SANTA MONICA UNITE HERE
HEALTH BENEFIT TRUST FUND

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February 2022

To: **All active Employees, their Dependents, and COBRA beneficiaries in the MLK Program of the Santa Monica UNITE HERE Health Benefit Fund**

From: **Santa Monica UNITE HERE Health Benefit Fund**

This Summary of Material Modifications ("SMM") describes changes that have been made to the Martin Luther King Community Healthcare Program (the "MLK Program") of the Santa Monica UNITE HERE Health Benefit Trust Fund (the "Fund"), effective January 1, 2022.

The changes described in this SMM supersede any contrary provisions of the Santa Monica UNITE HERE Health Benefit Trust Fund Summary Plan Description and Plan Document (Effective July 1, 2021) (the "SPD"). In addition, this SMM modifies the definitions of "Emergency," "Emergency Medical Condition" and "Emergency Services" contained in Article IV, Section 10 (page 42) of the SPD.

Please read this notice carefully and keep it with your important plan materials.

Except where the context indicates otherwise, references to "you" and "your" in this SMM generally refer to any person eligible and enrolled for benefits under the MLK Program, either as an Employee or as the Dependent of an Employee.

SECTION 1:
PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
FROM OUT-OF-NETWORK PROVIDERS
EFFECTIVE JANUARY 1, 2022

This section of the SMM describes certain limited circumstances for which the MLK Program will cover services provided by Out-of-Network Providers, and you will be protected from surprise medical bills. Please read this section carefully.

> **Remember:** As a general rule, the MLK Program does not cover services from Out-of-Network Providers, except for Emergency Services. In addition, you generally need a Referral and Prior Authorization for most services other than a visit with your Primary Care Physician (or another available Primary Care Physician within the MLK Community Medical Group). This SMM describes limited exceptions to this general rule.

A. General Explanation

Effective January 1, 2022, certain services provided by Out-of-Network Providers will be covered by the MLK Program as if the services had been provided by a Network Provider. This means that, for the services subject to these rules, you will pay the same cost sharing (e.g., Copayments) as if you had used a Network Provider, and you cannot be Balance Billed for such services. In addition, your Copayments for such services will count towards your annual out-of-pocket maximum.

> **Please Note:** For definitions of capitalized terms used in this Section 1, "Protections Against Surprise Medical Bills from Out-of-Network Provider," please refer to Subsection E., below.

There are three categories of services subject to these new rules, as explained in more detail below, and these new rules generally apply only to services that are otherwise covered under the MLK Program. The three categories of services to which these protections against surprise medical bills apply are:

1. Emergency Services provided by Out-Of-Network Providers;
2. Non-Emergency Services provided by Out-of-Network Health Care Professionals at a Network Health Facility; and
3. Air Ambulance Services provided by Out-of-Network Providers.

These new rules apply to a narrow set of circumstances. Most services from Out-of-Network Providers will not be covered. Please read this section carefully for detailed information.

B. Protections for Out-of-Network Emergency Services

The MLK Program does not cover services or supplies from Out-of-Network Providers, except for Emergency Services.

If you receive Emergency Services from an Out-of-Network Provider, the most the Provider may bill you for is your in-Network cost-sharing amount (such as your Copayment) for the service(s) you received. You **cannot** be Balance Billed for these Emergency Services. In addition, your out-of-pocket costs (e.g., your Copayment) for Emergency Services will count towards your annual out-of-pocket maximum.

As explained in the definition of Emergency Services in Subsection E., below, Emergency Services includes certain services you receive after you're stabilized, unless you give informed written consent to give up your protections not to be Balanced Billed for these post-stabilization services or you are able to travel using nonmedical transportation or nonemergency medical transportation to an available Network Provider or Facility within a reasonable distance.

Remember: You do not have to get a Referral or Prior Authorization for Emergency Services. (*This is not a change from how the Plan currently works).*

The Plan's $100,000 per Hospitalization limit does not apply to Emergency Services received from an Out-Of-Network Health Facility.

