

BAY AREA AUTOMOTIVE GROUP WELFARE FUND

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Date: September 23, 2022

To: All Participants (If you are enrolled in Kaiser, Kaiser will provide information on how it is implementing the changes described in this Notice.)

From: Board of Trustees, Bay Area Automotive Group Welfare Fund

**PLAN CHANGE NOTICE
SUMMARY OF MATERIAL MODIFICATIONS
RETAIN WITH YOUR BENEFIT PACKAGE FOR FUTURE REFERENCE.**

No Surprises Act
Effective December 2022

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

As of December 1, 2022, the “No Surprises Act” will limit your out-of-pocket costs and protect you against surprise medical bills. What your Plan pays for medical care depends on whether the hospital, doctor, or urgent care center is in the Anthem Blue Cross PPO Network *or* is “out of network” (“out-of-network” claims are also called “non-PPO” claims). If you are treated at an out-of-network hospital or urgent care center you generally must pay more out of pocket than at an “in-network” hospital or urgent care center. However, as of December 2022 your out-of-pocket costs for only the following types of out-of-network claims will be no greater than if you were treated “in network” and the out-of-network provider cannot “balance bill” you for additional payment:

- Emergency services,
- Services provided by an *out-of-network* doctor or other health care provider at an *in-network* hospital or urgent care center, and
- Air ambulance services.

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 to pay other costs or the entire bill if you see a provider or visit a health care facility that is not in the Anthem Blue Cross network.

“Out-of-network” describes providers and facilities that have not signed a contract to participate in the Anthem Blue Cross network (or the Teamsters Assistance Program provider networks for substance abuse treatment). 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 probably 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 cannot 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 cannot be balance billed for these emergency services. This includes services you may get after you

are in stable condition, unless you give informed written consent and give up your protections not to be balance billed for these post-stabilization services.

You are protected from balance billing for: **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, or where there is no in-network provider who can furnish the service. These providers cannot 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 cannot balance bill you, unless you give informed written consent and give up your protections. **If you do give written consent to continued treatment by the out-of-network provider, you will lose the protections of the No Surprises Act and, in most cases, likely to be responsible for greater cost-sharing than if you do not give written consent.** You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not 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 BAAG plan generally must:

- Cover out-of-network 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 at an in-network facility toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact the Administrative Office at (800) 267-3232 for assistance.

What should I do if I receive a surprise bill and have a billing disagreement?

If the Fund denies all or part of a claim for service, you can appeal that decision. Your Summary Plan Description contains information on the review process and how you request review of your plan's decision.

Starting on December 1, 2022, you generally will not be responsible for balance bills or out-of-network cost-sharing when getting emergency care, non-emergency care from out-of-network providers at certain in-network facilities, or air ambulance services from out-of-network providers. When this happens, instead of you paying for unexpected out-of-network costs, you will generally only need to pay your normal in-network costs (like coinsurance, copayments, and amounts paid towards deductibles). The health care provider and your health plan are responsible for negotiating the total payment amount from the plan to the provider through an independent dispute resolution process.

External Review

An adverse benefit determination related to an Emergency Service, Non-Emergency Service provided by a Non-Network Provider at an In-Network facility, and/or Air Ambulance Services, that is covered under the *No Surprises Act*, may be eligible for External Review, and this review includes BAAG plans that remain "grandfathered." Please see the External Review procedures in the SPD for further information.

Learn more about resolving billing disagreements

Where do I go to get more help or file a complaint?

If you have a question about the No Surprises Act or believe the law is not being followed, contact the Centers for Medicare & Medicaid Services No Surprises Help Desk at 1-800-985-3059 from 5 am to 5 pm PST, 7 days a week, to submit your question or a complaint. You can also submit a complaint online.

If you still need help with your health insurance and have a problem or question, contact your state Consumer Assistance Program. These programs help consumers experiencing problems with their health insurance or seeking to learn about health coverage options.

NEW MEMBERSHIP CARDS

Because the No Surprises Act requires new membership cards, the trust will issue you new member identification cards that will show your overall Plan deductible, overall out-of-pocket maximum and consumer contact information.

CONTINUITY OF CARE

You are allowed up to 90 days of continued coverage at the in-network cost sharing amount (to allow you to transition your care to an in-network provider/facility) if your provider or facility drops out of the Anthem PPO network while you are;

- Undergoing a course of treatment *or* a course of institutional or inpatient care from that provider or facility for a serious and complex condition;
- Scheduled to undergo non-elective surgery from that provider or facility, including post-operative care from such provider or facility with respect to that surgery;
- Pregnant and undergoing treatment for pregnancy from that provider or facility; or
- Determined to be terminally ill and receiving treatment for this illness from that provider or facility.

If you are undergoing care and a contract terminates, you will receive notification from the Plan and must elect continued coverage in writing according to the notice.

IN-NETWORK PROVIDER DIRECTORY

A list of in-network providers is available to you without charge on the Anthem Blue Cross website – <https://www.anthem.com/ca/findcare> or by calling the Anthem Blue Cross phone number on your new Bay Area Automotive Group Welfare Fund membership card. The Anthem “Prudent Buyer” network consists of providers, including hospitals of varied specialties as well as general practice.

Treatment for Autism Spectrum Disorder
Effective January 1, 2022

COVERAGE OF TREATMENT FOR AUTISM SPECTRUM DISORDER FOR PPO PLAN PARTICIPANTS

Effective immediately, the Fund’s Anthem Blue Cross PPO medical plans will cover treatment for Autism Spectrum Disorder (“ASD”), including Applied Behavior Analysis (“ABA”) and Applied Behavior Therapy (“ABT”), subject to the same conditions that apply to other kinds of outpatient therapy, such as co-pays, co-insurance, deductibles, review for medical necessity, and other medical management.

Please note that if your Autism provider is not in the Anthem Blue Cross network, your out-of-pocket costs are likely to be much higher than if you had selected an Anthem Blue Cross PPO provider.

FOR KAISER PARTICIPANTS

The Fund's Kaiser medical plans cover treatment for Autism, including ABA therapy. Contact your Kaiser primary care provider or visit kp.org to learn more about coverage and Kaiser's network of providers.

Coverage of Services Related to Gender Dysphoria
Effective January 1, 2017

Effective January 1, 2017, the Board removed any and all exclusions related to medically necessary treatment of gender dysphoria (including treatment related to change of gender).

If you have questions regarding this Notice please contact:

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Dublin, CA 94568
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In accordance with ERISA reporting requirements this document is intended to serve as a Summary of Material Modifications to the Plan.

PLEASE NOTE

This Notice is intended to amend your Summary Plan Description.

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 *Summary Plan Description*. 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 the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. 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 Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason.

Si usted gustaría una copia en español, favor de contactar la oficina de administración de Bay Area Automotive Group Welfare Fund.