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ANNOUNCEMENT TO PARTICIPANTS

BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Bakers Union and FELRA Health and Welfare Fund has adopted the following changes to the Bakers Union and FELRA Health and Welfare Fund Plans One, Two, and Three, in compliance with the No Surprises Act, which was included in the 2021 Consolidated Appropriations Act. The No Surprises Act generally seeks to protect patients from surprise bills arising out of emergency and certain other medical care.

Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits of Coverage ("SBC"). These changes become effective **January 1, 2022.**

A. First Change

The following definitions are inserted in the "Definitions" section of the SPD.

Continuing Care Patient

An individual who is: (1) receiving a course of treatment for a "serious and complex condition," defined as an acute illness requiring specialized treatment to avoid the reasonable possibility of serious harm, and which requires treatment 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

A situation which arises suddenly and which poses a serious threat to life or health. Medical Emergencies include heart attack, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and other acute conditions. The diagnosis or the symptoms, and the degree of severity, must be such that immediate Medical Care would normally be required. An *Emergency* also includes anything a prudent layperson possessing an average knowledge

of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care.

***No Surprises Service**s*

The following services, to the extent covered under the Plan: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) services ancillary to non-*Emergency Services* (such as anesthesiology, pathology, radiology and diagnostic services and other services defined as ancillary under the No Surprises Act and its implementing regulations) 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 federal notice and consent requirements.

B. Second Change

The following definition in the "Definitions" section of the SPD is changed to read:

Maximum Allowable Charge

Except for *No Surprises Services*, the *Maximum Allowable Charge* for any supply or service shall be the lesser of: a) the Cigna HealthCare allowed amount; b) an amount stipulated 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* is the "Qualifying Payment Amount" ("QPA"), as defined under regulations to the No Surprises Act, and is based on the median of the in-network rates payable for the same or similar service in the same geographic region, adjusted for inflation.

C. Third Change

The following notice is inserted after page 27 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. 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 Employee Benefits Security Administration.

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

D. Fourth Change

The section "Medical Services" under the "Summary of Benefits for Full-Time Plan 1 Participants" on page 55 of the SPD is changed to read:

> 80% up to the Cigna allowed amount, with deductible to the out-of-pocket maximum. Cigna Share Administration Network Mandatory or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

E. Fifth Change

The section "Medical Services" under the "Summary of Benefits for Full-Time Plan 2 Participants" on page 57 of the SPD is changed to read:

> 75% up to the Cigna allowed amount, with deductible to the out-of-pocket maximum. Cigna Share Administration Network Mandatory or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

F. Sixth Change

The section "Medical Services" under the "Summary of Benefits for Full-Time and Part-Time Plan 3 Participants" on page 59 of the SPD is changed to read:

> 70% up to the Cigna allowed amount, with deductible to the out-of-pocket maximum. Cigna Share Administration Network Mandatory or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

G. Seventh Change

The section "Exceptions to Mandatory Use of Cigna HealthCare" on page 76 of the SPD is changed to read:

There are some exceptions to the mandatory Cigna HealthCare requirement. They are:

Emergency Services (inpatient or outpatient), regardless of whether they occur inside or outside the Cigna HealthCare area

Eligible *Dependent* students who attend a school outside the Cigna HealthCare network area are not required to use a Cigna HealthCare provider

Claims from non-Cigna HealthCare providers for services ancillary to non-*Emergency Services*, including anesthesiology, pathology, radiology, and diagnostic services) if (1) the Participant uses a participating surgeon/physician, (2) the service is performed at a participating facility/Hospital, and (3) the member followed all other Fund rules for coverage of the service.

Ambulance transportation for *Emergency Services*.

Air ambulance services for *Emergency Services*.

Other *No Surprises Act Services*.

When this Plan's coverage is secondary, a Cigna HealthCare PPO provider is not required.

H. Eighth Change

The text box in the section "Hospital and Medical Benefits" on page 94 of the SPD is changed to read:

Important!

