EMPLOYMENT PARTNERS BENEFITS FUND

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IMPORTANT INFORMATION CONCERNING THE END OF THE COVID-19 COST-SHARING WAIVERS

&

LEGALLY REQUIRED COVERAGE AMENDMENTS TO YOUR BENEFITS BOOKLET

May 2023

I. Impact of Federal Declaration ending Emergency COVID-19 Mandates.

Temporary COVID related federal funding, together with mandates requiring health plans to provide some COVID related services to members on a no cost-sharing basis, were imposed under Executive and Administrative Agency Orders in early 2020. In January 2023, President Biden announced that these temporary Orders would end on May 11, 2023. As a result, you should be aware that in-network or out-of-network deductibles, co-insurance and co-pays may apply to COVID related services. In other words, the same provisions which apply to other services under your Plan will now apply to COVID related services.

To simplify transmission from the government mandates, your Plan will implement the following changes on June 1, 2023:

- **COVID-19 Vaccine and Testing Coverage**. Approved Vaccines will continue to be considered "preventative services". As such, there is no cost-sharing if obtained through an In-Network provider. Testing at a facility will be covered when performed by an In-Network medical professional. Cost-sharing varies depending on the terms of your specific plan. If you have questions about coverage or costs for COVID testing, call Highmark Blue Cross Blue Shield Member Service at the number on the back of your insurance card. Obtaining these services from an Out-Of-Network provider will result in greater co-insurance and may subject you to balance billing.

- **Over-The-Counter/Home Tests**. Even though the federal program providing free home COVID tests is ending, the Plan will continue to cover up to two (2) home tests per month, per covered individual through December 31, 2023.

- **COVID Treatment.** The same terms in your specific plan relating to cost-sharing for hospitalizations and outpatient visits apply for COVID treatment. Prescription antiviral treatments approved under COVID emergency use authorizations will be covered under your Rx schedule of benefits, subject to Tier 2 co-pays, Quantity Level Limits, and subject to change based on formulary updates.

- **End of Extended Deadlines for COBRA, HIPAA Special Enrollment, and benefit appeals.** Your Plan provides specific deadlines for you to take certain actions, such as electing COBRA (self-pay) coverage due to a loss of coverage, HIPAA Special Enrollment and benefit appeals. During the COVID National Emergency, these deadlines were extended by up to one year. Beginning July 11, 2023, any applicable extension will end. The deadlines provided under your Plan terms will apply. These include:

    1. The 60-day election period for Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage;
    2. The 30-day period (or 60-day period, if applicable) to request special enrollment under the Health Insurance Portability and Accountability Act (HIPAA);
    3. The date for making COBRA premium payments;
    4. The date for individuals to notify the plan of a COBRA qualifying event or determination of disability;
    5. The date within which individuals may file a benefit claim under the plan's claims procedure;
    6. The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure;
    7. The date to file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and
    8. The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

II. COVERAGE AMENDMENTS TO YOUR BENEFITS BOOKLET.

Highmark has advised that the final language, as approved by the Benefits Fund, will be incorporated into a new "Medical Benefit Booklet". The Benefits Booklet is the full detailed statement of medical and mental health coverages, expanding on the Benefits Fund's Summary Plan Descriptions. Members can access their Medical Benefit Booklet by logging on at www.highmarkbcbs.com and clicking on the Benefit Booklet link.

AMENDMENTS TO YOUR 2023 BENEFIT BOOKLET

1. **The following shall apply to Emergency Care Services Rendered by an Out-of-Network Provider:**
In the event that you receive emergency care services from an out-of-network provider and require an inpatient admission or observation immediately resulting from your injury or emergency medical condition, and upon stabilization:

   - you are unable to travel using nonmedical transportation or nonemergency medical transportation; or
   - you do not consent to be transferred,

   covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation will be covered at the network services level of benefits as set forth in the Hospital Services benefit in the Summary of Benefits section of this booklet. You will not be subject to any balance billing amounts.

2. **The following shall replace the Specialist Virtual Visit description under Outpatient Mental Health Care:**
A specialist virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee.

3. **The following shall be added to autism spectrum disorder benefits**
   Benefits are provided to members regardless of age for the following:
   Autism Spectrum Disorders
   Diagnostic Assessment of Autism Spectrum Disorders
   Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist, or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.
   Treatment of Autism Spectrum Disorders
   Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

4. **The "Learning Disabilities" provision under What is not Covered shall be replaced with the following :**

   For any care that is related to conditions such as learning disabilities, behavioral problems, or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b)

neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change; or for respite care.

For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.

