PAMCAH
UA LOCAL 675
ADMINISTRATIVE OFFICE · ANNUITY · COOPERATION
HEALTH & WELFARE · PENSION · TRAINING · VACATION & HOLIDAY
1109 Bethel Street • Suite 403 • Honolulu, HI 96813 • Ph: (808) 536-4408 • Fax: (808) 524-0658

Date: October 2022

To: All Active Employees, Retirees and their Dependents, including COBRA beneficiaries, enrolled in the Full and Abbreviated Benefit Plans of the PAMCAH-UA Local 675 Health and Welfare Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Participant Notice will advise you of certain material modifications that have been made to the PAMCAH-UA Local 675 Health and Welfare Fund Full and Abbreviated Benefit Plans (the "Plan"). **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully. Note: All benefits are subject to the terms of the Plan.

PLEASE CONTINUE TO USE IN-NETWORK (CONTRACT) PROVIDERS WHENEVER POSSIBLE TO HELP KEEP COSTS TO THE TRUST FUND AS LOW AS POSSIBLE.

NEW BILLING PROTECTIONS FOR CERTAIN SERVICES FROM NON-CONTRACT PROVIDERS

Effective August 1, 2022

The *No Surprises Act* limits your cost-sharing amounts and provides protections from surprise medical bills for you and your covered dependents in the following situations:

1. When you receive Emergency Services at a Non-Network (or "Non-Contract) hospital or a Non-Contract Independent Freestanding Emergency Department;

2. When you receive non-emergency services (otherwise covered by the Plan) from a Non-Contract Provider at an In-Network (or "Contract") facility, unless the Non-Contract Provider meets certain notice and consent requirements for such services; and

3. When you receive Air Ambulance Services (otherwise covered by the Plan) from a Non-Contract Provider.

IMPORTANT: Effective August 1, 2022, individuals receiving the above services will only be responsible for paying their Contract coinsurance, copayment, and/or deductible (if applicable) and cannot be Balance Billed by the Non-Contract provider or facility for these services.

Note: Capitalized terms are defined in the definitions section below.

Emergency Services

Emergency Services are covered under the Plan as follows:

- Without the need for prior authorization, even if the services are provided by a Non-Contract Provider;
- Without regard to whether the Emergency Services were provided by a Contract provider or a Contract emergency facility, as applicable, with respect to the services;
- Without any administrative requirement or limitation on Non-Contract Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Contract providers and Contract emergency facilities;
- Without Cost-sharing requirements on Non-Contract Emergency Services that are greater than the requirements that would apply if the services were provided by a Contract provider or a Contract emergency facility;
- The Cost-sharing requirement for Non-Contract Emergency Services will be calculated as if the total amount that would have been charged for the services was equal to the *No Surprises Act* "Recognized Amount" for the services; and
- Cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services will count toward any Contract deductible or Contract out-of-pocket maximums applied under the Plan and in the same manner as if the Cost-sharing payments were made with respect to Emergency Services furnished by a Contract provider or a Contract emergency facility.

In general, you cannot be Balance Billed for Emergency Services provided by a Non-Contract provider. The Cost-sharing Amount for Emergency Services from Non-Contract Providers will be based on the lesser of: (i) billed charges from the provider, or (ii) the Qualified Payment Amount (QPA).

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

Non-emergency items or services (that are otherwise covered by the Plan), when performed by a Non-Contract Provider at a Contract facility are now covered by the Plan as follows:

- The Cost-sharing requirement will be no greater than the Cost-sharing requirement that would apply if the items or services had been furnished by a Contract provider,
- Cost-sharing requirements will be calculated as if the total amount that would have been charged for the items and services by such Contract provider were equal to the *No Surprises Act* Recognized Amount for the items and services,
- Cost-sharing payments made by the participant or beneficiary will count toward any Contract deductible and Contract out-of-pocket maximums applied under the plan (and the Contract 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 Contract provider, and

In general, you cannot be Balance Billed for these items or services unless the Non-Contract Provider follows the notice and consent procedures described below (this is not applicable to all Non-emergency items and services when performed by a Non-Contract Provider at a Contract facility).