You must use a participating Cigna HealthCare provider in order to be covered. Services performed by non-Cigna HealthCare Providers will not be paid under the Fund, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

I. Ninth Change

The section "Ambulance Transportation" on page 97 of the SPD is changed to read:

Ambulance Transportation

Plan 1 *Participants*: Transportation by ambulance for *Emergency Services* within the continental United States and Canada or within the geographical boundaries of Puerto Rico and Hawaii will be covered at 100% with no *Deductibles*, provided the amount is deemed

reasonable by the *Fund Office*. However, regardless of the determination made by the Fund Office, you will never be responsible for payment of ambulance transportation for *Emergency Services*. Air transportation is covered from the city/town in which the *Injury* or *Illness* occurs to the nearest *Hospital* qualified to provide care for that *Illness* or *Injury*. If, under these circumstances, air transportation is required, it is only covered for the first trip to and from a *Hospital*.

Ambulance transportation from one facility to another in non-emergency situations is not covered. **The requirement to use a Cigna HealthCare provider is waived for *Emergency Services* ambulance transportation.**

Plan 2 and Plan 3 *Participants*. Coverage provided under the same conditions as listed above but all payment is made under Major Medical at 75% for Plan 2 *Participants* and 70% for Plan 3 *Participants* provided the amount is deemed reasonable by the Fund Office. However, regardless of the determination made by the Fund Office, you will never be responsible for payment of more than 25% (for Plan 2 *Participants*) or 30% (for Plan 3 *Participants*) of the amount that the Fund determines is reasonable for emergency medical transportation.

The requirement to use a Cigna HealthCare provider is waived for *Emergency Services* ambulance transportation.

J. Tenth Change

The section "Emergency Room Visits" on pages 99-100 of the SPD is changed to read:

Plan 1 *Participant*s: Facility charges for emergency room visits are covered with a $25 *Co-Payment* payable by you, a 20% *co-insurance* on *Physician* fees after you pay your $300 person, $600/family deductible. The *Co-Payment* will be waived if the patient is admitted to the *Hospital* on the same day as the emergency room charges are incurred. Remaining expenses are covered under Major Medical. The *Fund* will make a basic benefit payment of $10 for *Physician*'s charges for services performed in the emergency room. The balance of *Physician*'s charges will be payable under Major Medical. Out-of-network *Emergency Services* are covered the same as in-network.

Plan 2 *Participant*s: All expenses are paid under Major Medical at 75% coverage with a $25 facility fee *Co-Payment* per visit. Then you pay 25% Co-Payment. Out-of-network *Emergency Services* are covered the same as in-network.

Plan 3 *Participant*s: All expenses are paid under Major Medical at 70% coverage with a $25 facility fee *Co-Payment* per visit. Then you pay 30% co-insurance. Out-of-network *Emergency Services* are covered the same as in-network.

K. Tenth Change

The following subsection is inserted under the "Hospital and Medical Coverage" section on page 104 of the SPD:

Continuing Care Patients
If an in-network provider leaves the Cigna HealthCare network, a *Continuing Care Patient* who is receiving care with that provider may continue to receive such care at the same in-network *Co-Payment* for up to 90 days after the provider leaves the network.

L. Eleventh Change

Under the section "Major Medical Benefits" on page 110 of the SPD, the language is changed to:

You must receive services at a Cigna Shared Administration network or no benefits will be paid, with the exception of *No Surprises Services*, *Emergency Services* ambulance transportation, and other exceptions listed in the section "Exceptions to Mandatory Use of Cigna HealthCare."

M. Twelfth Change

Under the section "General Exclusions," Number 39 on page 117 of the SPD is changed to:

39. Services or supplies which are in excess of the Cigna HealthCare PPO allowed amount or in excess of the amount approved by CARE Programs, except that you will not be responsible for amounts in excess of the Cigna HealthCare PPO allowed amount or in excess of the amount approved by CARE Programs for *No Surprises Services* or *Emergency Services* ambulance transportation.

If you have any questions on the announcement or the Plan, please contact the Plan Administrator at (866) 662-2537.