December 2021

Summary of Material Modifications

To: All Participants and their Dependents Who Are Eligible for Health and Welfare Active or Retiree Plan Benefits, including COBRA Beneficiaries

This Participant notice will advise you of certain material modifications (plan changes) that have been made to the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Trust (the Plan). This information is **very important** for you and your eligible dependents. Please take the time to read it carefully.

Unless otherwise indicated, these changes become effective with the play year beginning on January 1, 2022.

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 may be protected from surprise billing or balance billing. Some out of network providers that you see in an in-network hospital can ask you to sign a consent form and if you do they may bill you.

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 may include services you get after you're in stable condition, unless the treating doctor says that you can be moved, 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 (based on the median rate of contracted providers) 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 BeneSys Administrators. You may also go to the following website for a description of the federal balance billing protections and contact information for the applicable federal and state agencies:

https://www.cms.gov/nosurprises/consumers

Starting January 1, 2022, the phone number for information and complaints will be 1-800-985-3059.

Independent External Review

The Plan's existing appeals procedures include the right to seek an independent external review of an adverse benefit determination that involves medical judgment or a rescission of coverage. Effective with the plan year beginning on January 1, 2022, the right to independent external review also applies to adverse determinations with respect to out-of-network emergency services, nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating

providers of air ambulance services. For example, a patient could ask for external review if the Plan decided that pre-stabilization emergency treatment in an out-of-network emergency room did not qualify as "emergency services" under the No Surprises Act and thus imposed greater cost sharing on the patient. External reviews are initiated by contacting the Trust Office.

Identification Cards
All participants will be given new identification cards effective January 1, 2022 that provide deductible and out-of-pocket maximum information as well as a telephone number and website address to get further information.

Coverage of COVID Testing
Effective October 18, 2021, the federal government extended the COVID-19 public health emergency for at least an additional 90 days, until January 16, 2022. During the COVID Public Health Emergency, COVID-19 testing for diagnostic purposes and related services are covered without any participant cost sharing, prior-authorization requirements or other medical-management standards whenever a licensed healthcare or otherwise authorized provider deems the testing medically appropriate. In addition, the Plan will cover the cost of up to six COVID-19 tests per year that have not been ordered by a doctor for diagnostic purposes.

Coverage of Hearing Aids
Effective October 1, 2021 Hearing aid devices are covered at 100% up to a maximum of $3,000 per ear in a 36-month period. Hearing aid batteries are covered at 100% subject to this $3,000 benefit. The hearing exam visit, and audiology-related tests received to obtain hearing aids are covered at 100%. The cost of the exam and related tests do not count towards the $3,000 maximum hearing aid benefit.

If you have questions, please contact the Trust office at the number below or the website at www.UBCbenefits.org.

Sincerely,
THE BOARD OF TRUSTEES

NOTICE OF GRANDFATHERED STATUS

This group health plan believes that this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, 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 PPACA 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 PPACA, 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 United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan c/o BeneSys Administrators. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.