March 2022

PIPELINE INDUSTRY BENEFIT FUND
NOTICE TO PARTICIPANTS
OF MATERIAL BENEFIT MODIFICATIONS
EFFECTIVE January 1, 2022

NO SURPRISES ACT NOTICE

This Notice explains the patient protections for surprise medical bills required by recent federal legislation under the No Surprises Act (NSA). The NSA was signed into law in December 2020, as part of the Consolidated Appropriations Act (CAA), 2021. These changes are effective January 1, 2022. This Notice is only a summary of the recent changes under the federal law and does not replace or modify the Plan. Please contact the Fund office if you have any questions about how the No Surprises Act applies to you or refer to the Plan's website at www.pibf.org.

What is a surprise medical bill and how am I billed?

When you receive care from an "out-of-network (OON) provider," as opposed to an "in-network provider," the Plan pays a smaller percentage or amount of the cost you incurred, which results in you receiving a bill for the difference between the billed charges and the amount paid by the Plan ("balance bill"). An unexpected balanced bill is the "surprise bill," that can happen in cases of an emergency or when you schedule an appointment with an in-network provider and are unexpectedly treated by an OON provider. Under the NSA, your cost share for a surprise bill in these circumstances will be limited to in-network levels, the amount you pay for these services will count toward your in-network deductibles and out-of-pocket limits, and you cannot be balance billed by your OON provider.

What services cannot be balanced billed?

Under the NSA, you will not be balanced billed for (1) certain "emergency services for emergency medical conditions," (2) air ambulance service from OON providers, and (3) specific non-emergency care from ONN providers at in-network facilities (in-network hospitals and ambulatory surgical centers), unless you are otherwise given notice and knowingly give your written informed consent to be treated by the OON provider. Additionally, pre-authorization is not required for "emergency services."

What are "emergency services for emergency medical conditions" at a hospital or free-standing emergency department?

"Emergency services" include (1) a medical screening examination within the capability of a hospital's emergency department or an independent freestanding emergency department, and ancillary services routinely available in the emergency department to evaluate the "emergency medical condition," (2) further examination and treatment required to stabilize the patient; and (3) certain covered services provided after stabilization as part of outpatient observation or an inpatient or outpatient stay related to the emergency condition, unless you otherwise consent after notice.

An "emergency medical condition" is a medical condition (including a mental health condition) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not seeking immediate medical attention would place his or her health, or if pregnant, the unborn child's health, in serious jeopardy, impair bodily functions or result in serious dysfunction of a bodily organ or part.

What are the notice and consent requirements to be treated by an OON provider at certain in-network facilities?

Under the NSA, you cannot be balanced billed for non-emergency services by an OON provider at certain in-network facilities unless the OON provider 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), furnishes you a written notice explaining that the provider is an OON provider with respect to the Plan, a good faith estimate of 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 advice that you may elect to be referred to one of the in-network providers listed and you consent to continued treatment. You must knowingly and voluntarily consent in writing to continued treatment by the OON provider, acknowledging that you understand that continued treatment by the OON provider may result in greater cost to you. You should receive a copy of your consent, in person or via email.

The notice and consent exception described above 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 OON provider satisfied the notice and consent requirement. Therefore, you cannot be balance billed for these services.

What services are considered "ancillary services"?

Examples of ancillary services include diagnostic services (radiology and laboratory services), and services from an OON anesthesiologist, radiologist, or neonatologist, assistant surgeon. You cannot be balanced billed for ancillary services provided by an OON provider.

What do I pay if these rules apply to me?

If a claim is subject to the NSA, you cannot be required to pay more than your cost-sharing responsibility for in-network services under the Plan. The OON provider is prohibited from balance billing you any amount in excess of the required cost-sharing amount for corresponding in-network services. Plan deductibles, co-pays, and out of pocket limitations continue to apply. The Plan will pay the required amount under the NSA directly to the OON provider that would have been charged for services by an in-network provider or facility that exceeds the cost-sharing amount for the in-network services, less any initial payment.

How do I find out if my provider is in-network and what happens if I was misinformed that a provider was an in-networker provider or facility?

You should always verify that your provider is in-network by calling the Fund office or consult the Plan's website at www.pibf.org for the link to the database of the provider directory for in-network providers and facilities. The Fund office will respond in writing, either electronically or in print, to your inquiry as soon as practicable and no later than one day after your telephone call is received. Provider directories will be updated at least every ninety (90) days. If you are informed by the Plan through a telephone, electronic, or internet-based inquiry, or you receive information from a print or electronic Provider Directory that a provider is an in-network provider, but, in fact, the provider is an OON provider, your claim will be processed as in-network, and in-network deductibles and out of pocket limits will be applied. In such a case, the OON provider must refund you any payments exceeding in-network costs.

What happens if my provider ceases to be in-network? Can I continue with my care?

If you are a "continuing care patient" undergoing treatment for (1) a "serious and complex condition;" (2) are undergoing a course of treatment for inpatient care; (3) are scheduled to undergo nonelective surgery, including receipt of postoperative care; (4) are pregnant and undergoing a course of treatment for the pregnancy; or (5) are or were determined to be "terminally ill" and are receiving treatment for such illness, the Plan will notify you in the event your provider or facility is terminated and ceases to be in-network network, and inform you of your right to elect continued transitional care from the provider or facility. You will have the right to elect continued transitional care by timely filing the appropriate election forms with the Fund office. Your continuing transitional care, at in-network cost sharing under the same conditions as if the provider's termination had not occurred, will end 90 days from the date you were notified or, if earlier, the date you no longer need continuing treatment.

What happens if I have a complaint or have received a balanced bill?

If you believe you have been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund office or the federal agencies at 1-800-985-3059 or https://www.cms.gov/nosurprises/consumers.

New ID cards were mailed in December 2021. Refer to the Plan's website at www.pibf.org for notices, the updated network provider database, and more information on the No Surprises Act and how it affects you.

Your receipt of this Notice is not a certification that you are eligible to receive any benefits under the Plan. You must satisfy the Plan's eligibility requirements to receive benefits. If you have any questions, please contact the Fund office.

PIBF COVERAGE FOR AT-HOME COVID-19 TESTS

On January 10, 2022, it was announced that starting Saturday, January 15, 2022, private health insurers will be required to cover up to eight home COVID-19 tests per person per month for participants on their plans. Coverage is only available for qualifying tests (FDA authorized) to be utilized by the covered participant and cannot be for employment purposes.

When purchasing a home COVID-19 test, participants should take their qualified kit to the pharmacy counter, present their Sav-Rx card, and it will process as an RX on the PIBF formulary, except with zero cost to the participant. If a participant makes a purchase and does not have it processed through Sav-Rx, the participant will have to submit their receipt and required forms to Sav-Rx's direct member reimbursement department (paper claim). To locate the OTC COVID-19 Test Reimbursement Form, please visit the PIBF Forms tab on our website. Tests purchased out of network will be subject to a $12 maximum per test.

With the minimal notification to create and implement this program, please know that all pharmacies may not be ready to process these claims beginning on January 15, 2022. If this is the case, please follow the direct member reimbursement procedures outlined above.

REMINDER OF GRANDFATHERED HEALTH PLAN STATUS: *The Plan is a group health plan that believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act".) As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing.) However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (for example, the elimination of lifetime limits on benefits.)*

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund office, at the address and telephone number listed in this letter. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at ***1-866-444-3272*** *or* ***www.dol.gov/ebsa/healthreform****. This website has a table summarizing which protections do and do not apply to grandfathered health plans.*

Sincerely,

Renée E. Vause

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Director