Five Rivers Carpenters District Council Health & Welfare Fund
C/O Eastern Iowa Fringe Benefit Funds, Inc.
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IMPORTANT NOTICE
REGARDING THE NO SURPRISES ACT

October 2022

To All Active Participants and Pre-Medicare Retiree Participants of the Five Rivers Carpenters District Council Health & Welfare Fund (the Plan):

Effective January 1, 2022, the No Surprises Act offers new billing protections to participants who receive services in certain situations, such as emergency care, non-emergency care from out-of-network providers during visits to certain in-network facilities, and air ambulance services without the participant's express consent. The purpose of this Notice is to announce the following changes and clarifications to bring the Plan into compliance with the No Surprises Act.

The changes described here apply only to the medical benefits (including prescription drug benefits to the extent relevant) offered under the Plan.

COVERGE OF EMERGENCY SERVICES

The Plan will cover Emergency Services provided at an out-of-network facility or by an out-of-network provider in the same manner as if such services were provided at an in-network facility or by in-network providers. Accordingly, the Plan is revised as follows:

1. **A new definition of "Emergency" is added to the Plan as follows:**

   Emergency means a medical condition that is evidenced by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or seriously impair bodily functions or the function of any bodily organ or part. If symptoms exist that reasonably may be interpreted as an Emergency, that condition will be considered an Emergency even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of a heart attack is not made. If you are taken for treatment to the nearest Hospital or trauma center by the police, fire department, or ambulance under circumstances beyond your control, this too will be treated as an Emergency.

2. **A new definition of "Emergency Services" is added to the Plan as follows:**

   Emergency Services means outpatient and inpatient services provided with respect to an Emergency and include treatment provided by and within the capabilities of the emergency department of a Hospital (including a Hospital outpatient department) or an independent, freestanding emergency department that is geographically separate and licensed separately from a Hospital under applicable state law, including an

appropriate medical screening examination and ancillary services routinely available to the emergency department to evaluate such Emergency and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services include treatment of an Emergency by an urgent care clinic or facility if such urgent care clinic or facility is permitted by applicable state licensure laws to provide such services.

Post-stabilization services provided by out-of-network providers and facilities generally also will be considered Emergency Services for purposes of applying the payment rules with respect to Emergency Services as set forth in the Schedule of Benefits unless certain conditions are met. Post-stabilization services include outpatient observation, or an inpatient or outpatient stay that is related to the Emergency or with respect to the visit in which other Emergency Services are furnished.

Post-stabilization services at an out-of-network facility or from an out-of-network provider are not considered Emergency Services for payment purposes if (i) the attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available in-network provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition, (ii) the out-of-network facility or provider furnishing such services provides adequate notice to the patient as required by federal law (including notice that the provider is an out-of-network provider with respect to the Plan, the estimated charges for treatment and any advance limitations that the Plan may put on the treatment, of the names of any in-network providers at the facility who are able to provide treatment, and notice that the patient may elect to be referred to one of the in-network providers listed); and (iii) receives informed consent from the patient to continued treatment despite the greater cost, in compliance with applicable law.

RECOGNIZED AMOUNT

Under the No Surprises Act, participant cost-sharing is determined using the Qualified Payment Amount.

A new definition of "Recognized Amount" is added to the Plan as follows:

Recognized Amount means an (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the lesser of the billed amount or the median in-Network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter. Currently, there is no applicable All-Payer Model Agreement, nor any applicable state law, meaning that the Recognized Amount will be the lesser of the billed amount or the median in-Network rate ("Qualifying Payment Amount").

COVERGE OF CERTAIN NON-EMERGENCY SERVICES RECEIVED FROM NON-NETWORK PROVIDERS AT NETWORK FACILITIES

1. **A new definition of "Ancillary Services" is added to the Plan as follows:**

   Ancillary Services mean 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 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.

2. **If you receive non-Emergency items or services that are otherwise covered by the Plan from an out-of-network provider who is working at an in-network facility, those non-Emergency items or services will be covered by the Plan as follows:**

   The non-Emergency items or services received from an out-of-network provider working at an in-network facility 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 an in-network provider. In other words, the co-insurance percentage and any co-payments applicable to such services will be the same as if the services were furnished by an in-network provider.

   Your coinsurance responsibility will be based on the Recognized Amount (as defined above). Any cost-sharing payments you make with respect to covered non-Emergency services will count toward your Network deductible and Network out-of-pocket maximum in the same manner as those received from an in-network provider.

   An exception applies with respect to certain out-of-network providers who have provided notice to the patient and received informed consent with respect to the out-of-network billing practices in compliance with applicable law.

   If the exception applies, the applicable out-of-network coinsurance to be paid by the Plan will be based on the Allowable Charge, and the out-of-network deductible and out-of-pocket maximum will apply.

   No exception is available with respect to providers of Ancillary Services, however, or with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or services is furnished, regardless of whether the notice and consent requirements have been satisfied.

COVERAGE OF AIR AMBULANCE SERVICES

The Plan will cover expenses associated with air ambulance services. The co-insurance rate that you pay for air ambulance (medial transport by fixed wing air-plane or rotary wing helicopter) will be the same whether the provider is an in-network or out-of-network provider, and your coinsurance responsibility will be calculated based on the lesser of the billed amount for the services or the median of the Network's contracted rates with participating providers in the geographic region for the respective services as of January 31, 2019, indexed for inflation thereafter, and any co-insurance payments you make with respect to covered air ambulance services will count toward your Network deductible and out-of-pocket maximum, regardless of whether received from a Network or Non-Network Provider.

CONTINUING COVERAGE WITH A NETWORK PROVIDER WHO LEAVES THE PLAN'S NETWORK

The No Surprises Act provides protections to "continuing care patients" in circumstances where your treating physician or healthcare facility's network status changes in the midst of treatment.

1. **The following definition of "Continuing Care Patient" is added to the Plan as follows:**

   An individual is a Continuing Care Patient with respect to a provider or facility if the individual is:

   - Undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
   - Undergoing a course of institutional or inpatient care from the provider or facility;
   - 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;
   - Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
   - Determined to be "terminally ill" and receiving treatment for such illness from such provider or facility.

An individual has a serious and complex condition if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. An individual is terminally ill if the individual has a medical prognosis that the individual's life expectancy is six months or less.

2. The Plan covers services provided to Continuing Care Patients in the following manner:

If you are a Continuing Care Patient and the Plan's PPO terminates its contract with your Network Provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will:

- Notify you in a timely manner of the Plan's termination of its contracts with the Network Provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
- Allow you ninety (90) days of continued coverage with benefits paid on the same terms and conditions under the Plan as if the provider or facility had remained in the Network in order to allow time for you to transition your care to a Network Provider.

EXTERNAL REVIEW

An external review is available with respect to adverse benefit decisions that involve coverage for Emergency Medical Services received at Non-Network facilities, services received from out-of-network providers at in-network facilities, air ambulance services, services provided by out-of-network providers believed to be in-network providers, and services provided to Continuing Care Patients (all as determined above) in order to determine compliance with the surprise billing and cost-sharing protections under the No Surprises provisions found in the Consolidated Appropriations Act of 2021.

If you have any questions on the information communicated above, please contact the Fund Office at (319) 366-3623.

Sincerely,

The Board of Trustees