

SEAFARERS HEALTH AND BENEFITS PLAN

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Administrator

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Re: Plan Changes

Please note that the following benefit changes apply to participants at the Core-Plus, Core and Non-Medicare Pensioner Benefit Levels:

No Surprises Act changes effective January 1, 2022

1. **Out-of-Network Emergency Treatment** – The Plan will pay 90% of the qualifying payment amount or the billed amount, whichever is less. This applies to emergency medical treatment received at a hospital emergency room. **Emergency medical treatment** is treatment you receive for a medical condition that is so severe that it would be reasonable for you to expect that the lack of immediate medical attention would cause serious harm to your health or damage to your body.

The Plan's \$300 copayment for emergency treatment will still apply if you go to a hospital emergency room and you are not treated for an injury, or are not admitted to the hospital.

2. **Out-of-Network Ancillary Services at an In-Network facility** – Sometimes, when you are being treated at an in-network facility, you may receive services from providers (such as an anesthesiologist, radiologist or surgeon) that are out-of-network. In this situation, the Plan will pay 90% of the qualifying payment amount or the billed amount, whichever is less.
3. **Out-of-Network Air Ambulance Services** – If you or a family member require transportation by an out-of-network air ambulance, the Plan will pay 90% of the qualifying payment amount or the billed amount, whichever is less.

Once you have satisfied your applicable copayment, coinsurance and deductible, in most cases the provider is not permitted to balance bill you for remaining charges. The provider can only balance bill you for care you receive after your condition is stabilized if you could be safely transferred to an in-network facility; or if you specifically consent to out-of-network treatment.

The amounts you pay for your copayment, coinsurance and deductible for out-of-network emergency care will count towards the Plan's in-network out-of-pocket maximum. Please note that the Plan does not require pre-certification for emergency treatment.

See attached Notice for more information.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are 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 in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your 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 an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network 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 services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- 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 in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Health and Human Services.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.