



HEALTH & WELFARE TRUST FUND

CENTRAL STATES JOINT BOARD

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Dear Participant:

The Trustees of the Central States Joint Board Health and Welfare Fund – Plan B (“Welfare Fund”) are pleased to announce the following changes to the plan of benefits. The changes are described in detail in the attached Summary of Material Modification and are summarized as follows:

- Effective January 1, 2022, several modifications have been made to the Plan to comply with the No Surprises Act.
- Effective May 12, 2023, the Welfare Fund is updating several benefit changes previously implemented during the COVID-19 public health emergency and national emergency periods.

Please keep this notice with your Summary Plan Description (“SPD”) booklet for future reference. If you have any questions, please call the Fund Office.

Sincerely,

Lynette Allen

Central States Joint Board Health & Welfare Fund – Plan B
Summary of Material Modification
March 2023

No Surprises Act

Effective January 1, 2022, several modifications have been made to the Plan to comply with the No Surprises Act. The No Surprises Act generally protects patients from “balance billing” for out-of-network emergency services, certain ancillary services provided by out-of-network providers at in-network facilities, out-of-network care provided at in-network facilities without the patient’s informed consent, and air ambulance services (collectively, “No Surprises Act Services”).

Generally, Participants and Dependents receiving No Surprises Act Services will only be responsible for paying their in-network cost sharing. Furthermore, cost sharing for No Surprises Act Services will count toward in-network deductibles and out-of-pocket maximums.

For example, if you have an emergency medical condition and receive emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the 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 balance billed for these post stabilization services.

When you receive 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 the Plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

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 the Plan’s network and are encouraged to do so when possible.

If you believe you have been wrongly billed under the No Surprises Act, you can appeal the adverse benefit determination in accordance with the Plan’s claims and appeals procedures. If your health care claim involving compliance with cost-sharing and surprise billing protections is denied under the internal appeals procedures, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.

If you have any other questions or concerns regarding the No Surprises Act, you may contact the Fund Office or the No Surprises Help Desk at 1-800-985-3059.

End of COVID-19 Public Health Emergency and National Emergency Periods

President Biden recently announced the public health emergency and the national emergency periods related to COVID-19 will end on May 11, 2023. This means your benefits will change as described below.

COVID-19 Diagnostic Testing

The Fund has been providing coverage for COVID-19 diagnostic testing, including services and supplies related to the furnishing or administration of the test during health care provider visits, urgent care center visits and emergency room visits, without any cost-sharing.

Effective May 12, 2023, the Fund will no longer provide coverage for COVID-19 diagnostic testing without any cost-sharing. The Fund will, however, provide coverage for COVID-19 diagnostic testing under the normal cost-sharing provisions of the Plan (e.g., 80% (PPO) and Non-PPO diagnostic testing will not be covered).

Over-the-Counter COVID-19 Testing

The Fund has been providing coverage for over-the-counter (“OTC”) COVID-19 diagnostic testing without any cost-sharing for the duration of the public health emergency. Effective May 12, 2023, the Fund will no longer provide coverage for OTC COVID-19 tests.

COVID-19 Vaccinations

The Fund has been providing coverage for COVID-19 vaccinations without any cost-sharing for the duration of the public health emergency.

Effective May 12, 2023, the Plan will continue to provide coverage for COVID-19 vaccinations, but under the normal cost sharing provisions of the Plan for other vaccinations/immunizations (e.g., 100% (PPO) and Non-PPO vaccinations will not be covered).

If you have any questions about these changes or your plan of benefits, please contact the Fund Office.