CONSTRUCTION
INDUSTRY LABORERS
FRINGE BENEFIT FUNDS
PO Box 909500
Kansas City, MO 64190
(816) 777-2669
(833) 479-9429 (toll free)
(816) 756-3659 (fax)

Managed for the Trustees by
Wilson-McShane Corporation

JANUARY 2023

TO: ALL ELIGIBLE PARTICIPANTS OF THE CONSTRUCTION INDUSTRY LABORERS WELFARE FUND

RE: PLAN CHANGES – SURPRISE MEDICAL BILLING AND VIRTUAL PHYSICAL THERAPY

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Dear Participant:

The Board of Trustees may occasionally modify benefits based on the financial status of the Plan or to comply with changes in federal law. We announce the following modifications to your Health and Welfare Plan. The following notice provides information on the No Surprises Act as well as a new virtual physical therapy benefit.

The No Surprises Act was signed into law in December 2020 and generally protects patients from "balance billing" for Out-of-Network emergency services or facilities, Out-of-Network air ambulance services, and certain non-emergency services performed by an Out-of-Network provider at a PPO Network facility (collectively "No Surprise Services").

As described in more detail below, Participants and Dependents receiving No Surprise Services will generally only be responsible for paying their PPO Network cost sharing. You are still encouraged to use PPO Network facilities and participating providers whenever possible. Additionally, this SMM describes other changes required by the No Surprises Act, including expanded emergency services and continuity of care provisions.

Consequently, the following changes are made to the Fund's plan of benefits effective January 1, 2022.

EMERGENCY SERVICES

The No Surprises Act requires emergency services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. Without regard to whether the health care provider furnishing the emergency services is a PPO network provider or an Out-of-Network emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on Out-of-Network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from PPO Network provider and PPO Network provider emergency facilities;

4. Without imposing cost-sharing requirements on Out-of-Network emergency services that are greater than the requirements that would apply if the services were provided by a PPO Network provider or a PPO Network provider emergency facility;

5. By calculating the cost-sharing requirement for Out-of-Network emergency services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and;

6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from a PPO Network provider.

NON-EMERGENCY SERVICES PERFORMED BY A OUT-OF NETWORK PROVIDER AT A NETWORK FACILITY

The No Surprises Act requires non-emergency services performed by an Out-of-Network provider at a PPO Network Health Care Facility to be covered as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO Network provider;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such PPO Network provider were equal to the Recognized Amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO Network provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network provider at a PPO Network facility will be covered based on your Out-of-Network coverage (meaning your cost sharing will be based upon the Usual and Customary amounts for non-network providers as defined in your Plan) if:

a) At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is a non-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any PPO Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO Network providers listed; and

b) You give informed consent to continued treatment by the Out-of-Network provider, acknowledging that you understand that continued treatment by the Out-of-Network provider may result in greater cost to you.

The notice and consent exception 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-network provider satisfied the notice and consent criteria.

AIR AMBULANCE SERVICES

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

- The Air Ambulance services received from a Non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO 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 PPO deductible and PPO out-of-pocket maximum in the same manner as those received from a PPO provider.

PAYMENTS TO OUT-OF-NETWORK PROVIDERS AND FACILITIES

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Network facilities by Out-of-Network providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Out-of-Network provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the Participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the Out-of-Network provider that is equal to the amount by which the Out-of-Network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

CONTINUITY OF COVERAGE

If you are a Continuing Care Patient, and the contract with your PPO Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

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 PPO Network cost sharing to allow for a transition of care to a PPO Network provider.

INCORRECT PROVIDER INFORMATION

A list of PPO Network providers is available to you without charge by visiting the website 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 Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is in the network from the Plan or its administrators, the Plan will apply the PPO Network cost-sharing to your claim, even if the provider was an Out-of-Network provider at the time the service was rendered.

COMPLAINT PROCESS

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office at 866-732-1919 or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

EXTERNAL REVIEW OF CERTAIN COVERAGE DETERMINATIONS

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by an Out-of-Network provider at a PPO Network facility, and/or Air Ambulances service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

NEW DEFINITIONS

Due to the nature of the changes required by the No Surprises Act, the Fund has adopted the following definitions, which will assist you in fully understanding the changes required by the No Surprises Act:

Air Ambulance Services means medical transport by helicopter or airplane for patients.

Ancillary Services means with respect to a network facility including the following:

- 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 subject to exceptions specified by the Secretary; and
- Items and services provided by a Out-of-Network provider if there is no PPO Provider who can furnish such item or service at such facility.

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 out-of-network providers, or the cost of items or services that are not covered under the plan.

Continuing Care Patient means an individual 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

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.

Covered Expenses means the Reasonable and Customary charges that apply to a Medically Necessary health care service, supply or expense, including deductibles, coinsurance or copayments, that is ordered by a licensed Physician for treatment of Injuries and Illnesses that are not work related. Out-of-pocket payments for out-of-network claims that are balance-billed to Participants are not considered covered expenses and are not applied to a Participant's out-of-pocket maximum, except in the case of claims relating to the No Surprises Act. This means that an expense or service (or any portion of an expense or service) that is not covered by the Plan is not a covered expense.

Emergency Department of a Hospital includes a hospital outpatient department that provides Emergency Services.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself 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 (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services with respect to an Emergency Medical Condition, "emergency services" include:

- a medical screening examination (as required under Section 1867 of the Social Security Act, or as would be required under such Section if it applied to an Independent Freestanding Emergency Department) 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 of a Hospital or of an Independent Freestanding Emergency Department, as applicable, to evaluate such Emergency Medical Condition; and

- within the capabilities of the staff and facilities available at the Emergency Department of a Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under Section 1867 of such Act, or as would be required under such Section if such Section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the Emergency Department of the Hospital in which such further examination or treatment is furnished).

The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta). Emergency Services furnished by a Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post-stabilization services

(services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

- The provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation;

- You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO Providers at the facility who are able to treat you, and that you may elect to be referred to one in the PPO Network or PPO Providers listed; and

- You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that the participant or Beneficiary understands that continued treatment by the Out-of-Network Provider may result in greater cost to the participant or Beneficiary.

Independent Freestanding Emergency Department means a health care facility that (i) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) Provides any "Emergency Services" as defined above.

Out-of-Network Emergency Facility - 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 the Plan, with respect to the furnishing of an item or service.

Out-of-Network Rate will be determined in the following order:
- the amount that the state approves under an All-Payer Model Agreement, if applicable
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

Qualifying Payment Amount (QPA) generally means, the median amount the Plan has contractually agreed to pay PPO Network providers, facilities, or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

Recognized Amount: For items and services furnished by an Out-of-Network provider or Out-of-Network emergency facility, the Recognized Amount will be determined in the following order:
- An amount determined by an All-Payer Model Agreement, if applicable
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

Reasonable and Customary (R&C) Charge means the charge for a service or supply that is not higher than the usual amount charged in the locality for similar services or supplies, for claims other than those relating to the No Surprises Act. The Fund will also consider the complexity of the service in determining R&C. However, the PPO negotiated rate will be deemed to be Reasonable and Customary for all in-network claims.

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;
2. in the case of a chronic illness or condition, a condition that is—
   a. is life-threatening, degenerative, potentially disabling, or congenital; and
   b. requires specialized medical care over a prolonged period of time.

Virtual Physical Therapy – Effective August 1, 2022 the Plan will provide virtual physical therapy to Covered Persons who qualify through the Fund's preferred musculoskeletal virtual provider SWORD Health at NO COST to the Covered Person. If qualified, the Covered Person will receive required monitoring equipment in the mail and will access their physical therapy sessions through a smart phone, computer or tablet. As mentioned above, there is no cost to the Covered Person and no annual visit limit for virtual physical therapy. Worker's compensation injuries are not covered under the Plan or this virtual program.

To see if you qualify for virtual physical therapy through SWORD Health, you may contact SWORD Health through the swordhealth.com Portal.

1. Enrollment.
   Participants will enroll through a dedicated online enrollment page through the SWORD website, to confirm eligibility.

2. Specialist.
   Enrolled Participants will be paired with a Specialist to support the Enrolled Participant throughout the Services.

3. Digital Therapist©, Mobile App, and Communications
   a. Digital Therapist.
      - All Enrolled Participants shall receive a Digital Therapist© to assist Enrolled Participants to perform the Preventive Exercise Visits. The Digital Therapist© will provide video and audio descriptions of the exercises, as well as real-time biofeedback during exercise execution, helping Enrolled Participants to perform the Exercise Visits.

      - In order to access and use the Digital Therapist©, Enrolled Participants will be required to have wireless internet connection sufficient to support the provision of Services.
      - Enrolled Participants will be provided with replacement motion sensors and/or a tablet, to the extent the motion sensors or tablet fail or break, at no cost to the fund or the Enrolled Participant.

      - Enrolled Participants will be asked to return the Digital Therapist upon completion of the program, or after an extended period of inactivity.

   b. Mobile App

- Enrolled Participants will be asked to download the Mobile App to their smartphones and create a user profile.

- Through the Mobile App, Enrolled Participants will receive educational articles on Musculoskeletal (MSK) health as well as behavioral advice to support wellness.

- Enrolled Participants can communicate directly with their Specialist through the Mobile App.

- In order to access and use the Mobile App, Participants will be required to have access to the latest iPhone iOS and/or Android smartphone operating systems.

Please keep this notice with your Summary Plan Description booklet. If you have any questions regarding this change, please contact the Fund's administrative office.

If you have any questions about these changes, please feel free to contact the Fund Office toll free at (833) 479-9429 or at (816) 777-2669.

Sincerely,

BOARD OF TRUSTEES

Statement Regarding Status as a Grandfathered Health Plan

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.