Laborers Funds Administrative Office of Northern California, Inc.
5672 Stoneridge Drive, Suite 100, Pleasanton, CA 94588 | Telephone: 707-864-2800 or 800-244-4530

IMPORTANT ANNOUNCEMENT

Please provide a copy of this Announcement to your Spouse and eligible children enrolled in the Plan

DATE: September 28, 2022

TO: Laborers Health and Welfare Trust Fund for Northern California Active, Retired, and Special Plan Participants and Dependents, including COBRA Beneficiaries

FROM: Board of Trustees

SUBJECT: Plan Improvements and New and Revised Definitions to the Plan

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This Notice is intended to advise you of certain material modifications that have been made to the Laborers Health and Welfare Trust Fund for Northern California. This information is **VERY IMPORTANT** to you and your dependents, please take the time to read it carefully.

IMPROVEMENTS TO BENEFITS FOR CERTAIN SERVICES FROM NON-PPO PROVIDERS
Effective June 1, 2022

The No Surprises Act was signed into law in December 2020. This Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Effective June 1, 2022, patients receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services. Also, effective June 1, 2022, the Plan is implementing several improvements to comply with the No Surprises Act.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;
- 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 a PPO provider or a PPO emergency facility;
- 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 was equal to the Recognized Amount for the services; and

- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO provider at a PPO facility, the items or services are covered by the plan:

- 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 a PPO provider,
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Non-PPO provider were equal to the Recognized Amount for the items and services.
- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider.
- Non-emergency items or services performed by a Non-PPO provider at a PPO facility will be covered based your out-of-network coverage if:
    - ✓ At least 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), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
    - ✓ The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater costs to the participant or beneficiary.
- 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 Non-PPO provider satisfied the notice and consent criteria, and therefore these services will be covered:
    - ✓ 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 a PPO provider,
    - ✓ With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the recognized amount for the items and services, and
    - ✓ With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider.

Your cost sharing amount for Non-emergency Services at PPO Facilities by Non-PPO Providers will be based on the lessor of billed charges from the provider or the QPA.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan, from a Non-PPO provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO provider will 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 a PPO provider.

- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO provider.

Payments to Non-PPO Providers and Facilities

The Plan will make an initial payment or provide notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the non-PPO provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a Non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD/Plan Document for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your PPO provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

Incorrect PPO Provider Information

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office or the Employee Benefit Security Administration's (EBSA's) toll free number at 1-866-444-3272.

Repeal of Emergency Department Payment Rules

The Plan provision concerning payment for Emergency Room services, as required by the Affordable Care Act, is repealed for services provided on or after January 1, 2022, and replaced with the No Surprises Act requirements.

NEW AND REVISED DEFINITIONS OF THE PLAN
Effective June 1, 2022

Air Ambulance means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Ancillary Services are, with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Cost Sharing means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Continuing Care Patient means an individual who, with respect to a provider or facility:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such 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 serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her 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, 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).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include 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:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

Health Care Facility (for non-emergency services) is each of the 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

Independent Freestanding Emergency Department is a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Non-PPO Emergency Facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

Non-PPO provider means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Out-of-Network Rate with respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

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 Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Serious and Complex Condition means with respect to a participant, beneficiary, or enrollee under the Plan 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 injury;
2. in the case of a chronic illness or condition, a condition that is—
    - ✓ life-threatening, degenerative, potentially disabling, or congenital; and
    - ✓ requires specialized medical care over a prolonged period of time.

Termination includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

If you should have questions about this Important Announcement, contact the Trust Fund Office, Monday through Friday, 8:00 AM to 5:00 PM.

Sincerely,

Board of Trustees
Laborers Health and Welfare Trust Fund
for Northern California

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, contact the Trust Fund Office.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan.

Keep this Important Announcement with
your Health and Welfare Plan Booklets