Welfare Fund
of Local No. One, I.A.T.S.E.

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SUMMARY OF MATERIAL MODIFICATIONS

CHANGES TO MEDICAL BENEFITS PURSUANT TO THE NO SURPRISES ACT

Effective July 1, 2022

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to the medical benefits of the Welfare Fund of Local No. One, IATSE (the "Welfare Fund" or "Plan"). You should take the time to read this SMM carefully and keep it with a copy of the Welfare Fund Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Welfare Fund, please contact the Fund Office as described at the end of this document.

Dear Participant:

The Board of Trustees of the Welfare Fund of Local No. One, IATSE (the "Welfare Fund" or "Plan") is pleased to announce the following changes to medical benefits provided to participants and their covered dependents, in accordance with the federal No Surprises Act. These changes are effective July 1, 2022.

Background Regarding the Balance Billing Protections of the No Surprises Act

The No Surprises Act (the "Act") is intended to protect medical 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 (unless, where permitted, the patient gives "informed consent" under the Act's rules) (collectively "No Surprise Services").

In general, Balance Billing occurs when you see a health care provider or visit a health care facility that is not in the Plan's network, and you are charged the difference between what the Plan agreed to pay the provider or facility, and the full amount charged for a service. "Surprise billing" is an unexpected Balance Bill that happens when you cannot control who is involved in your care—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.

As described in more detail below, Plan participants and covered dependents who receive "No Surprise Services" (defined in the glossary below) will be responsible for paying only their In-Network cost sharing for those services. In accordance with the Act, the provider is not permitted to Balance Bill the patient for No Surprise Services, and the Plan will only pay Out-of-Network providers for such No Surprise Services in accordance with the Plan's provisions regarding payment determined in accordance with the Act. To locate an In-Network medical provider, visit https://www.aetna.com/individuals-families/find-a-doctor.html.

Capitalized terms used in this notice, such as "No Surprise Services" and "Emergency Services," are defined in the Glossary at the end of this notice.

BENEFIT CHANGES

Emergency Services

As required by the Act, the Plan will cover Emergency Services that qualify as No Surprise Services, in accordance with the following requirements:

No Prior Authorization Requirement. The services will be covered by the Plan without the need for any prior authorization determination, even if the Emergency Services are provided on an Out-of-Network basis.

Coverage Regardless of Network Status. The services will be covered by the Plan without regard to whether the health care provider or facility furnishing the Emergency Services is an In-Network provider or an In-Network emergency facility, as applicable.

Administrative Requirements/Limitations. The Plan will not impose 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.

Cost-Sharing Requirements. The Plan will not impose cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if such services were provided by an In-Network provider or In-Network emergency facility.

Cost-Sharing Calculations (Use of "Recognized Amount"). The Plan will calculate the participant cost-sharing requirement (such as any applicable co-insurance) for Out-of-Network Emergency Services as if the total amount that would have been charged for such Emergency Services were equal to the Recognized Amount for the services (not the higher billed amount).

Deductibles and Out-of-Pocket Maximums. The Plan will count cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your in-network deductible and out-of-pocket limit in the same manner as those received from an In-Network provider.

In light of the Act's new rules, 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 the Plan's In-Network cost-sharing amount (such as copayments and coinsurance). You cannot be Balance Billed for these Emergency Services.

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

As required by the Act, the Plan will cover Non-Emergency Services performed by an Out-of-Network provider at an In-Network Health Care Facility in accordance with the following requirements (to the extent that those Non-Emergency Services qualify as No Surprise Services):

Cost-Sharing Requirements. The Plan will impose a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the Non-Emergency Services or related items had been furnished by an In-Network provider.

Cost-Sharing Calculations (Use of "Recognized Amount"). The Plan will calculate the participant cost-sharing requirement (such as any applicable co-insurance) as if the total amount that would have been charged for the Non-Emergency Services and related items by such Out-of-Network provider were equal to the Recognized Amount for such items and services (not the higher billed amount).

Deductibles and Out-of-Pocket Maximums. The Plan will count any cost-sharing payments you make toward any deductible and out-of-pocket limits applied under the Plan in the same manner as if such cost-sharing payments were made with respect to Non-Emergency Services and related items furnished by an In-Network provider.

Notice and Consent Exception: However, the Plan will cover Non-Emergency Services or related items performed by an Out-of-Network provider at an In-Network facility based on your Out-of-Network coverage (i.e., at the Out-of-Network rate and rules) if:

- 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 the Act, informing you: (i) that the provider is an Out-of-Network provider with respect to the Plan, (ii) of the good faith estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, (iii) of the names of any In-Network providers at the facility who are able to treat you, and (iv) that you may elect to be referred to one of the In-Network providers listed; and

- 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.

