care Patient).

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 requirements or limitations 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 NSA 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 Fund 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 Services or items provided by an Out-of-Network provider at an In-Network facility will be covered based on your Out-of-Network coverage if:

   a. At least seventy-two (72) hours before the day of the appointment (or three (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

Fund, the estimated charges for your treatment and any advance limitations that the Fund 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.

Provider Directory

Empire Blue Cross Blue Shield provider directory is accessible at https://www.empireblue.com/find-care/ and will be updated at least every ninety (90) days. If you are informed of or receive inaccurate information from a provider directory indicating that a provider is an In-Network provider, services provided by that Out-of-Network provider will be covered as if the provider was an In-Network provider.

**Complaint Process**

If you believe you've been wrongly billed, or otherwise have a complaint under the NSA, you may contact the federal government's NSA Helpdesk at 1-800-985-3059 or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272. If you have a question about an explanation of benefits issued by the Fund, you may contact the Fund Office at (516) 488-2822 or (718)-343-3322.

**External Review Process of Certain Coverage Determinations**

If your claim for benefits related to a No Surprises Service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome after exhausting the Fund's internal claims and appeals process, you may be eligible for External Review of the determination if your appeal relates to whether the Fund is complying with the NSA. Please contact the Fund Office at (516) 488-2822 or (718)-343-3322 for a copy of the Fund's External Review procedures.

**New Definitions Implemented from the No Surprises Act**

Following are definitions of certain terms that are used above.

**Maximum Allowable.** For the purpose of determining reimbursements under the Fund, the Maximum Allowable charge for any covered service or supply shall be the amount stipulated by the Board of Trustees as the Maximum Allowable charge for that service or supply. The Maximum Allowable charge is the maximum amount the Fund will pay for charges that are:

- covered under the Fund;
- Medically Necessary; and
- provided in accordance with all applicable preauthorization, medical management programs or other requirements.

The Maximum Allowable charge on our Out-of-Network provider fee schedule has been developed by reference to one or more of several sources, including the following:

- Amounts based on the Blue Cross and Blue Shield Network provider fee schedule/rate;
- Amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually;
- Amounts based on charge, cost reimbursement or utilization data;
- Amounts based on information provided by a third-party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable providers' fees and costs to deliver care;
- An amount negotiated by the Blue Cross and Blue Shield claims administrator or a third-party vendor which has been agreed to by the provider; or
- The Qualifying Payment Amount, as defined below.

**Ancillary Services** means, with respect to an In-Network health care facility, the following:

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 an Out-of-Network provider if there is no In-Network provider who can furnish such item or service at such facility.

**Continuing Care Patient** mean an individual who is: (1) receiving a course of treatment for a "serious and complex condition"; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the 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

1. Serious impairment to bodily functions; or

2. Serious dysfunction of any bodily organ or part; or

3. Placing the health of an individual or an 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 (some urgent care facilities, but not all, qualify), 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).

3. Emergency Services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes 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:

    a. The provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and

    b. You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Fund, of the estimated charges for your treatment and any advance limitations that the Fund 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

    c. 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.

**Health Care Facility** (for Non-Emergency Services) means each of 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

**No Surprises Services** means the following, to the extent covered under the Fund:

1. Out-of-Network Emergency Services;

2. Out-of-Network Air Ambulance Services;

3. Non-Emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network provider at an In-Network facility; and

4. Other Out-of-Network Non-Emergency Services performed by an Out-of-Network provider at an In-Network health care facility with respect to which the provider does not comply with federal notice and consent requirements.

**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 QPA

For Air Ambulance Services furnished by Out-of-Network Providers, the Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

**Qualifying Payment Amount or QPA** means generally the median contracted rate of the plan or issuer for the item or service in the geographic region, calculated in accordance with the federal regulation found at 29 CFR 716-6(c).

**Serious and Complex Condition** means 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; or

2. In the case of a chronic illness or condition, a condition that is the following:

    a. Life-threatening, degenerative, potentially disabling, or congenital; and

    b. Requires specialized medical care over a prolonged period of time.

Please contact the Fund Office if you have any questions.

## COVERAGE FOR AT-HOME COVID-19 TESTS

Effective January 15, 2022 and during the public health emergency period as determined by the federal government, the Fund will cover FDA-approved at-home COVID-19 tests, without participant cost-sharing, preauthorization, or medical management. Information from the Fund's pharmacy benefit manager, CVS/Caremark, about this benefit is available on their website at www.caremark.com. Coverage is available for tests purchased on or after January 15, 2022, limited to eight tests per 30-day period per covered individual.
The Caremark program includes options to get tests at In-Network pharmacies (at no cost to you), to order tests for direct shipment to you (at no cost to you), and to submit claims for reimbursement (up to $12 for tests) if you purchase tests from an Out-of-Network pharmacy or other established retailer. The Fund does not reimburse for tests purchased from sellers that use an on-line auction or resale marketplace, or from a private individual via an in-person or on-line sale.

**As a reminder, you also can order four free at-home COVID-19 tests per household from the federal government at www.covidtest.gov for direct shipment to you.**

Please contact the Fund Office or Caremark (at the phone number on the back of your ID card) if you have any questions.

This summary of material modifications ("SMM") is intended to provide you with an easy-to-understand description of certain changes to the Local 282 Welfare Trust Fund's program of benefits (the "Plan").

The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and/or factual, arising under the Plan.