NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS BENEFIT FUNDS

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Summary of Welfare Fund Changes Under the No Surprises Act – Effective July 1, 2022

The enclosed Summary of Material Modifications ("SMM") describes changes to the Summary Plan Description ("SPD") for the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund"). All changes listed in the SMM and described below are effective July 1, 2022.

These contain detailed changes to Welfare Fund provisions for active employees under the No Surprises Act (the "NSA"). Below is a high-level summary of these changes, which are described in more detail in the SMM:

- **In General.** The NSA protects patients from being balanced billed by the provider or facility if they receive emergency services (and some types of non-emergency services) at certain out-of-network facilities or from a non-PPO provider at an in-network facility or if they need an air ambulance.
  - Patient's Costs: Patients receiving these services will only be responsible for paying their in-network cost share of an amount that is similar to the rate that an in-network provider would charge.
- **Surprise Billing.** Starting July 1, 2022, when you get emergency care or get treated by an out-of-network provider at an in-network hospital, freestanding emergency department or ambulatory surgical center, you are protected from surprise billing or balance billing in the following situations:
  - Emergency Services: If you have an emergency medical condition and get emergency services (including air ambulance 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). Put another way, you can't be balance billed for these emergency services.
  - Certain Non-Emergency Services: This protection against balance billing under the NSA also applies to services you may get after you have been stabilized until you are able to use nonmedical transportation or non-emergency medical transportation, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Additional Protections.** In the circumstances described above when balance billing isn't allowed under the NSA, you also have the following protections:
  - Your Costs: You are only responsible for paying your share of the cost under the Plan, like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network. The plan will pay out-of-network providers and facilities directly.
  - Plan Coverage: The Welfare Fund generally will:

- Cover 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. Prior to this change, the provider or facility could balance bill you.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

- **Information on In-Network Providers.** A list of in-network providers will be made available to you without charge. If you obtain and rely upon incorrect information about whether a provider is a in-network provider from the Plan or its administrators, the Plan will apply in-network cost-sharing to your claim, even if the provider was out-of-network.
- **Continuity of Care.** The Welfare Fund will apply special rules if you are a "Continuing Care Patient," which applies if you are:
  - Undergoing a course of treatment for a serious and complex condition; undergoing a course of institutional or inpatient care;
  - Scheduled to undergo non-elective or postoperative care after a non-elective surgery; pregnant and undergoing a course of treatment for the pregnancy; or
  - Are terminally ill and receiving treatment for such illness and your provider or facility leaves the network.

  If you are a Continuing Care Patient as described above, the Welfare Fund's third-party administrator will:
  - Notify you in a timely manner of the provider or network's change in status and your right to elect continued transitional care from the provider or facility; and
  - Continue to cover claims for that complex care at the in-network cost sharing levels for up to 90-days to allow time for you to transition to an in-network provider.

Note: This Summary Does Not Describe the Complete Welfare Fund Rules

The official terms of the Welfare Fund govern all benefits under the Welfare Fund. This summary of the enclosed SMM does not contain official Welfare Fund terms, and this summary is being provided solely for informational purposes. In the event of any conflict between this summary and the official terms of the Welfare Fund, the official terms of the Welfare Fund will govern. In addition, the Board of Trustees reserves the right to amend of terminate the Welfare Fund, in whole or in part, for any time and for any reason.

NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS BENEFIT FUNDS

SUMMARY OF MATERIAL MODIFICATIONS

IMPORTANT INFORMATION REGARDING YOUR HEALTH BENEFITS

Effective July 1, 2022

This document is a Summary of Material Modifications ("SMM") intended to notify you of an important change made to medical and prescription drug benefits of the NYC District Council of Carpenters Welfare Fund (the "Welfare Fund" or "Fund"). You should take the time to read this SMM carefully and keep it with a copy of the Welfare Fund's Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes, please contact the Fund Office.