C. Protections for Certain Non-Emergency Services from an Out-of-Network Health Care Professional at an In-Network Health Facility

If you receive non-Emergency Services from a Health Facility that is in-Network (i.e., a Network Hospital or Ambulatory Surgical Center), certain Health Care Professionals there may be Out-of-Network. In this situation, if you receive items and services that are otherwise covered under the MLK Program, the most the Out-of-Network Health Care Professional(s) can bill you for is your in-Network cost-sharing amount (e.g., your Copayment(s)), and you **cannot** be Balance Billed, unless you have given informed written consent to give up cost sharing and Balance Billing protections with respect to

such services. In addition, your Copayment(s) and/or Coinsurance for such services will count towards your annual out-of-pocket maximum.

There is, however, an exception to this rule. You cannot give informed consent to give up cost sharing and Balance Billing protections (i.e., you will always be protected from Balance Billing) for the following:

(i) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

(ii) Items and services provided by assistant surgeons, hospitalists, and intensivists;

(iii) Diagnostic services, including radiology and laboratory services;

(iv) Items and services provided by an Out-of-Network Provider if there was no Network Provider who could furnish the item or service at the Health Facility; and

(v) Items or services furnished as a result of unforeseen, urgent medical needs that arose at the time the item or service was furnished.

You're <u>never</u> required to give up your protections from Balance Billing. You also aren't required to get care Out-of-Network. You can choose a Provider or Facility in the MLK Program's network.

Example: *If a participant in the MLK Program has a covered surgery at Miller Children's Hospital (a Network Hospital), but the doctor who administers anesthesia to the participant is Out-of-Network, this rule will protect the participant from receiving surprise medical bills from the Out-of-Network Anesthesiologist. The participant will be responsible only for his or her in-Network cost-sharing (i.e., zero dollar Copayment for surgery), and cannot be Balance Billed.*

D. Protections for Out-of-Network Air Ambulance Services

If you receive Air Ambulance Services from an Out-of-Network Provider that are covered under the MLK Program, the most the Provider may bill you for is your in-Network cost-sharing amount (i.e., Copayment(s)), and you **cannot** be Balance Billed. In addition, as described above, your Copayment will count towards your annual out-of-pocket maximum.

Air Ambulance Services are covered under the MLK Program only for an Emergency Medical Condition and when Medically Necessary.

E. Definitions

Capitalized terms used in Section 1 of this SMM have the meanings shown below. If a capitalized term in this SMM is not defined in this Subsection E., then it shall have the same meaning as in Article IV, Section 10 (pages 40-47) of the SPD.

In addition, the definitions of "Emergency," "Emergency Medical Condition" and "Emergency Services" contained in Article IV, Section 10 (page 42) of the SPD are hereby replaced with the definitions of the same terms below.

Air Ambulance Services means medical transport for patients by a rotary wing or fixed wing air ambulance, as defined in applicable regulations at 42 CFR 414.605.

Emergency. The term Emergency has the same meaning as Emergency Medical Condition (see below).

Emergency Medical Condition. A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 any of the following: (1) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. Active labor is considered an Emergency Medical Condition.–"Active labor" means that a pregnant woman is having contractions and : (1) there is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Participant or unborn child.

Emergency Services

(a) With respect to an Emergency Medical Condition, Emergency Services means an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, along with

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).

(b) Emergency Services also includes services otherwise covered by the MLK Program that are furnished by an Out-Of-Network Health Care Professional or an Out-Of-Network Emergency Facility (regardless of the department of the Hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which initial services were provided for an Emergency Medical Condition at such Out-Of-Network Emergency Facility or by such Out-Of-Network Health Care Professional, unless (1) the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available Network Provider or Facility within a reasonable travel distance (as determined by the attending emergency Physician or treating Health Care Professional), (2) the patient or the patient's authorized representative gives the Out-Of-Network Provider informed written consent to give up cost sharing and Balance Billing protections for these services, and (3) the Provider or Facility satisfies any additional requirements or prohibitions of the No Surprises Act or regulations issued thereunder.

(c) For purposes of paragraphs (a) and (b), 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 involving a pregnant woman who is having contractions, to deliver a newborn child, including the placenta).

Out-of-Network Emergency Facility means an emergency department of a hospital, an Independent Freestanding Emergency Department, or, with respect to services described in paragraph (b) of the definition of Emergency Services, a Hospital, that does not have a contractual relationship directly or indirectly with the Fund with respect to the furnishing of an item or service under the MLK Program.

Health Facility. In the context of non-Emergency Services, a Health Facility is each of the following: (a) a Hospital, (b) a Hospital outpatient department; (c) a critical access hospital; and (d) an ambulatory surgical center.

Independent Freestanding Emergency Department means a health care facility that (1) is geographically separate and distinct and licensed separately from a hospital under

applicable State law, and (2) provides any Emergency Services as defined in paragraph (a) of the definition of Emergency Services above.

F. Availability of External Review for Denied Health Claims

In accordance with the MLK Program's External Review Process, which is set forth in Article IV, Section 11.J. of your SPD (starting on page 56), External Review of a denied Health Claim will be available for a denial that involves consideration of whether the MLK Program is complying with the surprise billing and cost-sharing protections described above (applicable to Emergency Services from an Out-of-Network Provider, certain non-emergency services from an Out-of-Network Health Care Professional at a Health Facility that is a Network Provider, or Air Ambulance Services furnished by an Out-of-Network Provider). All other requirements for external review remain unchanged and continue to apply.

G. Plan's Payment to Provider.

For the three categories of services subject to these new rules, as described in Subsections B., C., and D. above, the Fund's payment to the Provider will be determined in compliance with the requirements of the No Surprises Act.

SECTION 2:
CONTINUING CARE RULES
EFFECTIVE JANUARY 1, 2022

Effective January 1, 2022, if you are a undergoing a course of treatment with a Network Provider, and there is a change in the MLK Program's Network so that your Provider is no longer a Network Provider (or if your Provider cannot continue to provide the treatment due to a change in the terms of the contract between the Provider and the MLK Program), you have the right to continue treatment with that Provider for up to 90 days under the same terms and conditions as before, if you qualify as a Continuing Care Patient. Under this new rule, you are only permitted to receive continued transitional care from the Provider for the condition that makes you a Continuing Care Patient.

You qualify as a Continuing Care Patient with respect to a Provider, and you may elect to continued transitional care with your Provider if:

1. You are undergoing a course of treatment for a "serious and complex condition" (as defined below) from the Provider;
2. You are undergoing a course of institutional or inpatient care from the Provider;
3. You are scheduled to undergo nonelective surgery (including receipt of postoperative care) from the Provider;
4. You are pregnant and undergoing a course of treatment for the pregnancy from the Provider; OR
5. You are or were determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and are receiving treatment for such illness from the Provider.

A "serious and complex condition" means either:

- 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 harm; OR
- In the case of a chronic illness or condition, a condition that (i) is life-threatening, degenerative, potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

In order to continue to receive medical care from your Provider who is no longer in-Network, you must complete a form, provided by the Fund, in which you elect to continue care with your Provider. If it is determined that you qualify as a Continuing Care Patient, you can then continue to receive medical care from the Provider, for the condition that makes you a Continuing Care Patient, until the earlier of: (i) 90 days from the date on which you are provided with notice of the right to elect continued transitional care with the Provider, or (ii) the date on which you are no longer a Continuing Care Patient with respect to the Provider.

If you qualify or may qualify as a "Continuing Care Patient" with respect to a Provider who is terminated from the MLK Program Network, you will be sent a notice with more information about how to apply to continue treatment with your Provider for up to 90 days.

SECTION 3:
PROVIDER DIRECTORY
EFFECTIVE JANUARY 1, 2022

Effective January 1, 2022, if you get health care from an Out-of-Network Provider because the Plan or DBA (the Plan Administrator) inaccurately told you (either through its website, provider directory, Referral, or a phone call) that the Out-of-Network Provider was a Network Provider, then you are only required to pay the applicable in-Network Copayment or Coinsurance for that health care, and your cost sharing (i.e., your Copayment or Coinsurance) will count toward your annual out-of-pocket maximum.

A list of the MLK Program's Network Providers is available without charge at http://www.MLKCHplan.com or you may call DBA, the Claims Administrator, at 833-961-3021. **Remember, while there are a few exceptions, you generally need a Referral and Prior Authorization to receive medical care/services from a Provider in the Extended Network or the Tertiary Network.**

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In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications ("SMM") to the Santa Monica UNITE HERE Health Benefit Trust Fund Summary Plan Description and Plan Document (Effective [insert date])("SPD"). Please keep this SMM with your SPD and other plan materials for easy reference to all Plan provisions. Should you have any questions, please contact the Fund Office.

Receipt of this SMM does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the changes described in this SMM, please contact the Fund Office.