Tuckpointers Local 52
Health and Welfare Trust

Benefit Update

April 2022

Dear Participant:

As the Board of Trustees of the Tuckpointers Local No. 52 Health and Welfare Fund (the "Fund"), we are providing this Benefit Update that includes important improvements to your benefits.

Coverage of Emergency Services and certain Non-Emergency Services received at In-Network Facilities

Effective May 1, 2022, this Plan will comply with the federal No Surprises Act. The No Surprises Act requires that the Plan be amended as follows:

(1) The Plan will cover Emergency Services provided at an out-of-network facility or by an out-of-network health care provider in the same manner as in-network Emergency Services. This means the following with respect to how Emergency Services are covered.

(A) You will pay the same cost-sharing whether you receive covered Emergency Services from an out-of-network facility or provider or an in-network facility or provider. In general, you cannot be balance billed for covered Emergency Services. Your cost-sharing will be based on the Recognized Amount payable for these services.

(B) Any cost-sharing payments you make with respect to out-of-network Emergency 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.

(C) The Plan will not impose prior authorization requirements for Emergency Services and will not impose more restrictive administrative requirements on out-of-network Emergency Services than in-network ones.

(2) If you receive non-emergency items or services that are otherwise covered by the Plan from an out-of-network provider who is working at an in-network facility, those non-emergency items or services will be covered by the Plan as follows:

(A) The non-emergency items or services received from an out-of-network provider working at an in-network facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider,

(B) In general, you cannot be balance billed for these non-emergency items or services. Your cost-sharing will be based on the Recognized Amount payable for these services.

(C) Any cost-sharing payments you make with respect to covered non-Emergency 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.

(3) In certain circumstances, you can be billed by an out-of-network provider who works at an in-network facility. This can occur if you are notified by the out-of-network provider that they do not participate with the Plan. The provider must give you a notice stating certain information required by federal law, including that the provider is a nonparticipating provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the

names of any participating providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed. If you give informed consent to be treated by the out-of-network provider, then the plan will pay for these services at the out-of-network rate, and the provider can bill you for the balance directly. This rule does not apply to services provided by hospital-based providers for Ancillary Services, such as anesthesiologists and radiologists.

(4) The Recognized Amount on which your cost sharing amount is based will be the lessor of billed charges from the provider or the Qualifying Payment Amount, which means the plan's median in-network rate.

Continuing Coverage with a Provider who leaves the Plan's Network

Effective May 1, 2022, if you are a Continuing Care Patient and the Plan terminates its contract with your in-network provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will do the following:

(1) Notify you in a timely manner of the Plan's termination of its contracts with the in-network provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and

(2) Allow you ninety (90) days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.

(3) You are a Continuing Care Patient with respect to a provider or facility if you are:

(A) undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;

(B) undergoing a course of institutional or inpatient care from the provider or facility;

(C) 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;

(D) pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) determined to be terminally ill and receiving treatment for such illness from such provider or facility.

External Review of Certain Coverage Determinations

Effective May 1, 2022, if your initial claim for benefits related to an Emergency Service, non-Emergency Service provided by an out-of-network provider at an in-network facility, and/or Air Ambulances Service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination.

New and Revised Definitions

Air Ambulance means medical transport services and supplies, as may be Medically Necessary, by a certified rotary wing Air Ambulance, as defined in 42 CFR 414.605, or certified fixed wing Air Ambulance, as defined in 42 CFR 414.605, for patients.

Ancillary Services: Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by an out-of-network provider at an in-network Health Care Facility, the term "Ancillary Services" means the following:

(1) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner,

(2) Items and services provided by assistant surgeons, hospitalists, and intensivists;

(3) Diagnostic services, including radiology and laboratory services;

(4) Item and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and

(5) Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

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 means:

(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 (meaning, a Health Care Facility that is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services), 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).

(3) Emergency Services furnished by an out-of-network provider or at an out-of-network Hospital (regardless of the department of the Hospital in which such items or services are furnished) or an independent freestanding emergency department 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 related to the Emergency Medical Condition, until:

(A) The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and

(B) The patient or their representative is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, an estimate of the charges for 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

(C) The patient or their representative gives informed written voluntary consent to continued treatment by the out-of-network provider, acknowledging that the patient understands that continued treatment by the out-of-network provider may result in greater costs to the patient.

Health Care Facility (for non-Emergency Services) means each of 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 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 Services: The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 27, 2020, as part of the Consolidated Appropriations Act of 2021. The term “No Surprises Act

Services" means the following, to the extent covered under the Plan: (1) out-of-network Emergency Services, (2) out-of-network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at an in-network facility; and (4) other out-of-network non-Emergency Services performed by out-of-network provider at an in-network facility with respect to which the provider does not comply with written federal notice and consent requirements.

Out-of-Network Rate: With respect to No Surprises Act Services, the term "Out-of-Network Rate" means one of the following in order of priority:

(1) If the state has an All-Payer Model Agreement, the amount that the state approves under that system;

(2) Applicable state law;

(3) The amount parties negotiate; or

(4) The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

Qualifying Payment Amount (QPA) 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 geographic region.

Reasonable and Customary Charge for claims not subject to the No Surprises Act means:

(1) The usual charge by the provider for the same or similar service or supply; or

(2) No more than 90% of the Prevailing Charge; or

(3) With respect to a PPO provider, the charge set forth in the agreement between the PPO provider and the PPO or the Plan; or

(4) The provider's actual charges.

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.

For Air Ambulance Services furnished by out-of-network provider, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

In Closing

If you have questions about the information in this notice or about your benefits generally, call the Fund Office at (630) 516-8008. Please keep this notice, which describes changes to information provided in the most recent SPD, with your SPD for future reference. Only the provisions described in this notice are changing; no other Plan changes are being made at this time.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan of the Tuckpointers Local No. 52 Health and Welfare Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at (630) 516-8008. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This notice is a Summary of Material Modifications (SMM), within the meaning of Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. This notice describes important changes to the Plan. You may find full details in the most recent Summary Plan Description and Plan Document that establish the Plan provisions. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.