Your Rights and Protections Against Surprise Medical Bills

For U.A. Local 350 Health, Welfare & Vacation Trust Fund ("Plan")

Effective September 1, 2022, when you get emergency care or get treated by an out- of-network provider (also known as non-contract 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 the U.A. Local 350 Health, Welfare & Vacation Trust Fund Plan's network.

"Out-of-network" or "Non-contract provider" describes providers and facilities that haven't signed a contract with your 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, you should not be charged more than your plan's copayments, coinsurance and/or deductible. 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 protectionsnot to be balance billed.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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 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 1-800-985-3058. This number is in coordination with the Department of Treasury, U.S. Department of Labor and the Office of Personnel Management, which will operate a telephone line with functionality for individuals to submit complaints regarding potential violations of the No Surprise Act. Department of HHS will route complaints to the appropriate federal agency. Please note, consumer and provider functionality for complaints inquiry and triage will not be operational until January 2022. If individuals call before January 1, 2022 they will hear: "Thank you for calling the No Surprises Helpdesk. We will begin accepting calls on January 1st, 2022. Please visit www.cms.gov/nosurprises for more information on the No Surprises Act and payment disputes. Thank you and have a wonderful day."

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