LOCAL 36 BENEFIT FUNDS
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The No Surprises Act, part of the Consolidated Appropriations Act, protects patients from being balanced billed by the provider or facility if they receive emergency services at certain out-of-network facilities or from a non-PPO provider at an in-network facility or if they need an air ambulance. Patients receiving these services will only be responsible for paying their in-network cost share of an amount that is similar to the rate that an in-network provider would charge.

Surprise Billing

Starting January 1, 2022, when you receive emergency care or are treated by an out-of-network provider at an in-network hospital, freestanding emergency department or ambulatory surgical center, you are protected from surprise billing or balance billing in the following situations:

- Emergency services: If you have an emergency medical condition and get emergency services (including air ambulance services) from an out-of-network provider or facility, the most the provider or facility may bill you is the 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 have been stabilized until you are able to use nonmedical transportation or non-emergency medical transportation unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. *Currently, you pay the in-network cost sharing, but providers are allowed to balance bill you.*

- 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. *This is similar to the current coverage of ancillary providers.*

  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.

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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.

In the circumstances described above when balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost under the Plan, like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network. The plan will pay out-of-network providers and facilities directly.

- The plan generally will:

  - Cover emergency services without requiring you to get approval for services in advance (prior authorization). *This is not a change from how the plan currently works.*

  - Cover emergency services by out-of-network providers. *This is not a change from how the plan currently works.*

  - 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. *Currently, the provider or facility can balance bill you.*

  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit. *This is not a change from how the plan currently works.*

Implementing these changes involves new definitions, changes in the definition of what is an emergency or emergency care, and some reorganizing of the SPD. A more detailed explanation of the changes will be distributed.

Information on In-Network Providers

A list of in-network providers is available to you without charge at www.meritain.com or by calling 866-209-3061. If you obtain and rely upon incorrect information about whether a provider is an in-network provider from the Plan or its administrators, the Plan will apply in-network cost-sharing to your claim, even if the provider was out-of-network.

Continuation of Care Coverage

If you are undergoing a course of treatment for a serious and complex condition; undergoing a course of institutional or inpatient care; scheduled to undergo non-elective or postoperative care after a non-elective surgery; pregnant and undergoing a course of treatment for the pregnancy; or are terminally ill and receiving treatment for such illness and your provider or facility leaves the network, the Plan will (1) notify you in a timely manner of the provider or network's change in status and your right to elect continued transitional care from the provider or facility and (2)

continue to cover claims for that complex care at the in-network cost sharing levels for up to 90-days to allow time for you to transition to an in-network provider.

If you believe you have been wrongly billed, or otherwise have a complaint under the No Surprises Act, you should contact the Fund Office at 314-652-8175.

Visit http://www.dol.gov/ebsa/ for more information about your rights under federal law.