SOUTHERN CALIFORNIA PIPE TRADES ADMINISTRATIVE CORPORATION
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SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND
(Active Plan)

SUPPLEMENT No. 20

To: All Participants

From: Board of Trustees

Date: December 2021

Re: Protections Against Balance Billing Under the No Surprises Act

KEEP THIS NOTICE WITH THE SUMMARY PLAN DESCRIPTION

Effective for services received on and after January 1, 2022, the Summary Plan Description has been changed as follows.

No Surprise Billing.

Under the federal No Surprises Act, for some out-of-network services you may receive, you are protected from receiving a bill from a provider for the difference between the provider's bill and the Plan's out-of-network payment to the provider. Effective for services received on or after January 1, 2022, the SPD will now provide that, after you have satisfied your deductible, when you receive services under the following conditions you will be responsible for the Plan's in-network copay only:

- Emergency care at an out-of-network facility (hospital or freestanding emergency facility) or from an out-of-network provider at an emergency facility; or
- Any type of medical care from an out-of-network provider at an in-network hospital or ambulatory surgical center; or
- Emergency transportation by an out-of-network air ambulance provider.

The Plan will pay the difference between your copay and the balance due to the provider. You will not receive an additional bill from the provider. In addition, your copays will count toward your in-network out-of-pocket maximums.

There are some exceptions. A provider may charge you an additional amount over the Plan's payment and your copay, if you have provided written consent to obtain treatment from an out-of-network provider in an in-network facility.

Note: Any language in the current SPD that is contrary to the above, will no longer be applicable.

Accompanying this Supplement is a Notice of Your Rights and Protections Against Surprise Medical Bills.

Independent External Review.

If the Appeals Committee of the Board of Trustees denies your appeal, in whole or in part, and that appeal involves balance billing or an issue which you believe violates the no surprise billing rules, you may file a request for your appeal to be reviewed by an Independent Dispute Resolution entity. Contact the Fund Office if you believe you have such an appeal.

This Southern California Pipe Trades Health & Welfare Fund believes 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 which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (800) 595-7473. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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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 are protected from surprise billing or balance billing.

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 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 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.

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 the United States Department of Health and Human Services at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.