5. **The following shall be removed from under What Is Not Covered**:

   a. Any limitation on methadone hydrochloride treatment for mental health/substance abuse services.
   b. Any limitation on nutritional counseling for mental health/substance abuse services.

6. **The following shall be added under What is Not Covered:**

   Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.

7. **When you receive covered services from an out-of-network provider, the following shall replace the description of Provider Reimbursement and Member Liability, as well as under Health Care Management**:

   When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described above, you will be responsible for the difference between your plan's payment and the provider's billed charge. If you receive services which are not covered under your plan, you are responsible for all charges associated with those services. However, the following covered services when received from an out-of-network provider will be provided at the applicable network level of benefits and you will not be responsible for such difference:

   1. Emergency care services provided in a hospital or freestanding emergency room; and
   2. Air Ambulance services

   Additionally, in very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers or ancillary providers who are not part of the network. A network facility provider may have an arrangement with a professional provider or ancillary provider who is not part of the network to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology, or pathology services) to patients of the network facility provider. The selection of such professional providers or ancillary providers may be beyond your control. In that situation, you will not be liable, except for applicable network deductible, copayment, or coinsurance obligations, for the charges of that professional provider or ancillary provider.

   Please review the Booklet's schedule of benefits for further details on cost sharing for Emergency Services.

   No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.

8. **The following shall be added under General Information:**
   Benefits After Provider Termination from the Network

   If at the time you are receiving medical care from a network provider, notice is received from Highmark that: Highmark intends to terminate or has terminated all or portions of the contract of that network provider for reasons other than cause; or the contract of that network provider will not be renewed, or the participation status of that network provider is changing; you may, at your option, continue an active course of treatment with that provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter. For purposes of this section, active course of treatment means: (i) an ongoing course of treatment for a life- threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (ii) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (iii) confirmed pregnancy, through the postpartum period; (iv) scheduled nonelective surgery, through postoperative care; (v) an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes; or (vi) treatment for a terminal illness. If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

9. **The Appeal Procedures and External Review Procedures shall Include the Review of Claims that Highmark Determined were not Subject to Legal Prohibitions Against Balance Billing.**

10. **The Following Shall be Added to Terms You Should Know when Reference-Based Pricing Applies:**
    Plan Allowance - The amount used to determine payment by your program for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law.

    In-Network Benefits
    When covered medical services are received from a network provider, then the plan allowance is determined in accordance with the provider's contract with Highmark or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

    Out-of-Network Benefits
    When covered medical services are received from an out-of-network provider as described below, the plan allowance is determined as follows:

    Non-Emergency Services Received at Certain In-Network Facilities from Out-of-Network Physicians

For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the (i) the reference price (as defined below) if out of area; (iii) the recognized amount (as defined below); (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

For the purpose of this preceding, "certain In-network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified under federal law and regulation.

Emergency Services Provided by an Out-of-Network Provider

For emergency services provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the reference price (as defined below) if out-of-area; (ii) recognized amount (as defined below) if out of area; (iii) the amount agreed to by the out-of-network provider and Highmark; or (iv) the amount determined by Independent Dispute Resolution (IDR).

Air Ambulance Transportation Provided by an Out-of-Network Provider

For Air Ambulance transportation provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable: (i) the recognized amount (as defined below); (ii) the amount subsequently agreed to by the out-of-network provider and Highmark; or (iii) the amount determined by Independent Dispute Resolution (IDR).

Your cost-sharing for each of the above out-of-network providers will be based on the recognized amount.

In All Other Cases

If you receive covered medical services from an out-of-network provider, the plan allowance for an out-of-network provider located in the Highmark service area is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment.

The plan allowance for an out-of-area network state-owned psychiatric hospital is what is required by law.

When covered medical services are received from an out-of-network provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Recognized Amount – Except as otherwise provided, the plan allowance and the amount which coinsurance and applicable deductible is based on for covered medical services when provided by: (i) out- of-network emergency service providers; and (ii) non-emergency service received at certain in-network facilities by non-network providers, when such services are either ancillary or non-ancillary provider services that have not satisfied the notice and consent criteria under federal law and regulation. For the purpose of this definition, "certain facilities" are limited to a hospital (a hospital outpatient department, a critical access hospital, an ambulatory surgical center), as defined in federal law and regulation. The Recognized Amount is based on: (i) an all-payer model agreement, if adopted; (ii) state law; or (iii) the lesser of the qualifying payment amount as determined by Highmark (or the local licensee of the Blue Cross Blue Shield Association when the claim is incurred outside of the Highmark service area) under applicable law and regulation, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law and regulation or the amount billed by the air ambulance service provider.

Reference Price – means a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, Highmark uses the price nationally recognized database or if no such price available, then 50% off billed charges.