PPO PLAN
(Blue Cross Blue Shield)

These changes only apply if you have the ***PPO PLAN*** *with* ***BLUE CROSS BLUE SHIELD****.*

UPDATES TO YOUR BENEFITS

CAA Introduction

Your Fund has made several changes following the passage of a new federal law, the Consolidated Appropriations Act of 2021 (CAA), which adds rules to protect you and your family from unexpected medical costs. **This SMM describes these changes to your benefits. All changes described in this SMM are effective April 1, 2022** (unless otherwise noted).

The changes described in this SMM only apply to the PPO benefits. If you are enrolled in the HMO, Kaiser has made similar changes to its benefits. When you have questions about your HMO benefits, call Kaiser at the number on your medical card.

UNITE HERE HEALTH

(866) 686-0003 • uhh.org

P.O. Box 6020, Aurora, IL 60598-0020

This document constitutes a Summary of Material Modifications (SMM) under the Employee Retirement Income Security Act of 1974, as amended, and summarizes recent actions taken by the Board of Trustees of UNITE HERE HEALTH. It describes benefit and administrative changes affecting the information included in your Summary Plan Description (SPD). This SMM addresses changes to all benefits in your SPD and may include changes and benefits that don't apply to you based on your or your employer's elections.

Please read this information carefully; then, keep it with your SPD for future reference. Except as described in this SMM, the information otherwise contained in your SPD continues to apply.

Because of the pandemic, you generally have more time to do certain things, like file or appeal a claim, enroll your new dependent, or elect COBRA and make COBRA payments. Call us for more information.

PPO PLAN
(Blue Cross Blue Shield)

These changes only apply if you have the ***PPO PLAN*** *with* ***BLUE CROSS BLUE SHIELD****.*

UPDATES TO YOUR BENEFITS

Benefits for emergency room services

Your emergency room copay will apply to all medical (including mental health/substance abuse disorder) care you receive during an emergency room visit.

	Network and Non-Network Providers
Emergency Room Services	$0 copay

The calendar year deductible does not apply to emergency room services.

Changes to your prior authorization list

- Non-emergency air ambulance transportation requires prior authorization. Call HealthCheck360 at **(844) 462-7812** before you use an air ambulance for non-emergency treatment.
- The rules for prior authorization will not apply to emergency medical treatment, including observation or admissions following an emergency visit. However, prior authorization is required for services or supplies on the prior authorization list in all other situations.

When a non-network provider may be considered a network provider

In the special circumstances listed below, the Plan will pay for non-network services at the network cost share, and the network cost-sharing will apply towards your out-of-pocket limit for medical care.

In some cases, you may have to pay the difference between the allowable charge and the provider's actual charge (called balance billing). In other cases, the provider cannot balance bill you. The below list will state whether or not the provider can balance bill you.

PPO PLAN
(Blue Cross Blue Shield)

These changes only apply if you have the ***PPO PLAN*** *with* ***BLUE CROSS BLUE SHIELD****.*

UPDATES TO YOUR BENEFITS

A non-network provider may be considered a network provider when:

Emergency medical treatment

You get emergency medical treatment from a non-network provider. The non-network provider cannot balance bill you for your emergency medical treatment. (A new definition of "emergency medical treatment" is included later in this SMM.)

You use a network hospital or network ambulatory surgical center

You get services and supplies from non-network providers in connection with a visit to a network hospital (including the outpatient department) or a network ambulatory surgical center. The non-network provider cannot balance bill you. However, this does not apply if you give informed consent to your healthcare professional agreeing to give up your protections from balance billing (you do not have to give consent if you don't want to).

Non-network providers who provide inpatient consultations or specialize in anesthesiology, emergency medicine, pathology, or radiology

You use non-network providers who provide inpatient consultations or who specialize in anesthesiology, emergency medicine, pathology, or radiology. You pay the network cost-sharing. Unless the rules above about emergency medical treatment or visits to a network hospital or network ambulatory surgical center apply, the provider may also balance bill you.

Ambulance services

You use a non-network ambulance service (ground, air, water). Non-network air ambulance providers cannot balance bill you. Non-network ground and water ambulance providers can balance bill you.

PPO PLAN
(Blue Cross Blue Shield)

These changes only apply if you have the ***PPO PLAN*** *with* ***BLUE CROSS BLUE SHIELD****.*

UPDATES TO YOUR BENEFITS

The provider directory is wrong

You rely on the Plan's provider directory, or the Fund or Blue Cross Blue Shield of Illinois tells you a provider is in the network when the provider really is not in your network. Contact the Fund if you think this rule applies to your claim. The provider may balance bill you.

Make sure you always ask if the provider is in your network.

