

## SUMMARY OF MATERIAL MODIFICATIONS

TO: Participants and Beneficiaries of Schedules 1, 1-A, 2 and 7 of the Northern California Sheet Metal Workers Health Care Plan

FROM: Board of Trustees

DATE: January 13, 2023

RE: New Protections Against Surprise Medical Bills; Changes to Death Benefits; Use of Reserve Hours Bank and Health Reimbursement Arrangement

*This document is a Summary of Material Modifications (“Summary”) intended to notify you of important changes made to the benefit plan of the Northern California Sheet Metal Workers Trust Fund, including Schedules 1, 1-A, 2 and 7.*

*Please take the time to read this Summary carefully and keep it with the copy of your Summary Plan Description (SPD). You should share this Summary with your spouse and children. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact the Trust Fund Office by telephone during normal business hours at 925-208-9992 or by mail at P.O. Box 1677 San Ramon, CA 94583.*

**YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS**

As of January 1, 2022, the “No Surprises Act” will limit your out-of-pocket costs and protect you against surprise medical bills. What your Plan pays for medical care depends on whether the hospital, doctor, or urgent care center is in the Blue Shield PPO Network *or* is “out of network” (“out-of-network” claims are also called “non-PPO” claims). If you are treated at an out-of-network hospital or urgent care center you generally must pay more out of pocket than at an “in-network” hospital or urgent care center. However, as of January 2022 your out-of-pocket costs for only the following types of out-of-network claims will be no greater than if you were treated “in network” and the out-of-network provider cannot “balance bill” you for additional payment:

- Emergency services,
- Services provided by an *out-of-network* doctor or other health care provider at an *in-network* hospital or urgent care center, and
- Air ambulance services.

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 to pay other costs or the entire bill if you see a provider or visit a health care facility that is not in the Blue Shield network.

**“Out-of-network”** describes providers and facilities that have not signed a contract to participate in the Blue Shield network (or the TARP provider networks for substance abuse treatment). 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 probably 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 cannot 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 cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give informed written consent and give up your protections not to be balance billed for these post-stabilization services.

You are protected from balance billing for: **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, or where there is no in-network provider who can furnish the service. These providers cannot 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 cannot balance bill you, unless you give informed written consent and give up your protections. **If you do give written consent to continued treatment by the out-of-network provider, you will lose the protections of the No Surprises Act and, in most cases, likely to be responsible for greater cost-sharing than if you do not give written consent.** You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan’s network.

**When balance billing is not 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 Plan generally must:

- Cover out-of-network 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 at an in-network facility toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact the Trust Fund Office at 925-208-9992 for assistance.

### **What should I do if I receive a surprise bill and have a billing disagreement?**

If the Plan denies all or part of a claim for service, you can appeal that decision. Your Summary Plan Description (SPD) contains information on the review process and how you request review of your plan's decision.

Starting on January 1, 2022, you generally will not be responsible for balance bills or out-of-network cost-sharing when getting emergency care, non-emergency care from out-of-network providers at certain in-network facilities, or air ambulance services from out-of-network providers. When this happens, instead of you paying for unexpected out-of-network costs, you will generally only need to pay your normal in-network costs (like coinsurance, copayments, and amounts paid towards deductibles). The health care provider and your health plan are responsible for negotiating the total payment amount from the plan to the provider through an independent dispute resolution process.

### **External Review**

An adverse benefit determination related to an emergency service, non-emergency service provided by a out-of-network Provider at an in-network facility, and/or air ambulance services, that is covered under the *No Surprises Act*, may be eligible for External Review. Please see the External Review procedures in the SPD for further information.

### **Learn more about resolving billing disagreements**

Where do I go to get more help or file a complaint?

If you have a question about the No Surprises Act or believe the law is not being followed, contact the Centers for Medicare & Medicaid Services No Surprises Help Desk at 1-800-985-3059 from 5 am to 5 pm PST, 7 days a week, to submit your question or a complaint. You can also submit a complaint online.