Notice and Consent Procedures

Certain Non-emergency items or services performed by a Non-Contract Provider at a Contract facility will not have the financial protections of the *No Surprises Act,* if the Non-Contract Provider follows the notice and consent requirements described below:

1. 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 that the provider is a Non-Contract Provider with respect to the Plan, an estimate of the charges for the treatment and any advance limitations that the Plan may put on the treatment, the names of any Contract providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the Contract providers listed; and

2. The participant or dependent gives informed consent to continued treatment by the Non-Contract Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-Contract Provider may result no coverage to the participant or beneficiary.

IMPORTANT: If you consent to continued treatment by a Non-Contract provider you will lose the protections of the *No Surprises Act* described in this SMM. You will have to pay a higher amount for the Non-Contract service than if the service was performed by a Contract Provider and you may be Balance Billed by the Non-Contract Provider.

The notice and consent exception for non-emergency items or services performed by a Non-Contract Provider at a Contract facility 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-Contract Provider satisfied the notice and consent criteria.

The Cost-sharing Amount for non-emergency services at Contract Facilities by Non-Contract Providers will be based on the *No Surprises Act* Recognized Amount, which is, generally, the lesser of (i) the billed charges from the Non-Contract Provider, or (ii) the Qualifying Payment Amount (i.e., the Plan's median of contract rates for the item or service in that location).

Air Ambulance Services

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

- The Cost-sharing requirement will be no greater than the Cost-sharing requirement that would apply if the services had been furnished by a Contract provider.
- The Cost-sharing Amount will be calculated as if the total amount that would have been charged for the services by a Contract 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 Contract deductible and Contract out-of-pocket maximum in the same manner as those received from a Contract provider.

  In general, you cannot be Balance Billed for these items or services. Please note these protections described above do **not** apply to ground ambulances services.

Please see below for a revised Schedule of Medical Benefits.

Ambulance (Ground, Air)	Contract Provider	Non-Contract Provider
• Services must be received from a properly licensed or certified automobile ground or air ambulance service. • Air ambulance services are limited to intra-island or inter-island transportation within the state of Hawaii. After you satisfy the annual Deductible, benefits for ground and air ambulance charges will be paid as follows.. • Transportation must be from the place where an injury occurred or first required care to the nearest facility equipped to furnish emergency treatment. • The injury or illness must require emergency medical treatment, surgical treatment or hospitalization.	**Ground Ambulance**: 100% of Allowed Charge, after Deductible **Air Ambulance**: 90% of Allowed Charge, after Deductible	**Ground Ambulance**: 70% of Allowed Charge, after Deductible **Air Ambulance**: 90% of Allowed Charges Amount, after Deductible

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a Non-Contract Provider at a Contract facility, and/or Air Ambulances 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.

Complaint Process

If you believe you've been billed incorrectly, or otherwise have a complaint under the *No Surprises Act,* you may contact (808) 948-6079 or (800) 776-4672 toll free for assistance.

CONTINUITY OF CARE COVERAGE

Effective August 1, 2022

If you meet the requirements of a "Continuing Care Patient" and the contract between the Fund and your Contract provider or facility terminates, or terminate your benefits because of a change in terms of the providers' and/or facilities' participation in the network,

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 the Contract Cost-Sharing Amount to allow for a transition of care to a Contract provider.

CONTRACT PROVIDER DIRECTORY

Effective August 1, 2022

A list of Contract providers is available to you without charge at https://www.hmsa.com/search/providers/ 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 Fund or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a Contract provider, the Fund will apply the Contract Cost-sharing Amount to your claim, even if the provider was a Non-Contract Provider.

NEW/REVISED DEFINITIONS OF THE PLAN

Effective August 1, 2022

To implement the protections of the No Surprises Act, effective August 1, 2022, the Fund is adopting the following new/revised definitions of terms in the Plan.

Air Ambulance

The term "Air Ambulance" means medical transport for patients 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.

Allowable or Allowed Charges for Claims Subject to the No Surprises Act

For Emergency Services provided by Non-Contract Providers, for Non-Emergency Services provided by a Non-Contract Provider at a Contract facility (excluding services for which the Non-Contract Provider obtained notice and consent from the participant or dependent), and for Air Ambulance Services, the term "Allowable Charge" means the Non-Contract Rate, as defined below.

