NECA-IBEW WELFARE TRUST FUND

2120 Hubbard Avenue, Decatur, IL 62526-2871
Phone: 217-875-0254 Toll-Free: 800-765-4239
Web: www.neca-ibew.org Email: info@neca-ibew.org

SUMMARY OF MATERIAL MODIFICATIONS

Effective July 1, 2022, the Trustees have amended the Plan to comply with the requirements of the No Surprises Act, a federal law which protects you from "surprise" medical bills and provides other patient protections. This summary of material modifications describes those protections. Please review the Fund's Summary Plan Description, as amended, for the complete details regarding the updated plan provisions required by the *No Surprises Act.*

Protections from Surprise Medical Bills and Other Protections

Congress passed the *No Surprises Act* which prohibits you from being "balance billed" for out-of-network Emergency Services, certain services by out-of-network providers also referred to as "Non-PPO provider" at an in-network hospital or ambulatory surgical center, and by out-of-network provider air ambulance services. In addition, the *No Surprises Act* added other patient protections concerning continuity of care, provider directories, and access to external review for denials related to surprise billing protections.

Prior to the *No Surprises Act*, out-of-network providers were permitted to bill you for the difference between what the Plan agreed to pay and the full amount the out-of-network providers or facilities charged for a service. This was called "balance billing." "Surprise billing" is another name for an unexpected "balance bill." This can happen when you have an emergency and are taken to an out-of-network facility, when you schedule a visit at an in-network provider (also referred to as PPO provider) facility but are unexpectedly treated by an out-of-network provider, or if you use an out-of-network provider air ambulance. The *No Surprises Act* prohibits out-of-network providers or facilities from "balance-billing" you in such situations unless you are informed of your option to receive the out-of-network services and consent to such and accept responsibility for any balance bill.

Protections Against Surprise Medical Bills

Out-of-Network Provider Emergency Services

Under the *No Surprises Ac*t, the Plan may not require preauthorization from an in-network provider or out-of-network provider of "Emergency Services" for an "Emergency Medical Condition" as defined by the *No Surprises Act*. If you have an Emergency Medical Condition and receive Emergency Services from an out-of-network provider or facility, the most you may be billed is the Plan's in-network cost-sharing amounts (such as copayments, coinsurance and deductibles). You cannot be balance billed for these Emergency Services. This includes services you may receive after you are in a stable condition as defined by the *No Surprises Act*, unless you give written consent to give up your protections not to be balanced billed for these post-stabilization services.

The Plan will pay the out-of-network providers and facilities directly for their services in accordance with payment rules under the *No Surprises Act.* Any amount you pay for Emergency Services or out-of-network services for claims covered by the *No Surprises Act* will apply toward your deductible and out-of-pocket maximum under the Plan.

Out-of-Network Services at an In-Network Provider Hospital or Ambulatory Surgical Center

If you receive services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network providers. In those cases, the most the out-of-network providers may bill you is the Plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). This applies to "ancillary services" as defined by the *No Surprises Act*, which generally include 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 wish to receive other services at these in-network facilities from out-of-network providers, you must give written consent to receive further medical treatment from them and pay out-of-network charges for such treatment. In such situations, you will be provided information about your rights and how to provide written consent to receive out-of-network medical treatment and pay out-of-network charges. If you consent to such out-of-network treatment, then you give up your protections against balance billing.

The Plan will pay the out-of-network providers and facilities directly for their services in accordance with payment rules under the *No Surprises Act.* Any amount you pay for Emergency Services or out-of-network services will apply toward your deductible and out-of-pocket maximum.

Services from Out-of-Network Air Ambulance Providers

If you receive services from an out-of-network air ambulance provider, the most the air ambulance provider may bill you is the Plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). Any amount you pay for Emergency Services or out-of-network services covered by the *No Surprises Act* will apply toward your deductible and out-of-pocket maximum.

Payments to Out-of-Network Providers for No Surprises Act Claims

The Plan will make an initial payment or notice of denial of payment for Emergency Services, non-Emergency Services at 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. If a claim relates to Emergency Services, non-Emergency Services from an out-of-network provider at a network facility or air ambulance services from out-of-network provider, you cannot be required to pay more than the in network cost-sharing amount under the Plan. The provider or facility is prohibited from billing you in excess of the in-network cost-sharing amount.

Other Patient Protections

Continuity of Care
If you are receiving treatment from an in-network provider or facility which ceases to be an in-network provider or facility and you need "continuing care," you will be informed of the change in network status. If you qualify as a "continuing care patient" as defined by the *No Surprises Act,* you will also be informed of your right to receive transitional care from the provider under the same terms and conditions as would have applied for an in-network provider for up to 90 days after the notice of network change is provided or until you no longer qualify as a continuing care patient (whichever is earlier). Providers cannot balance bill you during this time.

