TEAMSTERS CALIFORNIA STATE COUNCIL
OF CANNERY AND FOOD PROCESSING UNIONS

PRODUCERS ALLIANCE
OF CALIFORNIA

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Date **July 12, 2022**

To: **All Full-Time Health Benefits Plan and Seasonal Medical Benefits Plan Participants and their Dependents, including COBRA Beneficiaries**

From: **Board of Trustees, Joint Benefit Trust**

SUMMARY OF MATERIAL MODIFICATIONS

This information is VERY IMPORTANT to you and your dependents. Please take the time to read it carefully.

Effective January 1, 2022, the names of the Joint Benefit Trust's ("Trust") Plans have changed and effective May 1, 2022, federal law requires a number of Plan improvements to comply with the *No Surprises Act*. These improvements are described below. Capitalized terms are defined in the section labeled "NEW/REVISED DEFINITIONS OF THE PLAN."

CHANGES TO PLAN NAMES
Effective January 1, 2022

In keeping with changes made to the Plans over the last ten years, as of January 1, 2022 the Plan names have been changed as follows:

Old Plan Name	**New Plan Name**
1400 Hour Plan	"Full-Time Health Benefits Plan (Annual Minimum Work Hours Required)"
Non-1400 Hour Plan	"Seasonal Medical Benefits Plan (Pre 7/1/2003 Three-Year Seniority)"
New Entrants	"Seasonal Benefits Plan"
1400 Hour Retiree Plan	"Retiree Full-Time Plan"

Note that the parentheticals for the "Full-Time Health Benefits Plan" and "Seasonal Medical Benefits Plan" may not need to be used at all times. Please note, the words 'Seasonal' and 'Regular' as used in the new Plan names are descriptive terms used in the cannery industry. The use of these words in the new Plan names or in this document is not intended to limit or modify in any way the seniority provisions or job classifications contained in any collective bargaining agreement which provides for participation in the Joint Benefit Trust.

NEW BILLING PROTECTIONS FOR CERTAIN SERVICES FROM NON-NETWORK PROVIDERS
Effective May 1, 2022

The *No Surprises Act* limits your cost-sharing amounts and provides protections from surprise medical bills for you and your covered dependents in the following situations:

1. When you receive Emergency Services at a Non-Network hospital or a Non-Network Independent Freestanding Emergency Department;

2. When you receive non-emergency services (otherwise covered by the Plan) from a Non-Network Provider at an In-Network facility, unless the Non-Network Provider meets certain notice and consent requirements for such services; and
3. When you receive Air Ambulance Services (otherwise covered by the Plan) from a Non-Network Provider.

IMPORTANT: Effective May 1, 2022, individuals receiving the above services will only be responsible for paying their In-Network coinsurance, copayment, and/or deductible (if applicable) and cannot be Balance Billed by the Non-Network provider or facility for these services. Remember, the Plan generally does NOT cover services received from Non-Network Providers except in emergencies.

Emergency Services

Emergency Services are covered under the Plan as follows:

- Without the need for prior authorization, even if the services are provided by a Non-Network Provider;
- Without regard to whether the Emergency Services were provided by an In-Network provider or an In-Network emergency facility, as applicable, with respect to the services;
- Without any administrative requirement or limitation on Non-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network providers and In-Network emergency facilities;
- Without Cost-sharing requirements on Non-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network provider or an In-Network emergency facility;
- The Cost-sharing requirement for Non-Network Emergency Services will be calculated as if the total amount that would have been charged for the services was equal to the *No Surprises Act* "Recognized Amount" for the services; and
- Cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services will count toward any In-Network deductible or In-Network out-of-pocket maximums applied under the Plan and in the same manner as if the Cost-sharing payments were made with respect to Emergency Services furnished by an In-Network provider or an In-Network emergency facility.

In general, you cannot be Balance Billed for Emergency Services provided by a Non-Network provider. The Cost-sharing Amount for Emergency Services from Non-Network Providers will be based on the lesser of: (i) billed charges from the provider, or (ii) the Qualified Payment Amount (QPA).

Non-Emergency Items or Services from a Non-Network Provider at an In-Network Facility

Non-emergency items or services (that are otherwise covered by the Plan), when performed by a Non-Network Provider at an In-Network facility are now covered by the Plan as follows:

- The Cost-sharing requirement will be no greater than the Cost-sharing requirement that would apply if the items or services had been furnished by an In-Network provider,
- Cost-sharing requirements will be calculated as if the total amount that would have been charged for the items and services by such In-Network provider were equal to the *No Surprises Act* Recognized Amount for the items and services,
- Cost-sharing payments made by the participant or beneficiary will count toward any In-Network deductible and In-Network out-of-pocket maximums applied under the plan (and the In-Network deductible and out-of-pocket maximums must be applied) in the same manner as if such Cost-sharing payments were made with respect to items and services furnished by an In-Network provider, and

In general, you cannot be Balance Billed for these items or services unless the Non-Network Provider follows the notice and consent procedures described below (this is not applicable to all Non-emergency items and services when performed by a Non-Network Provider at an In-Network facility).

