IRON WORKERS TRUST FUND LOCAL NO. 5
WASHINGTON, D.C.

Fund Office: Zenith American Solutions, Administrator, 3 Gateway Center, 401 Liberty Avenue, Ste. 1200, Pittsburgh, PA 15222
Phone: (412) 471-2885 / 1-800-242-8923 / Fax: (412) 395-0002

SUMMARY OF MATERIAL MODIFICATION

Date:

Start of address
Line 1
Line 2
Line 3
City, State ZIP

The Summary Plan Description (SPD), dated January 1, 2020, for the Iron Workers Health Trust Fund Local No. 5, Washington D.C. ("Plan") has been amended by the Board of Trustees to comply with the No Surprises Act. This Act prevents facilities and providers from balance billing you for emergency services received from out-of-network providers and non-emergency services received from out-of-network providers when you are receiving care at an in-network hospital or outpatient facility. Under this amendment to the Plan, when you receive the out of-network services described herein, your financial obligation is limited to the in-network co-pay percentage – 20% - of the applicable charge.

The Plan will pay the difference between your copay, if any, 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.

These changes, as further described below, are for services received on and after July 1, 2022.

1. **Emergency Services**

   The Plan will cover hospital facility and professional charges for emergency services, including services rendered for stabilization of the patient's emergency medical condition, whether provided by an in-network or out-of-network facility or provider, at the in-network co-payment rate. This means once you have reached the individual or family deductible, the Plan will pay 80% of the agreed upon charges. You will be responsible for the remaining co-pay of 20% of either the in-network rate or the charge agreed upon by the Plan and the out-of-network facility/provider. You will not be responsible for any other charges. Your co-pay will be applied to your deductible if it has not yet been met at the time the services are rendered.

Note that the Plan already covers emergency services received at an urgent care center at 100%, whether the center is a CareFirst Blue Cross Blue Shield, in-network provider, or an out-of-network provider.

2. **Non-Emergency Services from Out-of-Network Providers at an In-Network Facility**

   If you go to an in-network facility (including a hospital, hospital outpatient department or ambulatory surgical center) and receive certain services from an out-of-network provider, once you have reached the individual or family deductible, the Plan will pay 80% of the charges. You will be responsible for the remaining co-pay of 20% of the charge agreed upon by the Plan and the out-of-network facility/provider. You will not be responsible for any other charges. Your co-pay will be applied to your deductible if it has not yet been met at the time of the services.

   The types of out-of-network /services that will be subject to the in-network 80%-20% co-pay split under this new rule include the following:

Anesthesiology	Assistant Surgeons	Radiology
Pathology	Hospitalists	Laboratory
Neonatology	Intensivists	Other Diagnostic Services

   In addition, the new rule will apply when there are no in-network providers at the facility that could furnish the service.

   Your co-pay for services rendered by an out-of-network provider may be limited to the co-pay for in-network providers if the Fund Office mistakenly informs you that the out-of-network provider is in-network.

3. **Air Ambulance Services**

   Your financial responsibility for emergency air ambulance services will be limited to a 20% co-pay on the lesser of the Plan's allowable charge or a charge established by federal government regulations.

Note: The SPD provisions referencing the Allowed Amount for out-of-network claims and balance billing on pages 16, 17 and 54 of the SPD are hereby modified to the extent the above prohibition on balanced billing applies, including the substitution of a qualifying payment amount in lieu of the out-of-network provider Allowed Amount applicable when the no-balance billing rules do not apply.

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

Independent External Review.
The Fund has adopted a procedure under which you may appeal decisions of the Board of Trustees regarding the surprise billing and cost-sharing protections you have under the No Surprises Act.

Examples of claims that are eligible for external review include: (1) whether treatment is for emergency services eligible for balanced billing protection; (2) whether a claim for items and services furnished by a non-participating provider at an in-network facility is subject to the protections under the No Surprises Act; (3) whether you were in a condition to receive a notice about the availability of the protections against balance billing and gave informed consent to waive these protections; (4) whether a claim for items and services is coded correctly, consistent with the treatment you received, thus entitling you to the protections against balance billing; and (5) whether cost-sharing was correctly calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility.
For the above types of claims, the decision of the Board of Trustees is final and binding unless you timely file a request with the Fund Office for a review by an independent dispute resolution entity ("IDR entity"). In that case, the decision made by an IDR entity will be binding on you and the Plan.