Your provider leaves the network

You are getting a course of treatment with a provider who leaves the network and you are a "continuing care patient" as defined by federal law because:

- You are pregnant and getting care for your pregnancy.
- You are getting treatment for a serious and complex condition requiring specialized medical care.
- You are getting inpatient care.
- You have scheduled a non-elective surgery (including post-operative care).
- You are terminally ill (expected to live for 6 months or less).

The Fund may continue to pay network benefits for covered services you get from that provider for up to 90 days (or until your continuing care ends, if earlier). In this case, the non-network provider cannot balance bill you.

If your provider leaves the network, you will get a notice and a continuity of care application. If you think you qualify as a continuing care patient, and you want to continue treatment with your provider, you should return the application to the Fund. Your provider will have to document that you meet the definition of a continuing care patient (as listed above).

PPO PLAN
(Blue Cross Blue Shield)

These changes only apply if you have the ***PPO PLAN*** *with* ***BLUE CROSS BLUE SHIELD****.*

UPDATES TO YOUR BENEFITS

The notice will include the deadline to apply for continuity of care and information on how to submit your application. Appeals for denied continuity of care applications are treated as pre-service claim appeals. However, your only level of appeal is to the Appeals Subcommittee. You may appeal the denial within 180 days of your receipt of the denial to:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, IL 60504-4197

There is no network provider in the required specialty

The network does not have a provider in the required specialty. You pay the network cost-sharing, but the provider may also balance bill you.

If you feel your claim was not paid correctly under these rules, you may submit an appeal. Your SPD gives you information about appealing claims, including your right to external review. (External review is only available for denials based on medical judgement, claims subject to federal no surprises billing protections, and rescissions of coverage.)

Changes to Plan exclusions

The exclusions and limitations listed in the medical and general plan exclusions and limitations sections of your SPD will generally not apply to emergency medical treatment. The Fund will still not cover any treatment that would otherwise be excluded, regardless of the circumstances (for example, the Fund does not cover any treatment that is not medically necessary).

PPO PLAN
(Blue Cross Blue Shield)

These changes only apply if you have the ***PPO PLAN*** *with* ***BLUE CROSS BLUE SHIELD****.*

UPDATES TO YOUR BENEFITS

Changes to definitions

Allowable Charge

The definition of "allowable charge" shown in your SPD for non-network providers is updated.

Except where a different allowable charge is required by federal law for non-network emergency medical treatment or for claims subject to the federal surprise billing protections, the Plan calculates benefits for non-network providers based on an independent metric, such as Medicare rates, or the contracted network rates. This Plan will not pay the difference between what a non-network provider actually charges, and what is considered an allowable charge. You pay this difference in cost. (This is sometimes called "balance billing.")

Emergency Medical Treatment

The definition of emergency medical treatment shown in your SPD is updated.

Emergency medical treatment means covered medical services used to treat a medical condition, including a mental health condition or substance abuse disorder, displaying acute symptoms of sufficient severity (including severe pain) that an individual with average knowledge of health and medicine could expect that not receiving immediate medical attention could place the health of a patient, including an unborn child, in serious jeopardy or result in serious impairment of bodily functions or bodily organs or body parts.

Emergency medical treatment includes services provided in the emergency department of a hospital or an independent freestanding emergency department. It also includes pre-stabilization services if you are admitted to the hospital from an emergency room, and post-stabilization services connected to the emergency medical treatment, such as outpatient observation or an inpatient or outpatient stay. However, emergency medical treatment will not include covered expenses after you give informed consent agreeing to give up your protections against balance billing as allowed under federal law.

Whether your treatment meets the definition of emergency medical treatment will be determined based on this definition rather than solely on your final diagnosis.

PPO PLAN
(Blue Cross Blue Shield)

These changes only apply if you have the ***PPO PLAN*** *with* ***BLUE CROSS BLUE SHIELD****.*

UPDATES TO YOUR BENEFITS

Change to interpretation of Plan provisions

The following language is added to the "Interpretation of Plan provisions" section of your SPD:

For claims subject to the independent dispute resolution process under the federal surprise billing protections, the independent dispute resolution entity has the sole authority to determine the allowable charges for purposes of provider payment. However, the independent dispute resolution entity has no authority over any other aspect of the Fund's administration, including but not limited to the determination of what benefits are payable and what expenses are covered.

Download the UHH Member Portal mobile app!

Get 24/7 access to your benefits and more! Features include:

- Easy login—use the same username and password as the member portal (or create an account)
- Instant access to your medical ID cards
- View claims and eligibility information

To download the app, scan the QR code or search "UHH Member Portal" in your app store.

IPHONE

ANDROID