TEAMSTERS LOCAL 639 – EMPLOYERS HEALTH FUND
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SUMMRY OF MATERIAL MODIFICATIONS

Date: December 13, 2021

To: ALL PARTICIPANTS
TEAMSTERS LOCAL 639 - EMPLOYERS HEALTH TRUST FUND

From: The Board of Trustees of the Teamsters Local 639 - Employers Health Trust Fund

Subject: Notice of Plan Improvements and Changes

This Notice announces numerous improvements and changes to the Fund's coverage. Please note that these changes have varying effective dates.

Please read this document carefully and keep it in a safe place.

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1. **Wellness Benefits**

Effective January 1, 2022, the Fund will cover 100% of the cost of the Cologuard colon cancer screening test prescribed by a physician for all participants and dependents age 50 to 85 once every three years. This service is provided at no charge to you and is not subject to the Deductible. Please note that if you have already had a routine colonoscopy, the Cologuard screening test will be covered after five years from that date and a routine colonoscopy will be covered three years after the date of the Cologuard test.

2. **Flu Vaccine**

Effective November 1, 2021, the Fund will cover the cost of seasonal influenza vaccinations at 100% through the pharmacy portion of the plan of benefits. This means that you can now get your flu vaccine at a participating pharmacy without an appointment. Previously, the flu vaccine was covered only through the medical portion of the plan and had to be administered at a doctor's office.

3. COVID-19 Vaccine

The Fund will cover 100% of the administration cost of the COVID-19 vaccine provided in a doctor's office under the medical benefit through at least June 30, 2022. Please note that the Fund also covers 100% of the administration cost of the COVID-19 vaccine provided in a participating pharmacy under the pharmacy benefit.

4. COVID-19 Tests

The Fund will cover 100% of the costs of COVID-19 tests, including over-the-counter tests approved by the U.S. Food and Drug Administration for emergency use authorization, prescribed by a health care provider, including a licensed pharmacist, for diagnostic or treatment purposes. The Fund **will not** pay for tests conducted for employment purposes. To get reimbursed for the cost of a prescribed over-the-counter test, please contact the Fund Office for a reimbursement form. This benefit will be provided during the period of a declared National Emergency which is still in effect.

5. Telehealth Benefits (video and audio visits)

The Fund will continue to provide telehealth benefits (video and audio visits) for **in-network providers only** through June 30, 2022. These charges will be processed in the same way as an in-person visit would be. The normal participant cost sharing (deductibles and co-insurance rates) for in-network providers will apply. The Fund will **not** accept or process any claims for telehealth visits from out-of-network providers incurred after October 31, 2020, except for telehealth visits for COVID-19 testing which continue to be covered at 100% with no cost sharing for both in-network and out-of-network providers through the emergency period as required by the Families First Coronavirus Response Act. The Fund will continue to cover the costs of medically necessary diagnostic tests, items and services incurred in connection with a telehealth visit (including the visit) that results in an order for, or administration of, a COVID-19 test with no participant cost sharing through the declared National Emergency period. Notwithstanding this temporary coverage for COVID-19 related claims, you and your family are always urged to use an in-network provider.

Improvements and Changes Due to the No Surprises Act

The following changes are being made to help protect participants from balance billing on certain medical bills incurred for out-of-network emergency room services, out-of-network air ambulance services, and from out-of-network providers of ancillary services at in-network facilities. The protections compute your cost sharing based on an amount similar to an in-network provider and the out-of-network provider cannot balance bill you for any difference between the full amount charged and what the Fund pays for the service.

6. Emergency Services

Effective for claims incurred on or after January 1, 2022, the Fund will pay for out-of-network emergency room services as in-network (20% coinsurance instead of 40%) after the $100 emergency room copay/visit and the in-network deductible has been applied. The coinsurance you pay will also be applied to the in-network out-of-pocket annual maximum ($400 per person/$800 per family). The Fund will also pay for services provided at an out-of-network facility as in-network after stabilization as part of outpatient observation or if you are admitted through the emergency room as related to the emergency condition "(unless there is notice and your consent is obtained)." If you choose to remain at the out-of-network facility, the Fund will pay for your post-stabilization services at the out-of-network rates.

7. Air Ambulance Services

Effective for claims incurred on or after January 1, 2022, the Fund will pay for the cost of out-of-network air ambulance services as in-network (20% coinsurance instead of 40%) after the in-network deductible has been applied. The coinsurance you pay will also be applied to the in-network out-of-pocket annual maximum ($400 per person/$800 per family).

8. Out-of-Network Non-Emergency Services at In-Network Facilities

Effective for claims incurred on or after January 1, 2022, the Fund will pay for the cost of out-of-network ancillary services (such as those provided by anesthesiologists, radiologists and pathologists) rendered at an in-network hospital or ambulatory surgical center as in-network (20% coinsurance

instead of 40%) after the in-network deductible has been applied. The coinsurance you pay will also be applied to the in-network out-of-pocket annual maximum ($400 per person/$800 per family).

9. Continuity of Care Requirements

If your in-network provider ceases to participate in the network you may be able to qualify for transitional care at in-network cost sharing for up to 90 days to allow you to transition care to an in-network provider. This applies if you are receiving treatment for a serious and complex condition, pregnancy, or terminal illness, undergoing inpatient care, or scheduled for non-elective surgery. Additional information is available from the Fund Office.

10. ID Cards and Accuracy of Provider Directory Information

The Fund's Identification Card now has additional information, and you will be receiving a new card soon. In addition, the list of network providers will be periodically reviewed, verified and updated as required by law. You may call the telephone number on your ID Card, contact the Fund Office, or consult the provider list through the link on the Fund's website, www.ourbenefitoffice.com/teamsterslocal639trustfunds/benefits, to determine if a particular provider or facility participates in the Fund's network.

11. Notice

The Fund will be posting an important notice about "Your Rights and Protections Against Surprise Medical Bills" on the website as required by the No Surprises Act.
www.ourbenefitoffice.com/teamsterslocal639trustfunds/benefits

If you have any questions about this notice, your health benefits or eligibility, you can contact the Fund Office at 1-800-983-2699. Currently, assistance is only available by telephone. Walk-in or in-person service is not available at this time.

The Trustees continue to reserve the right to amend, modify, or terminate the Fund and any or all benefits provided thereunder.

GRANDFATHERED HEALTH PLAN

This group health plan 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. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or ww.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov