

**NATIONAL IAM BENEFIT TRUST FUND  
SUMMARY OF MATERIAL MODIFICATIONS**

**July 2022**

The following is a summary of changes to the National IAM Benefit Trust Fund’s (the “Plan”) January 2018 Summary Plan Description (“Medical SPD”) for Medical Plans A+, A, B, C, and D2 (January 1, 2021). This Summary of Material Modifications (“SMM”) supplements the information in the Medical SPD. Please keep this document with your copy of the Medical SPD for future reference.

**1. No Surprises Act, effective January 1, 2022**

The No Surprises Act (the “Act”) was signed into law in December 2020. The Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department, and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO Provider at an in-network facility. Effective January 1, 2022, beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be billed for the balance by the provider or emergency services facility.

Effective January 1, 2022, the Plan is implementing improvements to comply with the No Surprises Act.

**Emergency Services**

Emergency Services are covered:

- Without the need for a 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 a PPO Provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirements or limitations on out-of-network Emergency Services that are more restrictive than the requirements or limitations that apply to Emergency Services received from PPO Providers and PPO 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 a PPO Provider or a PPO 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 any cost sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the Plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost sharing payments were made with respect to Emergency Services furnished by a PPO Provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (“QPA”).

### **Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility**

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO Provider at a PPO facility, the items or services are covered by the Plan:

- With a cost sharing requirement that is no greater than the cost sharing requirement that would apply if a PPO Provider had furnished the items or services.
- By calculating the cost sharing requirements as if the total amount that would have been charged for the items and services by such PPO Provider were equal to the Recognized Amount for the items and services.
- By counting any cost sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the Plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost sharing payments were made with respect to items and services furnished by a PPO Provider.
- Non-emergency items or services performed by a Non-PPO Provider at a PPO facility will be covered based on your out-of-network coverage if:
  - At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO Providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO Providers listed; and
  - The participant or dependent gives informed consent to continued treatment by the Non-PPO Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO Provider may result in greater cost to the participant or beneficiary.
- 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 Non-PPO Provider satisfied the notice and consent criteria, and therefore these services will be covered:
  - With a cost sharing requirement that is no greater than the cost sharing requirement that would apply if a PPO Provider had furnished the items or services,
  - With cost sharing requirements calculated as if the total amount charged for the items and services were equal to the recognized amount for the items and services, and
  - With cost sharing counted toward any in-network deductible and in-network out-of-pocket maximums, as if such cost sharing payments were with respect to items and services furnished by a PPO Provider.

Your cost sharing amount for Non-Emergency Services at PPO Facilities by Non-PPO Providers will be based on the lesser of billed charges from the provider or the QPA.

## **Air Ambulance Services**

If you receive Air Ambulance Services that are otherwise covered by the Plan from a Non-PPO Provider, the Plan will cover those services as follows:

- The Air Ambulance Services received from a Non-PPO Provider will be covered with a cost sharing requirement that is no greater than the cost sharing requirement that would apply if a PPO Provider had furnished the services.
- In general, you cannot be balance billed for these items or services. Your cost sharing will be calculated as if the total amount that would have been charged for the services by a PPO Provider of Air Ambulance Services were equal to the lesser of the QPA or the billed amount for the services.
- Any cost sharing payments you make with respect to covered Air Ambulance Services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO Provider.

## **Payments to Non-PPO Providers and Facilities**

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services, within thirty (30) calendar days of receiving a Clean Claim from the Non-PPO Provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost sharing under the Plan, and the provider or facility cannot bill the participant or dependent more than the required cost sharing.

The Plan will pay a total plan payment directly to the Non-PPO Provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost sharing amount for the services, less any initial payment amount.

## **External Review**

In addition to the two (2) reasons for External Review listed in the Medical SPD, External Review is also available for a claim denial that is related to an Emergency Service, Non-Emergency Service provided by a Non-PPO Provider at a PPO facility, and/or Air Ambulance Service, as covered under the federal No Surprises Act.

Please see the External Review Procedures in the Medical SPD for further information.

