OREGON TEAMSTER EMPLOYERS TRUST

**2022 OPEN ENROLLMENT AND BENEFIT CHANGES
INFORMATION FOR ACTIVES**

OVERVIEW

This packet contains the 2022 active open enrollment material for the Oregon Teamster Employers Trust. This material provides you an opportunity to select your medical and/or dental health care delivery system for 2022. This packet also identifies changes effective January 1, 2022 to the Trust's self-funded plans. If you participate in a medical or dental HMO, any applicable changes will be identified in material from the HMO. Finally, it contains various required legal notices.

If you do not wish to change your medical or dental coverage, you do not need to do anything.

If you wish to change your medical or dental coverage effective January 1, 2022, the Trust requires you to submit an enrollment form to the Trust Administration office by no later than December 20, 2021. Enrollment forms should be mailed to:

The William C. Earhart Company
12029 NE Glenn Widing Dr.
P.O. Box 4148
Portland, OR 97208

Please visit our website at www.wcearhart.com to download an enrollment form or call the number below to request one. If you are considering a change and would like to receive additional information on options available to you or get an enrollment form mailed to you, please call the Trust Administration Office at 1-877-396-4612 or 503-460-5212.

YOUR MEDICAL AND DENTAL OPTIONS

For medical and prescription drug coverage, participants have the following choices. Active participants with FW, GW or JW coverage have a choice between the Trust Indemnity Plan (administered by Regence BlueCross BlueShield of Oregon) and a Kaiser Health Plan option. You must live in the Kaiser service area in order to participate in one of its options.

For dental coverage, participants in any of the Trust's dental plans (Dental Plans 4, 5 or 6) can choose between the Trust Indemnity Dental Plan, Kaiser Dental or Willamette Dental. To participate in Willamette Dental or Kaiser Dental, you must live in the service area.

To determine the service area of any of the medical or dental HMO option or to receive additional information, please contact the Trust Administration Office at 877-396-4612 or 503-460-5212.

How to Choose a Medical or Dental Plan Option

If you wish to make a change you must submit an enrollment form to the Trust Administration Office by December 20, 2021. Any change in your medical and prescription drug option will be effective **January 1, 2022.** If you are considering a change and would like to receive additional information on options available to you, please call the Trust Administration Office at 1-877-396-4612 or 503-460-5212. These are numbers specifically for the Oregon Teamsters Employers Trust.

PLAN CHANGES

1. Self-Funded Medical Plan Preventive Services—January 1, 2022

The Trust's self-funded plan covers at 100% preventive care as defined by applicable federal law if the services are by Category 1 or Category 2 providers. These are providers which have an effective participating contract with Regence or one of its affiliates. This benefit does not apply if preventive services are received from a Category 3 (non-participating provider). The list of preventive services is updated annually. To see the full list of covered preventive services for 2022 go to https://www.regence.com/web/regence_individual/preventive-care-list.

2. Self-Funded Medical Plans – Zero Cost-Share for COVID Treatment—Ongoing

For 2022 the Trust's self-funded medical plan will continue to provide recognized and medically appropriate COVID-19 treatment with no Participant cost share. This will apply to medications, vaccines, office visits, telehealth, visual care, emergency room or hospital care that is medically necessary.

3. Self-Funded Medical Plans Infusion Site of Care Program—Ongoing

If you receive certain infused or injectable drugs, you may be notified about an opportunity to receive your care at an alternative location. Alternative locations such as standalone infusion sites, doctor's offices and home infusion can offer more comfort, convenience, and reduced costs compared to most Hospital settings. You may contact Regence for a list of drugs included in the Infusion Site of Care Program or for help finding an alternative location.

4. Self-Funded Active Medical Plans No Surprises Act—January 1, 2022

A new federal law, the No Surprises Act, will protect you against balance billing for emergency services at an out-of-network facility, air ambulance services, and services at an in-network facility provided by out-of-network providers. This law is described more fully in the Statutory Notices section. Please note this law does not apply to individuals in the Non-Medicare Retiree Plan.

NOTICE REGARDING HEALTH CARE REIMBURSEMENT AGREEMENT

Some collective bargaining agreements or written special agreements provide for participation in the Trust's Health Care Reimbursement Arrangement (HRA). Federal law

requires that a Healthcare Reimbursement Arrangement (HRA) must allow individuals to permanently opt-out of coverage under the HRA. This statutorily mandated opt-out requirement is to be offered annually and upon termination of employment. You should understand that electing to opt-out will not result in any additional amounts being paid to you in cash or reimbursements. Your employer will still be obligated to contribute to the Trust. Opting out will be irrevocable and will end future contribution to your HRA account. Opting out will result in the forfeiture of all amounts in your HRA account to the Trust. A decision to opt-out will only apply to your HRA and not your medical coverage. If you have questions about your HRA or this notice, you should contact the Trust Office. To opt-out, you must submit a written form which is available upon request from the Trust Office.

