Alaska Teamster-Employer Welfare Trust

Your Rights and Protections Against Surprise Medical Bills

Please Read Carefully – This Notice Modifies the Plan's Summary Plan Description

Important Notice of Plan Changes

To Participants and Covered Family Members of the Alaska Teamster-Employer Welfare Trust (the "Plan")

Effective for services provided on and after July 1, 2022 covered by the Plan, federal law and the Plan provide new protections against unexpected medical bills.

On and after July 1, 2022, when you get emergency care, are treated by a Non-Preferred Provider at a Preferred Provider hospital or ambulatory surgical center, or receive air ambulance services, you will be protected from "surprise billing" or "balance billing."

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't a Preferred Provider.

An **"Out-of-network"** or **"Non-Preferred Provider"** is a provider or facility that hasn't entered into a contract setting its charges under the Plan. Usually, Non-Preferred Providers are allowed to bill you for the difference between what the Plan pays and the full amount they charge. This is called **"balance billing."** This amount is often more than a Preferred Provider charges for the same service, and might not count toward your deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at a Preferred Provider facility, but are unexpectedly treated there by a Non-Preferred Provider.

Effective July 1, 2022, you are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services covered by the Plan from a Non-Preferred Provider or facility, the most that provider or facility may bill you is the Plan's Preferred-Provider cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get for that emergency condition 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.

Certain services at a Preferred Provider hospital or ambulatory surgical center

When you get services covered by the Plan from a Preferred Provider hospital or ambulatory surgical center, certain providers there may be Non-Preferred Providers. In these cases, the most those Non-Preferred Providers providers may bill you is the Plan's Preferred-Provider cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other covered services at a Preferred Provider facility, Non-Preferred Providers can't balance bill you, unless you give written consent and give up your protections.

Air Ambulance Services

If you receive air ambulance services covered by the Plan, the most that provider or facility may bill you is the Plan's Preferred-Provider cost-sharing amount. You can't be balance billed for these services.

You're never required to give up your protections from balance billing. You also aren't required to get care from Non-Preferred Providers. You can choose a Preferred Provider or facility in the Plan's network.

When balance billing isn't allowed, you also have the following protections (effective July 1, 2022):

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was a Preferred Provider). For covered services, the Plan will pay Non-Preferred Providers and facilities directly.
- The Plan will:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by Non-Preferred Providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay a Preferred Provider or facility, and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or Non-Preferred Provider services toward your and your family's deductible and annual out-of-pocket limits.

Independent External Review

The Plan has rules that allow you to request review of certain medical claims by an independent review organization, and requiring that the decision by that independent organization be followed. Effective July 1, 2022, this right to voluntary independent review also applies to all of the following claims under the Plan:

- Whether pre-authorization was improperly required for emergency services
- Whether emergency services by a Non-Preferred Provider should have been covered at the Plan's Preferred Provider rates
- Whether treatment at a Preferred Provider facility by a Non-Preferred Provider should have been covered by the Plan at its Preferred Provider rates
- Whether Non-Preferred Provider air ambulance services should have been covered at the Preferred Provider rates for those services

If you believe that you've been wrongly billed, you can contact the Alaska Teamster-Employer Welfare Trust at (907) 751-9700 for further information and assistance.

Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.