Notice and Consent Procedures

Certain Non-emergency items or services performed by a Non-Network Provider at an In-Network facility will not have the financial protections of the *No Surprises Act*, and will NOT be covered by the Plan if the Non-Network Provider follows the notice and consent requirements described below:

1. At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice that the provider is a Non-Network Provider with respect to the Plan, an estimate of the charges for the treatment and any advance limitations that the Plan may put on the treatment, the names of any In-Network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the In-Network providers listed; and
2. The participant or dependent gives informed consent to continued treatment by the Non-Network Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-Network Provider may result no coverage to the participant or beneficiary.

IMPORTANT: If you consent to continued treatment by a Non-network provider you will be responsible for the entire cost of your treatment and will lose the protections of the *No Surprises Act* described in this notice because the Plan does not cover services received from Non-Network providers unless they are subject to the *No Surprises Act.*

The notice and consent exception for non-emergency items or services performed by a Non-Network Provider at an In-Network facility does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria.

The Cost-sharing Amount for non-emergency services at In-Network Facilities by Non-Network Providers will be based on the *No Surprises Act* Recognized Amount, which is, generally, the lesser of (i) the billed charges from the Non-Network Provider, or (ii) the Qualifying Payment Amount (i.e., the Plan's median of contract rates for the item or service in that location).

<u>Air Ambulance Services</u>

If you receive Air Ambulance services from a Non-Network Provider that are otherwise covered by the Plan, those services will be covered by the Plan as follows:

- The Cost-sharing requirement will be no greater than the Cost-sharing requirement that would apply if the services had been furnished by an In-Network provider.
- The Cost-sharing Amount will be calculated as if the total amount that would have been charged for the services by an In-Network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any Cost-sharing payments you make with respect to covered Air Ambulance 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.

In general, you cannot be Balance Billed for these items or services.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a Non-Network Provider at an In-Network facility, and/or Air Ambulances services, that is covered under the *No Surprises Act*, may be eligible for External Review. Please see the External Review procedures in the SPD for further information.

Complaint Process

If you believe you've been billed incorrectly, or otherwise have a complaint under the *No Surprises Act,* you may contact the Administrative Office at 1-800-JBT-HELP (1-800-528-4357) for assistance.

Repeal of Emergency Department Payment Rules

The Plan provision concerning payment for Emergency Room services, as required by the Affordable Care Act, is repealed for services provided on or after May 1, 2022, and replaced with the *No Surprises Act* requirements described above.

CONTINUITY OF CARE COVERAGE
Effective May 1, 2022

If you meet the requirements of a "Continuing Care Patient" and the contract between the Fund and your In-Network provider or facility terminates, or terminate your benefits because of a change in terms of the providers' and/or facilities' participation in the network,

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at the In-Network Cost-Sharing Amount to allow for a transition of care to an In-Network provider.

IN-NETWORK PROVIDER DIRECTORY
Effective May 1, 2022

A list of In-Network providers is available to you without charge on the https://www.anthem.com/ca/find-care or by calling the phone number on your Anthem ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information provided by the Plan's Dr./Facility Helpline (833-346-3365) about whether a provider is an In-Network provider, the Plan will apply the In-Network Cost-sharing Amount to your claim, even if the provider was a Non-Network Provider.

NEW/REVISED DEFINITIONS OF THE PLAN
Effective May 1, 2022

To implement the protections of the No Surprises Act, effective May 1, 2022, the Fund is adopting the following new/revised definitions of terms in the Plan.

Air Ambulance

The term "Air Ambulance" means medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605.

Allowable Charges for Claims Subject to the No Surprises Act

For Emergency Services provided by Non-Network Providers, for Non-Emergency Services provided by a Non-Network Provider at an In-Network facility (excluding services for which the Non-Network Provider obtained notice and consent from the participant or dependent), and for Air Ambulance Services, the term "Allowable Charge" means the Non-Network Rate, as defined below**.**

Ancillary Services

The term "Ancillary Services" means, with respect to services furnished by Non-Network Providers at an In-Network health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, and items and services provided by other specialty practitioners as specified by the Secretary of HHS; and
- Items and services provided by a Non-Network Provider if there is no In-Network provider who can furnish such item or service at such facility.

With respect to Hospital Services (Inpatient), Ancillary Services also include services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Balance Billing

The term "Balance Billing" means a bill from a health care provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with balance billings are not covered by this Plan, even if the Plan's Out-of-Pocket limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and Allowed Charges.

Under the *No Surprises Act*, you may not be balance billed for Emergency Services, Air Ambulance Services, and, unless appropriate notice and consent criteria are met, for any Non-Emergency Services performed by non-participating providers at an In-Network participating facility. For these services, cost-sharing payments will count toward any In-Network deductible and In-Network out-of-pocket maximum. You will be responsible for the entire billed amount for all services received from a Non-Network Provider that are not subject to the protections of the *No Surprises Act.*

Continuing Care Patient

The term "Continuing Care Patient" means a participant or beneficiary who, with respect to a provider or facility:

1. Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. Is 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;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Cost-sharing

The term "Cost-sharing" means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost-sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, Balance Billing by Non-Network Providers, or the cost of items or services that are not covered under the plan.

The **Cost-sharing Amount** for Emergency and Non-emergency Services at In-Network Facilities performed by Non-Network Providers, and Air Ambulance services from Non-Network Providers will be based on the *No Surprises Act* Recognized Amount.

Emergency Medical Condition

The term "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.

Emergency Services

The term "Emergency Services" means the following:

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 emergency medical condition; 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 patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-Network Provider or Non-Network Emergency Facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services were furnished, until:

- The attending emergency physician or treating provider determines that the participant or beneficiary is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and
- The participant or covered dependent is supplied with a written notice of the following:
  1. The provider is a Non-Network Provider with respect to the Plan,
  2. An estimate of the charges for treatment and any advance limitations that the Plan may put on a patient's treatment,
  3. The names of any In-Network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the In-Network providers listed; and
  4. The patient (or their authorized representative) gives informed voluntary consent to continued treatment by the Non-Network Provider, acknowledging that the patient (or their authorized representative) understands that continued treatment by the Non-Network Provider may result in greater cost to the participant or covered dependent.

Health Care Facility

The term "Health Care Facility" (for non-emergency services) means each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent Freestanding Emergency Department

The term "Independent Freestanding Emergency Department" means a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

No Surprises Act

The term "No Surprises Act" means the No Surprises Act (Public Law 116-260, Division BB).

Non-Network Emergency Facility

The term "Non-Network Emergency Facility" means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

Non-Network Provider

The term "Non-Network Provider" means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Non-Network Rate

With respect to Emergency Services provided by a Non-Network Provider, non-emergency services furnished by a Non-Network Provider at an In-Network facility, and Air Ambulance Services by a Non-Network Provider, the term "Non-Network Rate" means one of the following:

- The amount the parties negotiate;
- The amount approved under the independent dispute resolution (IDR) process; or
- If the State has an All-Payer Model Agreement, the amount that the state approves under that system.

Out-of-Pocket Limit on Medical Plan In-Network Cost-Sharing (Annual Out-of-Pocket Limit).

The *No Surprises Act* modifies the definition of Annual Out-of-Pocket Limit provided in the Summary Plan Description for Emergency Services, non-emergency services furnished by a Non-Network Provider at an In-Network facility, and Air Ambulance Services as follows: any cost-sharing payments (e.g., copayments, coinsurance, and deductibles) made by the participant or beneficiary are counted towards any In-Network deductible or Out-of-Pocket Limit.

Qualifying Payment Amount (QPA)

The term "Qualifying Payment Amount" means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the plan or issuer for the item or service in the area.

Recognized Amount

The term "Recognized Amount" means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

For Air Ambulance Services furnished by Non-Network Providers, the **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Serious and Complex Condition

The term "Serious and Complex Condition" means with respect to a participant, beneficiary, or enrollee under the Plan one of the following:

1. 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 injury;
2. In the case of a chronic illness or condition, a condition that is—
    1. Is life-threatening, degenerative, potentially disabling, or congenital; and
    2. Requires specialized medical care over a prolonged period of time.

In the context of Continuity of Care, **Termination** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

DEPENDENT DISENROLLMENT DURING OPEN ENROLLMENT
Effective July 1, 2022

Effective July 1, 2022, you will only be able to disenroll dependents covered under your JBT health plan during the open enrollment period each year. Dependents who are disenrolled during the open enrollment period will not be able to re-enroll in your JBT health plan until the next open enrollment period, or if you or your dependent experiences a HIPAA special enrollment event that would permit enrollment in your JBT Health Plan.

This Notice is intended to amend all JBT documents, notices and correspondence, including (but not limited to) the Summary Plan Description (SPD). This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the SPD. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of your JBT Plan. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under the JBT Plan, or any benefits provided under the JBT Plan, in whole or in part, at any time and for any reason.