Your Rights and Protections Against Surprise Medical Bills

When you receive services for an Emergency or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you should not be charged more than the Pipe Fitter's Local No. 533 Health and Welfare Plan's (the "Plan") copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

The Plan offers the Aetna network of physicians, hospitals, facilities, and other health care providers. Aetna contracts with these providers to offer medical treatment to you and your dependents at a reduced rate. This network of providers is called a Preferred Provider Organization ("PPO"), and the providers in the network are called "in-network providers."

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in the Plan's network. "Out-of-network" means providers and facilities that have not signed a contract with Aetna to provide services. Out-of-network providers may be allowed to bill you for the difference between what the Allowable Charge (as defined in the Plan's Plan Document and Summary Plan Description) 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 the Plan's deductible or Comprehensive Medical Benefit annual out-of-pocket maximum.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you receive services for an Emergency from an out-of-network provider or facility, the most they can bill you is the Plan's cost-sharing amount (such as copayments, coinsurance, and deductibles) for in-network providers. You **cannot** be balance billed for these services. This includes services you may get after you are 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, the most those providers can bill you is the 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 **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are <u>never</u> required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in the Plan's network.

<u>When balance billing is not allowed, you also have these protections:</u>

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). The Plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, the Plan must:
    - Cover services rendered for an Emergency without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover services rendered by out-of-network providers for an Emergency.
    - 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 services rendered for an Emergency or out-of-network services toward your in-network deductible and Comprehensive Medical Benefit annual out-of-pocket maximum.

If you think you have been wrongly billed, you may contact the Fund Office at (816) 361- 0206 or by mail at Pipe Fitters Local No. 533 Health and Welfare Plan , 8600 Hillcrest Road, Suite A, Kansas City, MO 64138. You may also contact the Centers for Medicare & Medicaid Services ("CMS") by visiting https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing or calling the CMSphone number for information and complaints: 1-800-985-3059.

Visit www.local533.com or www.cms.gov/nosurprises/consumers for more information about your rights under federal law.