LIMITED SCOPE DENTAL AND VISION PLANS

The Affordable Care Act exempts limited scope dental and vision benefits from certain statutory requirements. To qualify, a self-funded plan is required to have a provision allowing an individual to opt out of dental and vision coverage. The Trust's dental and vision plans do have such a provision. If you do affirmatively opt out, it will not result in any additional money for you. It will mean only that you will not receive dental or vision benefits. If for some reason you want additional information, please contact the Trust Office.

STATUTORY NOTICES

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) FOR FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility:

OREGON—Medicaid and CHIP
Medicaid and CHIP Website:
https://www.oregon.gov/oha/hsd/ohp/pages/index.aspx
Medicaid and CHIP Phone: 1-877-314-5678

IDAHO—Medicaid and CHIP
Medicaid Website: https://healthandwelfare.idaho.gov/services-programs/medicaid-health
Medicaid Phone: 1-877-456-1233
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-877-456-1233

WASHINGTON—Medicaid
Website:
http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

To see if any other States have added premium assistance, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services
https://www.cms.gov/
1-877-267-2323, Ext. 61565

PRIVACY NOTICE

The Trust's Privacy Notice is available upon request from the Trust Administrative Office. It is also contained in your Plan Booklet.

NOTICE REGARDING YOUR RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Pursuant to the Women's Health and Cancer Rights Act of 1998, the Plan covers, for eligible Participants, the following procedures and supplies related to mastectomy:

- Reconstruction of the breast in which the mastectomy has been performed;

- Surgery and reconstruction of the other breast in order to produce a symmetrical appearance; and

- Prosthesis and treatment of physical complications of all stages of the mastectomy, including lymphedemas in a manner determined to be medically appropriate in consultation with the attending Physician and the Participant.

Consult your Plan booklet or contact the Trust Administration Office if you have questions.

NO SURPRISES ACT

1. What is the No Surprises Act?

The No Surprises Act is a new law that is intended to protect Plan participants from balance billing for the following services:

- Emergency Services at an out-of-network facility
- Air Ambulance services
- Services provided at an in-network facility by an out-of-network provider (a common example is an anesthesiologist providing services at a network hospital).

2. What is a balance bill?

If you obtain services or treatments from an out-of-network health care provider, your provider can bill you for the balance of costs not covered by the health plan. This is called "balanced billing." Balance billing charges are often significant and do not count towards your deductible or annual out-of-pocket maximum.

3. How does the new law protect against balance bills?

The new law prohibits health care providers from balance billing you when you obtain emergency care at an out-of-network facility; when you receive care by an out-of-network provider at an in-network facility; or when you receive emergency air ambulance services. The law provides that your costs for these services must be limited to no more than what you would have paid, had you gone to an in-network facility and any cost sharing must count towards your deductible and annual out-of-pocket maximums.

4. What if a provider asks me to waive my rights and permit balance billing?

The law's protections do not apply if you sign a consent to be balance billed by the provider. Certain non-emergency physician specialties, however, are not eligible to qualify for this exception and may not request a waiver. These physicians include assistant surgeons and hospitalists, anesthesiologists, pathologists, radiologist, laboratories, and other specialists that a patient typically does not select.

You must consent to waiving your protection against balance billing. If a health care provider covered by the No Surprises Act requests consent to balance bill:

- The written consent must be clear and understandable;

- Generally, the written consent form must be provided at least 72 hours prior to the date of the item or service;
- The written consent form must state that payment of the out-of-network bill may not accrue towards the individual's deductible or annual out-of-pocket maximum;
- The written consent form must state that by signing the consent, the individual agrees to be treated by the non-participating provider and understands the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by the nonparticipating provider; and
- The written consent form must document the time and date on which the individual received the written notice and the time and date on which the individual signed the written consent form.

You must also be provided with an estimate of the cost for the service or treatment and additional information.

5. What if I receive a balance bill for services or treatments received after January 1, 2022 from an out-of-network emergency department, air ambulance, or out-of-network provider at an in-network facility and I did not sign a consent form?

First, request a copy of any consent form from your provider or the facility in which you were treated. If they are unable to provide you one, then you have options under federal law to enforce your right to not be balance billed. Please contact Centers for Medicare and Medicaid Services at its website https:\\www.cms.gov\nosurprises\consumers, or call 1-800-935-3059 if you believe you have been balance billed inappropriately.

CONTACT INFORMATION

Questions regarding all matters other than medical and dental benefits should be addressed to the Trust Administrative Office. This includes questions regarding eligibility, obtaining enrollment forms or Plan Documents and other general inquiries:

William C. Earhart Co.
12029 NE Glenn Widing Dr.
P.O. Box 4148
Portland, OR 97208
503-282-5581 or 1-800-547-1314
www.wcearhart.com