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Procedure for Handling Participant and Dependent Complaints or Concerns Relating to Claims Covered Under No Surprises Act of 2021

Effective January 1, 2022

The No Surprises Act of 2021 provides rules relating to the coverage of the following types of claims under the Fund's plan of benefits, including rules limiting the amount of cost-sharing for which participants are responsible:

- Out-of-network emergency services, including air ambulance services.
- Ancillary services (including anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist) performed by an out-of-network provider at an in-network facility
- Non-ancillary, non-emergency out-of-network services performed at in-network facilities when the provider fails to give the appropriate notice to, and does not obtain consent from, the patient.

Effective January 1, 2022, when any Participant or covered Dependent, or their authorized representative, contacts the Fund Office to make a complaint or raise a concern relating to the Fund's processing of any of the above-described types of claims, the recipient of such call or correspondence will direct the caller, or the correspondence, to Jack Witt, Fund Administrator, who is the designated Fund Office contact to review all such complaints and concerns and address them in accordance with the requirements of the No Surprises Act and any other applicable law or regulations. Participants and covered Dependents also have a separate and independent right under the No Surprises Act to submit a complaint to the Department of Health and Human Services relating to the processing of the above-described types of claims.

Notwithstanding the foregoing, nothing in this Procedure document is intended to amend the Fund's rules for the review of claimant appeals under the Fund's plan of benefits.