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IMPORTANT NOTICE TO PLAN PARTICIPANTS

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes being made to the plan of benefits (the "Plan") of the Teamsters Local 705 Health and Welfare Plan. You should take the time and read this SMM carefully and keep it with your Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office.

Coverage of Emergency Services and certain Non-Emergency Services received at In-Network Facilities

Effective *January 1, 2022*, this Plan will comply with the federal No Surprises Act. An explanation of your rights under the No Surprises Act is attached to this SMM. The No Surprises Act requires that the Plan be amended as follows:

1. The Plan will cover Emergency Services provided at an out-of-network facility or by an out-of-network health care provider in the same manner as in-network Emergency Services. This means the following with respect to how Emergency Services are covered.

    a. You will pay the same cost-sharing whether you receive covered Emergency Services from an out-of-network facility or provider or an in-network facility or provider. In general, you cannot be balance billed for covered Emergency Services. Your cost-sharing will be based on the Recognized Amount payable for these services.

    b. Any cost-sharing payments you make with respect to out-of-network Emergency Services will count toward your in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider.

    c. The Plan will not impose prior authorization requirements for Emergency Services and will not impose more restrictive administrative requirements on out-of-network Emergency Services than in-network ones.

2. If you receive non-emergency items or services that are otherwise covered by the Plan from an out-of-network provider who is working at an in-network facility, those non-emergency items or services will be covered by the Plan as follows:

a. The non-emergency items or services received from an out-of-network provider working at an in-network facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider.

b. In general, you cannot be balance billed for these non-emergency items or services. Your cost-sharing will be based on the Recognized Amount payable for these services.

c. Any cost-sharing payments you make with respect to covered non-emergency services will count toward your in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider.

3. In certain circumstances, you can be billed by an out-of-network provider who works at an in-network facility. This can occur if you are notified by the out-of-network provider that they do not participate with the Plan. The provider must give you a notice stating certain information required by federal law, including that the provider is a nonparticipating provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any participating providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed. If you give informed consent to be treated by the out-of-network provider, then the Plan will pay for these services at the out-of-network rate, and the provider can bill you for the balance directly. This rule does not apply to services provided by hospital-based providers, such as anesthesiologists and radiologists.

4. Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

5. Emergency Services means the following:

    a. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

    b. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

    c. Emergency Services include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient

stay related to the emergency medical condition, until the provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation.

6. The Recognized Amount on which your cost sharing amount is based will be the lessor of billed charges from the provider or the Qualifying Payment Amount, which means the Plan's median in-network rate.

Continuing Coverage with a Provider who leaves the Plan's Network

Effective *January 1, 2022*, if you are a Continuing Care Patient and the Plan terminates its contract with your in-network provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

1. Notify you in a timely manner of the Plan's termination of its contracts with the in-network provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and

2. Allow you ninety (90) days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.

3. You are a Continuing Care Patient with respect to a provider or facility if you are:

    a. undergoing a course of treatment for a serious and complex condition from the provider or facility;

    b. undergoing a course of institutional or inpatient care from the provider or facility;

    c. scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

    d. pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

    e. determined to be terminally ill and receiving treatment for such illness from such provider or facility.

This announcement, which serves as a Summary of Material Modification, contains only highlights of recent changes to the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees/Plan Sponsor reserve the right to amend, modify, or terminate the Plan at any time.

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 balanced 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 federal agencies at 1-800-985-3059. Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

For technical assistance and complaints, you should call EBSA's toll free number at 1-866-444-3272. You may contact us electronically at www.askebsa.dol.gov.