RAILROAD MAINTENANCE AND INDUSTRIAL HEALTH AND WELFARE FUND

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April 20, 2022

PLAN ANNOUNCES NEW RIGHTS AND PROTECTIONS FOR YOU AND YOUR FAMILY

(THIS IS A SUMMARY OF MATERIAL PLAN MODIFICATIONS - PLEASE READ CAREFULLY)

EFFECTIVE MAY 1, 2022

Dear Participant:

On December 27, 2020 the President signed the Consolidated Appropriations Act of 2021. One section of that bill, referred to as the No Surprises Act, establishes new rights and protections for participants in employer-sponsored group health plans like the Railroad Maintenance and Industrial Health and Welfare Fund. While the No Surprises Act imposes a number of new requirements on plans like this one, two of the requirements which most directly affect your rights and entitlements under the Railroad Maintenance and Industrial Health and Welfare Fund become effective on May 1, 2022 and have been widely reported in the media. One of them pertains to your share of health care costs when you incur charges for emergencies with an out-of-network provider or when out-of-network providers otherwise administer care to you or a covered family member unexpectedly or without your knowledge. The other provides protection for you and your family under certain situations when a health care provider that has been treating you elects to no longer participate in the Plan's PPO network with United HealthCare. This notice will explain how these new rights may impact you and your family.

<u>What Is Balance Billing Under The No Surprises Act?</u>

One provision of the No Surprises Act basically guarantees that neither you nor any of your covered dependents will ever be responsible for medical bills that are incurred unexpectedly or without your knowledge with an out-of-network provider. An unexpected medical bill can result from emergency treatment by a provider who does not participate in the Plan's PPO. It could also be a charge from an out-of-network provider who administers treatment that was not directly authorized by you. For example, if you undergo a medical procedure that is performed by an in-network surgeon in an in-network facility but anesthesia services are administered by an anesthesiologist who does not participate in the Plan's PPO, you may be billed the full cost of the anesthesiologist's services.

As is explained in your Summary Plan Description (SPD), your Plan does not generally cover out-of-network charges. In those instances where it does, it will pay only an amount that is determined to be

a usual, customary and reasonable (UCR) charge, which is typically an amount equal to what would have been charged had the service been performed by an in-network provider. Assume that in the above example the anesthesiologist billed $5,000 and the value of those services was determined to be $2,000 had the services been performed by an in-network provider. This would leave $3,000 of the bill unpaid. In many situations, that provider will bill the balance to you. This is known as balance billing.

There may also be times when you experience an emergency situation and the closest facility qualified to treat your condition does not participate in the Plan's PPO network. If your condition is determined to be a true emergency, the Plan will cover the treatment, but it may base its payment on an amount that is equal to what the charges would have been had the charges been incurred on an in-network basis. So again, this would leave an amount for which you would be responsible.

While the Fund office staff has worked diligently in the past to minimize the amount of any balance billing, in some situations providers have been unwilling to waive any portion of the balance due. The No Surprises Act changes that. It provides a legal mechanism for the Plan and the provider to resolve any disputes which may arise over the value of services provided. Simply stated, should the Plan and the provider fail to agree on the fair value of the service rendered, the No Surprises Act requires that the dispute be resolved by an independent party. This process will not involve you. What this means is that you will never be responsible for any "balance billing" amount incurred under the circumstances described above that exceeds your deductible, your co-payment percentage and your annual out-of-pocket maximum.

This is only a summary of how the new rights and protections afforded by the No Surprises Act for balance billing work. For specific questions, you should always contact the Fund office. To determine if a provider participates in United HealthCare's PPO network, you may access the provider directory online at http://welcometouhc.com/uhss or call 844-849-5748.

IMPORTANT REMINDER - It is extremely important that you ensure that every health care provider with whom you consult for treatment participates in United HealthCare's (UHC) preferred provider network. Some participants have recently experienced problems because they have sought the services of a provider they know to be in-network only to be treated by another provider within the same practice who does not participate in UHC's network. Also, periodically a provider who has been treating you will decide to no longer participate in UHC's network. In many cases, and as indicated in this notice and your Summary Plan Description, charges incurred with a provider that does not participate in UHC's network are not covered under this Plan. Two steps you should take before incurring any charge for health care services are to: (1) inquire directly with the provider that will treat you whether they participate in UHC's network, and (2) determine whether the provider is an in-network provider by accessing UHC's website at http://welcometouhc.com/uhss.

What Is Continuation Of Care Under The No Surprises Act And How Does It Affect You?

As with all aspects of life, changes frequently occur. With tens of thousands of health care providers participating in United HealthCare's network, it is possible that at some point in time a provider from which you have been receiving treatment may elect to opt out of UHC's network or may no longer be qualified to participate in the network. Such a change can have a significant impact upon how you receive health care services. Generally, the Plan requires that all services be obtained from an in-network provider. However, it is understood that unexpected or undisclosed changes in a provider's in-network status can affect the care available to your family and the amount of coverage, if any, provided by the Plan.

Because of that, the new law offers protections in some of those situations. Basically, if you are a "continuing care patient" being treated for:

1. **a serious and complex condition;**
2. **a course of treatment for inpatient care;**
3. **a scheduled non-elective surgical procedure, including post-operative care;**
4. **a pregnancy and a course of treatment resulting from the pregnancy; or**
5. **a terminal illness and care for that illness,**

and one or more providers responsible for your treatment should discontinue their participation in the Plan's PPO, you will be notified in writing of your right to elect continued transitional care from such provider(s) by timely filing the appropriate election forms with the Fund office. Your continuing transitional care will be provided as though the provider continued to be in-network and will end 90 days from the date you were notified or the date you no longer need the continuing care, if earlier.

What If You Fail To Receive These Rights?

As always, the Fund office is available to assist with any questions or issues if you believe you have been denied any of the rights described in this notice. You may also contact the federal agencies responsible for the oversight of these new requirements at 1-800-985-3059 or https://www.cms.gov/nosurprises/consumers.

With Best Regards,
Board of Trustees

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