This "notice and consent" exception does not apply to Ancillary Services or to items and 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.

In light of the Act's new rules, the most that an Out-of-Network provider may bill you for non-emergency No Surprise Services is the Plan's In-Network cost-sharing amounts, unless the notice and consent exception applies and is satisfied. Moreover, unless that exception applies and is satisfied, Out-of-Network providers cannot Balance Bill you for No Surprise Services, and they may not ask you to give up your right to be protected from being Balance Billed after the fact.

Out-of-Network Air Ambulance Services

As required by the Act, the Plan will cover Out-of-Network Air Ambulance services (to the extent covered by the Plan) with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if such services had been furnished by an In-Network provider. In general, you cannot be Balance Billed for Out-of-Network air ambulance services. The Act does not apply to ground ambulances, which are subject to the normal terms of the SPD.

Continuing Care Patients

If you are a Continuing Care Patient, and the Plan terminates its In-Network contract with an In-Network Provider or facility providing services to you, or your benefits are terminated because of a change in terms of the provider's and/or facility's participation in the Plan's network, you will be:

1. Notified in a timely manner of the contract termination (or change in participation terms) and of your right to elect continued transitional care from the provider or facility; and
2. Provided with ninety (90) days of continued coverage at the In-Network cost sharing to allow for a transition of care to a different In-Network Provider (provided you remain enrolled in the Plan's coverage).

External Review for No Surprise Services Claims

Currently, the Plan provides that after you exhaust your internal appeals, you can file a request for external review with the Plan under certain circumstances. Beginning January 1, 2022, external review will also be available for adverse benefit determinations based on compliance with the surprise billing protections under the Act or its implementing regulations. Please contact Aetna for a copy of the Plan's External Review procedures for claims covered by the Act.

Provider Directory

To help you find care from In-Network Providers and facilities, Aetna maintains a provider directory. Aetna updates these directories every ninety (90) days and will respond to your inquiry about the network status of a Provider or facility within one business day. If you receive inaccurate information from Aetna or the Fund office about a Provider or facility's network status, you will be liable only for In-Network cost-sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the Provider or facility that you have selected is In-Network at the time you receive services.

GLOSSARY

The following additional definitions apply for purposes of the changes described in this notice and should be included as part of your SPD:

Ancillary Services mean 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 an Out-of-Network/ nonparticipating provider if there is no In-Network/participating provider who can furnish such item or service at such facility.

Balance Billing means that a provider, service or facility, will bill you the difference between their charge and what the Plan will pay.

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 an individual (or, with respect to a pregnant woman, her unborn child) in serious jeopardy.

Emergency Services means the following with respect to an Emergency Medical Condition:

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 (some urgent care facilities, but not all, qualify), 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. Post-Stabilization services, which are 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) 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 to an available participating provider or facility located within a reasonable travel distance; and

    b. You are supplied with a written notice, as required by the Act, that the provider is an Out-of-Network Provider with respect to the Plan, of the good faith estimated charges for your treatment and any advance limitations that the Plan 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 Surprise Services means the following, to the extent covered under the Welfare Fund and subject to the Act's rules:

1. Out-of-Network Emergency Services;

2. Out-of-Network air ambulance services;

3. Non-emergency Ancillary Services for anesthesiology, pathology, radiology, neonatology, 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 the Act's notice and consent requirements.

Recognized Amount means one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or

3. If there is no applicable All-Payer Model Agreement or state law, 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, the Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

Qualifying Payment Amount or QPA generally means the median contracted rates of the plan 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 disability; 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.

If you have any questions about these changes, or about any aspect of the Welfare Fund, please contact the Fund Office by calling (212) 247-5225 or emailing fundoffice@fundoneiatse.com.

You should take the time to read this notice carefully and share it with your family. It is very important that you retain this notice; it is intended to serve as a Summary of Material Modifications ("SMM") to the Welfare Fund Plan rules. While every effort has been made to make this SMM as complete and as accurate as possible, it does not restate the existing terms and provisions of the Welfare Fund Plan other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPD (other than with respect to the specific terms and provisions this summary is modifying), or if any point is not discussed in this summary or is only partially discussed, the terms of the SPD will govern in all cases.

The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Welfare Fund. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Welfare Fund or any benefits provided under the Welfare Fund (or qualification for such benefits), in whole or in part, at any time and for any reason.