Dear Participant:

The Board of Trustees is pleased to announce that, **effective July 1, 2022**, the Fund is implementing a number of improvements to the Plan to comply with the No Surprises Act (the "NSA"). This SMM advises you of changes to certain Welfare Fund benefits pursuant to the NSA.

The NSA was signed into law in December 2020 and protects patients from "balance billing" for Out-of-Network emergency services, Out-of-Network air ambulance services, and certain non-emergency services performed by an Out-of-Network provider at an In-Network facility (collectively "No Surprise Services"). For the Welfare Fund, the protections described in this SMM apply to claims incurred for No Surprises Services on and after July 1, 2022.

You are still encouraged to use In-Network facilities and participating providers whenever possible. Please review these changes carefully and contact the Fund Office with any questions that you may have.

Effective July 1, 2022, Participants and Dependents receiving No Surprises Services will only be responsible for paying their In-Network cost sharing, and cannot be balance billed by the provider or facility for emergency services.

Emergency Services

The NSA requires emergency services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. Without regard to whether the health care provider furnishing the emergency services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on Out-of-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;

4. Without imposing cost-sharing requirements on Out-of-Network emergency services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;

5. By calculating the cost-sharing requirement for Out-of-Network emergency services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and

6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider.*

*The Fund already applies the same cost-sharing provisions to emergency services regardless of whether they are provided In-Network or Out-of-Network.

Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

The No Surprises Act requires non-emergency services performed by an Out-of-Network Provider at an In-Network Health Care Facility to be covered as follows:

1. 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 an In-Network Provider;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the recognized amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Welfare Fund in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

4. **Notice and Consent Exception**: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:

a. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Welfare Fund, the estimated charges for your treatment and any advance limitations that the Welfare Fund may impose on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

b. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network provider may result in greater cost to you.

The notice and consent exception 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 Out-of-Network Provider satisfied the notice and consent criteria.

Out-of-Network Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Welfare Fund from an Out-of-Network provider, those services will be covered by the Welfare Fund as follows:

- The Air Ambulance services received from an Out-of-Network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing 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.

Continuity of Coverage

If you are a Continuing Care Patient (see the definitions at the end of this SMM), and the Fund terminates its In-Network contract with an 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 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 In-Network cost sharing to allow for a transition of care to an In-Network provider.

Incorrect In-Network Provider Information

A list of In-Network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Fund or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is an In-Network provider from the Fund or its administrators, the Fund will apply In-Network cost-sharing to your claim, even if the provider was an Out-of-Network provider at the time the service was rendered.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

External Review Process of Certain Coverage Determinations

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 Ambulance service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Fund's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

New Definitions Implemented from the NSA

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

Ancillary Services means, with respect to a participating health care facility, 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; and

4. Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a "serious and complex condition"; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or 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:

1. Serious impairment to bodily functions; or

2. Serious dysfunction of any bodily organ or part; or

3. Placing the health of a woman or her unborn child in serious jeopardy.

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).

3. Emergency services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post stabilization services (i.e., services 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 provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and

    b. You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Welfare Fund, of the estimated charges for your treatment and any advance limitations that the Welfare Fund may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

    c. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

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.

No Surprises Services means the following, to the extent covered under the Welfare Fund:

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 an out-of-network provider at an in-network health care facility with respect to which the provider does not comply with federal notice and consent requirements.

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 Out-of-Network providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

Qualifying Payment Amount or QPA means generally the median contracted rates of the Fund or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR § 716-6(c).

Serious and Complex Condition means 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 harm; or

2. In the case of a chronic illness or condition, a condition that is the following:

    a. Life-threatening, degenerative, potentially disabling, or congenital; and

    b. Requires specialized medical care over a prolonged period of time.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, you may also call the Fund Office.

This Summary of Material Modifications ("SMM") is intended to provide you with an easy-to-understand description of certain changes to the Welfare Fund's benefits. The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Welfare Fund, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Welfare Fund. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Welfare Fund, make any promises to you about benefits under the Welfare Fund, or to change any provision of the Welfare Fund. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Welfare Fund and decide all matters, legal and/or factual, arising under the Welfare Fund.