Hagerstown Teamsters and Motor Carriers
Health and Welfare Fund
Hagerstown Motor Carriers and Teamsters Pension Plan
10312 REMINGTON DRIVE
HAGERSTOWN, MD 21740
(301) 733-2602
1 (800) 962-3972

HAGERSTOWN TEAMSTERS & MOTOR CARRIERS HEALTH AND WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS #5

The Board of Trustees of the Teamsters & Motor Carriers Health and Welfare Fund ("Fund") has adopted the following changes to the Teamsters & Motor Carriers Health and Welfare Plan. Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits and Coverage ("SBC"). These changes are effective as of July 1, 2022.

1. **First Change**

Under the section "Other Limitations," subsection number 5 on pages 15-16 of the SPD is changed to read:

5. Charges which exceed the Maximum Allowable Charge.

2. **Second Change**

Under the section "Part B: Schedule of Benefits for Active Participants and Their Eligible Dependents," the subsection "Personal and Dependent Health Coverage" on page 18 of the SPD is changed to read:

PERSONAL AND DEPENDENT HEALTH COVERAGE
Deductible per Calendar Year

Individual ……..$200
Family……$400

If PPO Provider used, or non-PPO provider used for No Surprises Services, Plan Pays:…..80% of Covered Expenses

If non-PPO Provider used for Services other than No Surprises Services, Plan Pays: ……70% of Covered Expenses

Out of Pocket Maximums

Individual Out of Pocket Maximum
(excluding deductible) ……..$1,500
Family Out of Pocket Maximum
(excluding deductible) ……$3,000
Except for No Surprises Services, if a PPO Provider is not used, then benefits are paid at 70% even if the Out of Pocket Maximums have been reached.

3. **Third Change**

Under the section "Medical Expense Limitations," subsection number 1 on pages 40-41 of the SPD is changed to read:

1. Any part of the expense for medical services and supplies which exceeds the Maximum Allowable Charge for such services and supplies.

4. **Fourth Change**

Under the section "Medical Expense Limitations," subsection number 14 on pages 41-42 of the SPD is changed to read:

14. To the extent permitted by the CAA, Emergency Room Charges for non-Emergency Services.

5. **Fifth Change**

The following sections are inserted on page 39 of the SPD:

CONTINUING CARE PATIENTS
If a participating provider leaves the CareFirst BCBS network, a Continuing Care Patient who is receiving care with that provider may continue to receive such care at the same in-network co-insurance for up to 90 days after the provider leaves the network.

NO SURPRISES SERVICES
Notwithstanding any provision to the contrary, all No Surprises Services will be administered and covered in compliance with the standards set forth in the CAA. In addition, if you receive No Surprises Services from a non-PPO provider that you thought was a PPO provider, based on inaccurate information in a current provider directory, then the No Surprises Services provided by that non-PPO provider will be covered as if the provider was a PPO provider.

6. Sixth Change

The following definitions are inserted in the "Definitions" section of the SPD on pages 43-44:

CAA
The Consolidated Appropriations Act, 2021 (including the No Surprises Act) and all regulations thereto.

Continuing Care Patient
An individual who is: (1) receiving a course of treatment for a "serious and complex condition," defined as (a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; or (4) determined to be terminally ill and receiving treatment for the illness.

Emergency Services
With respect to a Medical Emergency:

(1) 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 Medical Emergency (as outlined by the CAA); and

(2) 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 individual (regardless of the department of the hospital in which such further examination or treatment is furnished).

(3) Services provided by an out-of-network provider or facility after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

   A. The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;

   B. The individual is supplied with a written notice pursuant to the federal notice and consent requirements outlined in the CAA; and

   C. The individual gives informed consent to continued treatment by the out-of-network provider pursuant to the federal notice and consent requirements outlined in the CAA.

Independent Freestanding Emergency Department
A health-care facility that is geographically separate and distinct from a hospital under

applicable state law and that is licensed under state law to provide Emergency Services.

Maximum Allowable Charge
Except for No Surprises Services, the Maximum Allowable Charge for any supply or service shall be the lesser of: a) the CareFirst Blue Cross/Blue Shield allowed amount; b) an amount determined by the Board as the maximum allowable or reasonable charge for that service or supply; or c) the amount normally charged by a selected segment of Physicians or other providers in that geographic area (such segment and areas as defined by the Board).

For No Surprises Services, the Maximum Allowable Charge will be determined based on the requirements of the CAA.

Medical Emergency
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 the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. Medical Emergencies include, but are not limited to, heart attack, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and other acute conditions.

No Surprises Services
The following services, to the extent covered: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) services ancillary to non-Emergency Services (as outlined by the CAA) when performed by out-of-network providers at in-network facilities; and (4) other out-of-network non-Medical Emergency services performed at in-network facilities with respect to which the provider does not comply with the federal notice and consent requirements outlined in the CAA.

7. **Seventh Change**

The following notice is inserted beginning on page 65 of the SPD

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 or PPO network. 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 Department of Health and Human Services (HHS) at 1-800-985-3059 for issues related to federally regulated plans or alternatively, the Fund Office at (301) 733-2602.

Visit https://www.cms.gov/nosurprises/consumers or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

BOARD OF TRUSTEES

The current Board of Trustees is as follows:

Tom W. Krause, Chairman Teamsters Local Union No. 992 10312 Remington Drive Hagerstown, MD 21740	Michael Underkoffler, Secretary c/o Fund Office 10312 Remington Drive Hagerstown, MD 21740
Daniel Craytor Teamsters Local Union No. 992 10312 Remington Drive Hagerstown, MD 21740	Robert Cowie c/o Fund Office 10312 Remington Drive Hagerstown, MD 21740
Daryl Jamison, Alternate Teamsters Local Union No. 992 10312 Remington Drive Hagerstown, MD 21740	Gregory Hill, Alternate c/o Fund Office 10312 Remington Drive Hagerstown, MD 21740

Sincerely,

THE BOARD OF TRUSTEES

Please place this in your Summary Plan Description for handy reference. If you do not have a Summary Plan Description or are missing any of the subsequent Summary of Material Modifications, you may write to the Fund Office and request copies.