Central States Joint Board Health & Welfare Fund
Summary of Material Modification
March 2023

No Surprises Act

Effective January 1, 2022, several modifications have been made to the Plan to comply with the No Surprises Act. The No Surprises Act generally protects patients from "balance billing" for out-of-network emergency services, certain ancillary services provided by out-of-network providers at in-network facilities, out-of-network care provided at in-network facilities without the patient's informed consent, and air ambulance services (collectively, "No Surprises Act Services").

Generally, Participants and Dependents receiving No Surprises Act Services will only be responsible for paying their in-network cost sharing. Furthermore, cost sharing for No Surprises Act Services will count toward in-network deductibles and out-of-pocket maximums.

For example, if you have an emergency medical condition and receive emergency 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're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post stabilization services.

When you receive 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 the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

You're never 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 Plan's network and are encouraged to do so when possible.

If you believe you have been wrongly billed under the No Surprises Act, you can appeal the adverse benefit determination in accordance with the Plan's claims and appeals procedures. If your health care claim involving compliance with cost-sharing and surprise billing protections is denied under the internal appeals procedures, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.

If you have any other questions or concerns regarding the No Surprises Act, you may contact the Fund Office or the No Surprises Help Desk at 1-800-985-3059.