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April 2022

TO: All Participants and Dependents, including COBRA beneficiaries, enrolled in the HMSA PPO Plan of the Hawaii Health and Welfare Trust Fund for Operating Engineers

FROM: Board of Trustees
Hawaii Health & Welfare Trust Fund for Operating Engineers

The information described in this document is **important**, so please read it carefully.

SUMMARY OF MATERIAL MODIFICATIONS TO THE HMSA PPO PLAN:
IMPROVEMENTS TO BENEFITS FOR CERTAIN SERVICES FROM OUT-OF-NETWORK PROVIDERS

Effective January 1, 2022

This Summary of Material Modifications advises you of changes in the information contained in the Hawaii Health and Welfare Trust Fund for Operating Engineers ("SPD"), as required by the Employee Retirement Income Security Act of 1974. The Trustees of the Hawaii Health and Welfare Trust Fund for Operating Engineers (the "Fund") have amended the Summary Plan Description (SPD) to comply with the No Surprises Act. Specifically, this SMM affects services provided through the Fund's HMSA PPO Plan, a self-funded preferred provider organization (PPO) Plan option that is administered through Hawaii Medical Service Association (HMSA).

If you have elected to enroll in the fully insured Kaiser Foundation Health Plan Hawaii Region option, information about the No Surprises Act will be included in the Evidence of Coverage issued by Kaiser Permanente.

The No Surprises Act was signed into law in December 2020, as part of the Consolidated Appropriations Act, 2021 (CAA). This federal law protects patients from Balance Billing for Emergency Services, certain non-emergency services performed by an Out-of-Network Provider at an In-Network facility (unless the patient gives informed written consent), and Air Ambulance Services by a Out-of-Network Provider (collectively "No Surprises Services"). Effective January 1, 2022, patients receiving these services will only be responsible for paying their in-network Cost-Sharing requirement and cannot be Balance Billed by the provider or facility for these services.

The Fund is implementing a number of improvements to the Plan, effective January 1, 2022, to comply with the No Surprises Act, as discussed below. Capitalized terms are defined in the section labeled "NEW/REVISED DEFINITIONS OF THE PLAN" or the SPD.

Please review these changes carefully and contact the Fund Office with any questions that you may have.

IMPROVEMENTS TO BENEFITS FOR CERTAIN SERVICES FROM OUT-OF-NETWORK PROVIDERS

Effective January 1, 2022

Emergency Services

The No Surprises Act requires Emergency Services to be covered as follows:

- Without the need for any prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is an In-Network Provider or an in-network emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and in-network emergency facilities;
- Without imposing Cost-Sharing requirements on out-of-network emergency services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or in-network emergency facility;
- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting Cost-Sharing payments with respect to out-of-network Emergency Services toward any in-network Deductible and in-network Out-of-Pocket Limit or Maximum in the same manner as those received from an In-Network Provider.

Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

The No Surprises Act requires non-emergency services performed by an Out-of-Network Provider at an In-Network Health Care Facility to be covered as follows:

- With a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by an In-Network Provider;
- By calculating the Cost-Sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the recognized amount for the items and services; and
- By counting any Cost-Sharing payments made toward any deductible and out-of-pocket maximums applied under the plan in the same manner as if such Cost-Sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network Health Care facility will be covered based on your Out-of-Network coverage if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

- You give informed written consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Air Ambulance Services

The No Surprises Act requires Air Ambulance Services (to the extent covered by the plan) to be covered with a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the services had been furnished by an In-Network Provider. In general, you cannot be Balance Billed for these Air Ambulance services.

Continuing Care Patients

If you are a Continuing Care Patient and the Plan terminates its In-Network contract with an In-Network Provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

1. Notify you in a timely manner of the Plan's termination of its In-Network contracts with the In-Network Provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
2. Allow you ninety (90) days of continued coverage at the In-Network cost sharing to allow for a transition of care to an In-Network Provider

Provider Directory – Incorrect Provider Information

The provider directory will be updated at least every ninety (90) days. If you are informed by a Plan representative or receive inaccurate information from a current provider directory that a provider is an In-Network Provider, services provided by that Out-of-Network Provider will be covered as if the provider was an In-Network Provider.

Complaint Process

If you believe that you have been billed incorrectly, or otherwise have a complaint under the No Surprises Act, you may contact HMSA for assistance at the following numbers:

Oahu – (808) 948-6111
Hilo – (808) 935-5441
Kona – (808) 329-5291
Kauai – (808) 245-3393
Maui – (808) 871-6295

EXTERNAL REVIEW OF CLAIMS PROCESS
Effective January 1, 2022

The EXTERNAL REVIEW OF CLAIMS section in the 2020 SPD (pages 127 to 128), paragraphs 1 through 6, is deleted and replaced with the following:

This **External Review** process is intended to comply with the No Surprises Act and the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered Dependent(s), and you and your covered Dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

You may seek further external review, by an Independent Review Organization (IRO), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits any of the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment.

- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

- The adverse benefit determination involves whether the Plan is complying with the surprise billing and Cost-sharing protections concerning No Surprise Services under the No Surprises Act.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this **external review process does not pertain to** Dental, Life insurance, Accidental Death and Dismemberment, Weekly Disability Income benefit and the Burial benefit.

There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document. The Plan retains at least three IROs from which it can select an IRO to perform external reviews. The Plan requires its contracted IROs to maintain written records for at least three years.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

Two types of claims for External Review are outlined below: (1.) Standard (Non-Urgent) Claims and (2.) Expedited Urgent Claims. [End of amended addition; the remainder of the description on pages 128 through 131 is unchanged.]