If you still need help with your health insurance and have a problem or question, contact your state Consumer Assistance Program. These programs help consumers experiencing problems with their health insurance or seeking to learn about health coverage options.

## **NEW MEMBERSHIP CARDS**

Because the No Surprises Act requires new membership cards, the Plan issued you new member identification cards that will show your overall Plan deductible, overall out-of-pocket maximum and consumer contact information.

## **CONTINUITY OF CARE**

You are allowed up to 90 days of continued coverage at the in-network cost sharing amount (to allow you to transition your care to an in-network provider/facility) if your provider or facility drops out of the Blue Shield PPO network while you are;

- Undergoing a course of treatment *or* a course of institutional or inpatient care from that provider or facility for a serious and complex condition;
- Scheduled to undergo non-elective surgery from that provider or facility, including post-operative care from such provider or facility with respect to that surgery;
- Pregnant and undergoing treatment for pregnancy from that provider or facility; or
- Determined to be terminally ill and receiving treatment for this illness from that provider or facility.

If you are undergoing care and a contract terminates, you will receive notification from the Plan and must elect continued coverage in writing according to the notice.

## **IN-NETWORK PROVIDER DIRECTORY**

A list of in-network providers is available to you without charge on the Blue Shield website – <http://blueshieldca.com/pponetwork> or by calling the Blue Shield phone number on your new membership card. The Blue Shield network consists of providers, including hospitals of varied specialties as well as general practice.

## **DEATH BENEFITS**

Effective July 1, 2022, death benefits under the Plan are as awardable, subject to the limitations set forth in the Plan, in the case of a deceased employee:

<b>Employment Status</b>	<b>Death Benefit Sch 1</b>	<b>Death Benefit Sch 1A &amp; 7</b>	<b>Accidental Death Benefit Sch 1, 1A &amp; 7</b>
Employee	\$50,000	\$10,000	\$10,000
Unemployed employee	50,000	10,000	10,000
Disabled employee	50,000	10,000	N/A
Retired employee < age 65	10,000	10,000	10,000
Retired employee age 65 +	4,000	4,000	N/A
Disabled retiree < age 65	4,000	4,000	N/A

Effective July 1, 2022, death benefits under the Plan are as awardable, subject to the limitations set forth in the Plan, in the case of a deceased dependent:

<b>Dependent Status</b>	<b>Death Benefit</b>	<b>Accidental Death Benefit</b>
Your covered dependents, if you are an employee, unemployed employee or a retiree under age 65	\$8,000	\$4,000
dependents 6 months of age or >		
dependents under 6 months of age	\$2,000	2,000
Your covered dependents, if you are a disabled employee or a retiree age 65 or over	\$8,000	Not applicable
dependents 6 months of age or >		
dependents under 6 months of age	\$2,000	Not applicable
Covered dependents of your surviving spouse (your widow or widower) who is age 65 or over	\$8,000	Not applicable
dependents 6 months of age or >		
dependents under 6 months of age	\$2,000	Not applicable
Covered dependents of your surviving spouse (your widow or widower) who is under age 65	\$8,000	\$500
dependents 6 months of age or >		
dependents under 6 months of age	\$2,000	\$100

**USE OF RESERVE HOURS BANK AND HRA ACCOUNT BALANCE TRANSFERS**

Effective June 1, 2021, members who perform covered work for a SMART-affiliated Local may continue to use their accrued reserve hours bank to continue coverage for the period that they have sufficient reserve hours to pay for a full month of coverage.

If you have a Health Reimbursement Arrangement Account with a remaining balance, you may transfer the account balance to another Health Reimbursement Arrangement account held by another Trust providing benefits to Local 104 members. You may also transfer funds into your District 2 account.

Si usted gustaría una copia en español, por favor de contactar la oficina de administración del Northern California Sheet Metal Workers Health Care Plan.