Complaint Process
If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act, you may contact the Fund Office at 800-765-4239 or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

Provider Directory
If you rely on information in the provider directory that inaccurately states that an out-of-network provider is in-network, or you have requested information on the network status of a provider or facility but did not receive a timely response, you will only be subject to the in-network cost-sharing amounts, even if the provider or facility is out-of-network.

External Review Process
The *No Surprises Act* requires grandfathered and non-grandfathered plans to provide for external review of adverse benefit determinations for claims subject to the cost-sharing and surprise billing protections in the *No Surprises Act.* Your request for external review of claims subject to the *No Surprises Act* must be made in writing within four months of the date that you receive notice of an adverse benefit determination or adverse appeal claim benefit determination. Please contact the Fund Office for a copy of the Plan's external review procedures.

Statement of Grandfathered Status

The Trustees believe that this Plan is a "grandfathered health plan" under the Affordable Care Act, which permits us to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, our Plan does not have to include certain consumer protections of the Affordable Care Act that apply to other plans (for example, providing preventive health services without any cost sharing). However, grandfathered health plans, like our Plan, must comply with other consumer protections in the Affordable Care Act (for example, the extension of coverage for dependent children to age 26).

Contact the Welfare Trust Fund Administrative Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

Please read this Summary of Material Modifications (SMM) carefully and save it with your Summary Plan Description and other benefits documents. This Summary of Material Modifications contains only highlights of certain features of the NECA-IBEW Welfare Trust Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

Nondiscrimination Notice Under Section 1557 of the Affordable Care Act

Discrimination is against the law. The NECA-IBEW Welfare Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Fund:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- o Qualified sign language interpreters
- o Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

- o Qualified interpreters
- o Information written in other languages.

If you need these services, contact Mr. Kevin Cope, the Civil Rights Coordinator. If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Mr. Kevin Cope, Civil Rights Coordinator, NECA-IBEW Welfare Trust Fund, 2120 Hubbard Avenue, Decatur, IL 62526-2871; Phone: 800-765-4239; Fax: 217-875-2084; Email: info@neca-ibew.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mr. Kevin Cope is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201; Phone: 800-368-1019; TDD: 800-537-7697 (TDD).
Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html

Illinois/Indiana Languages

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-765-4239.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-765-4239.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-765-4239.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-765-4239.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-765-4239.
Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-765-4239.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-765-4239. 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-765-4239.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-765-4239.
Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 800-765-4239. पर कॉल कर।
Panjabi	ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-765-4239. 'ਤੇ ਕਾਲ ਕਰੋ।
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 800-765-4239.
Dutch	AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 800-765-4239.
Gujarati	ચુના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 800-765-4239.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 800-765 4239. まで、お電話にてご連絡ください。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-765-4239.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-765-4239.
Urdu	4239-765-800 نیرک رادربخ: اگر آپ ودرا ےتلوب ،نیہ وت آپ وک نابز یک ددم یک تامدخ تفم نیم بایتسد نیہ ۔ لاک.
Arabic	ةظوحلم: اذإ تنك ثدحتت ركذا ةغللا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. لصتا مقرب 4239-765-800) مقر . اه

We're Online and Accessible 24/7!

Visit Our Website:
www.neca-ibew.org

Like Our Facebook Page:
www.facebook.com/NECAIBEWBenefits

Follow Us on Twitter:
https://twitter.com/NECAIBEWBenefit

And Make Sure to Use the Member Benefits Portal, the Wellness Power Portal and the HRA Participant Portal!

The Member Benefits Portal, Wellness Power Portal and HRA Participant Portal are separate sites that are NOT connected. Your accounts for each site are separate. If you have not already created accounts for the portals, you will need to register for each portal. Be sure to highlight the "Login to Member Benefits" link on our website. Electronic Explanations of Benefits (EOBs) statements can be viewed and printed directly from our Member Benefits portal. If you have any questions about how you can access your eEOB or the portals, please contact the Fund Office at 800-765-4239.

Go Paperless!

If you would like to get your required correspondence, such as newsletters and Summary Annual Reports, electronically, you can sign up to go paperless on the Fund's website. We hope this option will make your life easier, save on postage costs and help the environment at the same time. If you wish to continue receiving information by mail, you do not need to do anything. EOBs (explanation of benefits) will continue to be mailed regardless of whether or not you sign up to go paperless.

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