1. **Deadline for Filing a Request for External Review**
You may file a written request for an external review with the Fund Office within four months after you receive from the Fund a notice of denial of an appeal about a claim that involves consideration of whether the Plan is complying with the no balance/surprise billing and related cost-sharing protections under federal law. If there is no corresponding date four months after the date of receipt of such a notice, then your request must be filed by the first day of the fifth month following the receipt of the notice.

2. **Preliminary Review**
Within five business days following the date of receipt of the external review request, the Fund Office will complete a preliminary review of the request to determine whether:

   a. you are covered under the Plan at the time the health care item or service was provided;
   b. the adverse benefit determination pertains to a balance billing issue;
   c. you have exhausted the Plan's internal appeal process; and
   d. you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Fund Office will send you a notice in writing. If your request is complete but not eligible for external review, the notice will include the reasons it is ineligible and contact information for the Employee Benefits Security Administration.

If the request is not complete, the notice will describe what is needed to make the request complete, and you will be allowed to fix your request within the four-month filing period or within the 48-hour period following the receipt of the notice, whichever is later.

3. Referral to Independent Dispute Resolution Entity

If the Fund Office determines that your request for external review is complete, it will assign a certified Independent Dispute Resolution entity ("IDR entity") that is accredited by an appropriate nationally recognized accrediting organization to conduct the external review. The Fund Office will refer the claim to one of three IDR entities with which the Plan has contracted and will rotate claims assignments among them. The IDR entities are not eligible for any financial incentives based on the likelihood that the IDR entity will support the denial of benefits.

a. The assigned IDR entity will use legal experts, where appropriate, to make coverage determinations under the Plan.

b. The assigned IDR entity will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IDR entity, within ten business days following the date of receipt of the notice, additional information that the IDR entity will consider during the external review.

c. Within five business days after the date of assignment of the IDR entity, the Fund Office will provide to the assigned IDR entity the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide this will not delay the external review. If the Plan fails to timely provide the documents and information, the assigned IDR entity may terminate the external review and decide to reverse the adverse benefit determination. Within one business day after making the decision, the IDR entity will notify you and the Plan.

d. Upon receipt of any information submitted by you, the assigned IDR entity will, within one business day, forward the information to the Fund Office. Upon receipt of any such information, the Fund may reconsider its adverse benefit determination that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Fund decides, upon completion of its reconsideration, to reverse the adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Fund Office will provide written notice of its decision to you and the assigned IDR entity. The assigned IDR entity will then terminate the external review.

e. The IDR entity will review all information and documents timely received. In reaching a decision, the assigned IDR entity will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IDR entity, to the extent the information or documents are available, and the IDR entity considers them appropriate, will consider all information required to be considered under the No Surprises Act and regulations issued thereunder.

f. The assigned IDR entity will provide written notice of the final external review decision within 45 days after the IDR receives the request for the external review. The IDR entity will deliver notice of its decision to you and the Plan. The assigned IDR entity's notice will contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
ii. The date the IDR entity received the assignment to conduct the external review and the date of the IDR entity's decision;
iii. References to the evidence or documentation, including the specific Plan, provider, patient, and other records considered in reaching its decision;
iv. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
v. A statement that the determination is binding, except to the extent that other remedies may be available under State or Federal law to either the Fund or you;
vi. A statement that judicial review may be available to you; and
vii. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

g. After a final external review decision, the IDR entity will maintain records of all claims and notices associated with the external review process for six years. An IDR entity will make such records available for examination by you, the Fund, or a State or Federal oversight agency upon request, except where this would violate State or Federal privacy laws.

4. **Reversal of Plan's Decision**
Upon receiving a notice of a final external review decision reversing the internal appeal adverse benefit determination, the Fund will immediately comply.

Please keep this Summary of Material Modification with your SPD.

Should you have any questions about these changes, please contact the Fund Office.

Sincerely,

Board of Trustees
Iron Workers Health Trust Fund Local No. 5,
Washington D.C.

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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.

Contact the Iron Workers Health Trust Fund Local No. 5, Washington D.C Fund's Office at (412) 471-2885 / (800) 242-8923, if you have questions about your rights under the Health Trust Plan.