Ancillary Services

The term "Ancillary Services" means, with respect to services furnished by Non-Contract Providers at a Contract 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 items and services provided by other specialty practitioners as specified by the Secretary of HHS; and
- Items and services provided by a Non-Contract Provider if there is no Contract provider who can furnish such item or service at such facility.

With respect to Hospital Services (Inpatient), Ancillary Services also include services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Balance Billing

The term "Balance Billing" means a bill from a health care provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with balance billings are not covered by this Plan, even if the Plan's Out-of-Pocket limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and Allowed Charges.

Under the *No Surprises Act*, you may not be balance billed for Emergency Services, Air Ambulance Services, and, unless appropriate notice and consent criteria are met, for any Non-Emergency Services performed by non-participating providers at a Contract participating facility. For these services, cost-sharing payments will count toward any Contract deductible and Contract out-of-pocket maximum. You will be responsible for the entire billed amount for all services received from a Non-Contract Provider that are not subject to the protections of the *No Surprises Act.*

Continuing Care Patient

The term "Continuing Care Patient" means a participant or beneficiary 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.

Cost-sharing

The term "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-Contract Providers, or the cost of items or services that are not covered under the plan.

The **Cost-sharing Amount** for Emergency and Non-emergency Services at Contract Facilities performed by Non-Contract Providers, and Air Ambulance services from Non-Contract Providers will be based on the *No Surprises Act* Recognized Amount.

Emergency Medical Condition

The term "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

The term "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-Contract Provider or Non-Contract Emergency Facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services were furnished, until:

- The attending emergency physician or treating provider determines that the participant or beneficiary is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and
- The participant or covered dependent is supplied with a written notice of the following:
  1. The provider is a Non-Contract Provider with respect to the Plan,
  2. An estimate of the charges for treatment and any advance limitations that the Plan may put on a patient's treatment,
  3. The names of any Contract providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the Contract providers listed; and
  4. The patient (or their authorized representative) gives informed voluntary consent to continued treatment by the Non-Contract Provider, acknowledging that the patient (or their authorized representative) understands that continued treatment by the Non-Contract Provider may result in greater cost to the participant or covered dependent.

Health Care Facility

The term "Health Care Facility" (for non-emergency services) means 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

The term "Independent Freestanding Emergency Department" means 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

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

Non-Contract Emergency Facility

The term "Non-Contract 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-Contract Provider

The term "Non-Contract 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.

Non-Contract Rate

With respect to Emergency Services provided by a Non-Contract Provider, non-emergency services furnished by a Non-Contract Provider at a Contract facility, and Air Ambulance Services by a Non-Contract Provider, the term "Non-Contract Rate" 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.

Out-of-Pocket Limit on Medical Plan Contract Cost-Sharing (Annual Out-of-Pocket Limit).

The *No Surprises Act* modifies the definition of Annual Out-of-Pocket Limit provided in the Summary Plan Description for Emergency Services, non-emergency services furnished by a Non-Contract Provider at a Contract facility, and Air Ambulance Services as follows: any cost-sharing payments (e.g., copayments, coinsurance, and deductibles) made by the participant or beneficiary are counted towards any Contract deductible or Out-of-Pocket Limit.

Qualifying Payment Amount (QPA)

The term "Qualifying Payment Amount" means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the plan or issuer for the item or service in the area.

Recognized Amount

The term "Recognized Amount" means (in the order listed below) one of the following as applicable:

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-Contract Providers, the **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Serious and Complex Condition

The term "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—
   - Is life-threatening, degenerative, potentially disabling, or congenital; and
   - Requires specialized medical care over a prolonged period of time.

In the context of Continuity of Care, **Termination** includes, with respect to a contract, 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.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact the Trust Fund Office at 808-536-4408.

Sincerely,
Board of Trustees

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, please contact the Administrative Office.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan. Please keep this document with your copy of the Summary Plan Description. In the event of any conflict, the terms of the Plan and SPD will control unless specified otherwise herein. The Board of Trustees reserves its right to amend or terminate the Plan in whole or in part at any time in its sole discretion.