## **Continuity of Coverage**

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms

of the providers' and/or facilities' participation in the Plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days from the date of notification of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

### **Incorrect PPO Provider Information**

A list of PPO Providers is available to you without charge by visiting the Cigna website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO Provider from the Plan or its administrators, the Plan will apply PPO cost sharing to your claim, even if the provider was a Non-PPO Provider.

### **Complaint Process**

If you believe you have been wrongly billed, please contact Cigna Customer Service at 1-800-244-6224 for assistance or the Employee Benefits Security Administration (“EBSA”) toll-free number at 1-866-444-3272.

### **Repeal of Emergency Room Payment Rules**

The Plan provision concerning payment for Emergency Room Services, as required by the Affordable Care Act, is repealed for services provided on or after January 1, 2022, and replaced with the No Surprises Act requirements.

### **Glossary**

**Air Ambulance** means medical transport by a rotary-wing air ambulance, as defined in 42 CFR 414.605, or fixed-wing air ambulance, as defined in 42 CFR 414.605, for patients.

**Ancillary Services** are, with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and critical care doctors;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by a Non-PPO Provider if there is no PPO Provider who can furnish such item or service at such facility.

**Clean Claim** means a medical claim that has no defects or special circumstances, including incomplete documentation that delays timely payment.

**Continuing Care Patient** means an individual who, with respect to a provider or facility —

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

**Emergency Medical Condition** means a medical condition 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 serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

**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 a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary can travel using non-medical transportation or non-emergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO Providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO Providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO Provider may result in greater cost to the participant or beneficiary.

**Health Care Facility** (for Non-Emergency Services) is each of the 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.

**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 federal No Surprises Act (Public Law 116-260, Division BB).

**Non-PPO emergency facility** means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

**Non-PPO 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 items and services furnished by a Non-PPO Provider, Non-Network emergency facility, or Non-PPO Provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (“IDR”) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

**Qualifying Payment Amount** means the amount calculated using the methodology described in 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.
4. For air ambulance services furnished by Non-PPO 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 with respect to a participant, beneficiary, or enrollee under the Plan, 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 disability; or

2. in the case of a chronic illness or condition, a condition that is —
  - a. is life-threatening, degenerative, potentially disabling, or congenital; and
  - b. requires specialized medical care over a prolonged period.

**Termination** includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

## **2. PrudentRx Copay Program for Specialty Medications**

The National IAM Benefit Trust Fund’s Board of Trustees has elected to have the Plan participate in the CVS PrudentRx Copay Program (“PrudentRx Copay Program”) for certain specialty medications, effective April 1, 2022. Participant enrollment in the PrudentRx Copay Program becomes effective after the participant has met the enrollment requirements, outlined below.

The PrudentRx Copay Program helps participants who enroll in manufacturer copay assistance programs. Medications in the specialty tier are subject to a 30% co-insurance. Participants enrolled in the PrudentRx Copay Program who get a copay card for their specialty medication (if applicable), will have a \$0 out-of-pocket responsibility for their covered prescriptions under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications — in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a participant’s cost share for eligible medications, thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs. Any data sharing is done in compliance with HIPAA.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can contact PrudentRx, or they will proactively contact you to enroll. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The Plan may periodically update the PrudentRx Copay Program Drug List.

Copayments for these medications, whether made by you, your plan, or a manufacturer’s copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as “essential health benefits” under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan’s out-of-pocket maximum. A list of specialty medications that are not considered to be “essential health benefits” is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

## **Enrollment**

If you currently take one or more medications included in the PrudentRx Copay Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible participants are enrolled in the PrudentRx Copay Program via an easy two-step process: 1) The first step of enrollment is already complete as your member information is on file with PrudentRx; 2) You need to call PrudentRx at 1-800-578-4403 within five (5) days of receipt of the letter to register for any copay assistance available from drug manufacturers.

Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications — in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

## **Opting Out of the PrudentRx Copay Program**

You can choose to opt out of the PrudentRx Copay Program, by calling 1-800-578-4403.

As noted above, if you opt out, you will be responsible for the 30% co-insurance on specialty medications.

## **Prudent Rx Contact**

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

*Receipt of this notice does not constitute a determination of eligibility or coverage. If you wish to verify eligibility or have general questions about this notice, please contact the National IAM Benefit Trust Fund, Customer Service, at 1-800-457-3481.*