NEW/REVISED DEFINITIONS OF THE PLAN
Effective January 1, 2022

To implement the protections of the No Surprises Act, the Fund is adopting the following new/revised definitions of terms in the Plan effective January 1, 2022.

Allowed Charge/Allowed Amount/Allowable Charge. The definition of Allowed Charge/Allowed Amount/Allowable Charge provided in the SPD (2020 version, pages 140 to 141) is replaced with the following definition:

Allowed Charge/Allowed Amount/Allowable Charge means as follows:

a. For No Surprises Services (i.e., Emergency Services provided by an Out-of-Network Provider, non-emergency services provided by an Out-of-Network Provider at a network facility without proper notice and consent, and for Air Ambulance Services), the Allowed Charge is the Out-of-Network Rate, as defined below.

b. For all other eligible Medically Necessary services or supplies, the Allowed Charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

- With respect to a Network Provider, the negotiated fee/rate set forth in the agreement between the participating network and the Plan; or
- With respect to an Out-of-Network Provider, Allowed Charge means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies, other than Emergency Services performed by Out-of-Network Providers. The Plan's Allowed Amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter; or

- For an In-Network Provider or facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third-party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an in-network claim; or
- The provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after the patient has paid any applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "allowed charge" amount for services or supplies.

NOTE: Balance Billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use an Out-of-Network Provider you may be Balance Billed by that provider, except for No Surprises Services. Balance Billing does not apply to Emergency Services provided in an Out-of-Network's hospital or Independent Freestanding Emergency Department and might not apply in cases where state law prohibits a person from being required to pay Balance-Billed charges or where the Plan is contractually responsible for such charges.

Ancillary Services are, with respect to services furnished by Out-of-Network Providers at an In-Network facility, the following:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services; and
4. Items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility.

Balance Billing. The definition of Balance Billing provided in the SPD (2020 version, page 142) is replaced as follows:

Balance Billing: A bill from a provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with Balance Billing <u>are not covered</u> by this Plan. **Out-of-Network Providers commonly engage in balance billing.** This means a Plan participant may be billed for any balance that may be due in addition to the amount payable by the Plan, except for No Surprises Services. Generally, you can avoid Balance Billing by using In-Network Providers. Typically, In-Network Providers do not Balance Bill except in situations of third-party liability claims.

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a Serious and Complex Condition from the provider or facility; (2) scheduled to undergo non-elective surgery from the provider, including receipt of post-operative care from such provider or facility with respect to such a surgery); (3) pregnant and undergoing a course of treatment for the

pregnancy from the provider or facility; (4) determined to be terminally ill and receiving treatment for such illness from such provider or facility; or (5) undergoing a course of institutional or inpatient care from the provider or facility.

Cost-Sharing means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the Plan. Cost-Sharing generally includes Copayments (Copays), Coinsurance, and amounts paid towards Deductibles, but does not include amounts paid towards premiums, balance billing by Out-of-Network Providers, or the cost of items or services that are not covered under the plan.

The **Cost Sharing** requirement for Emergency and Non-emergency Services at In-Network facilities performed by Out-of-Network Providers, and Air Ambulance Services from Out-of-Network Providers will be based on the Recognized Amount.

Emergency Medical Condition. The definition of Emergency Medical Condition on page 143 of the SPD (2020) is replaced with the following definition:

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such 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 –

1. Serious impairment to bodily functions;
2. Serious dysfunction of any bodily organ or part; or
3. Placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services. The definition of Emergency Services on pages 143 and 144 of the SPD (2020) is replaced with the following definition:

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, 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).

Emergency Services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post-stabilization services (i.e., items and services provided after the patient is

stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

1. The attending emergency physician or treating provider determines that the patient is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and
2. The patient or their authorized representative is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on treatment, the names of any In-Network Providers at the facility who are able to treat the patient, and the patient may elect to be referred to one of the In-Network Providers listed; and
3. The patient or their authorized representative gives informed written consent to continued treatment by the Out-of-Network Provider, acknowledging that the patient understands that continued treatment by the Out-of-Network Provider may result in greater cost to the participant or beneficiary.

Health Care Facility (for non-emergency services) means each of following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

In-Network Provider (also known as a Network Provider or Non-Participating Provider), means a health care provider who has a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Independent Freestanding Emergency Department is a health care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct from a hospital under applicable state law and provides Emergency Services.

No Surprises Act means the No Surprises Act (Public Law 116-260, Division BB).

No Surprises Services means the following, to the extent covered under the Plan: (1) Out-of-Network Emergency Services, (2) Out-of-Network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network Provider at an In-Network facility; and (4) other Out-of-Network non-emergency services performed by an Out-of-Network Provider at an In-Network Health Care Facility with respect to which the provider does not comply with federal notice and consent requirements.

Out-of-Network Provider (also known as a Non-Network Provider or Non-Participating Provider) means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Out-of-Network Rate. With respect to Emergency Services provided by an Out-of-Network Provider, non-emergency services furnished by an Out-of-Network Provider at a participating facility, and Air Ambulance Services by an Out-of-Network Provider, **Out-of-Network Rate** means, in order of priority, one of the following:

1. If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
2. The amount specified by applicable state law;
3. The amount negotiated by the parties; or
4. The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

Qualifying Payment Amount means, generally, the median contracted rates of the Plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR § 716-6(c).

Recognized Amount means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by Out-of-Network Providers, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

Serious and Complex Condition means one of the following:

1. 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
2. In the case of a chronic illness or condition, a condition that is the following:

    a. Life-threatening, degenerative, potentially disabling, or congenital; and
    b. Requires specialized medical care over a prolonged period of time.

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Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, please contact the Trust Fund Office at (800) 251-5014. You may also call the Fringe Benefits office at (800) 532-2105.

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