VERY IMPORTANT NOTICE TO ACTIVE PARTICIPANTS OF THE LOCAL 475 HEALTH BENEFIT FUND
Important Information Regarding Your Health Plan Benefits

This document is a Summary of Material Modifications ("SMM") intended to notify you of an important change in the plan of benefits of the Local 475 Health Benefit Fund (the "Plan"). You should take the time to read this SMM carefully and keep it with the copy of the summary plan description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office at (914) 738-6555.

Date: April 2022

To: All Active Participants in the Local 475 Health Benefit Fund and their covered dependents

From: The Board of Trustees

Introduction

The Board of Trustees of the Local 475 Health Benefit Fund (the "Fund") is pleased to announce that, effective January 1, 2022, the Fund is implementing a number of improvements to the Plan to comply with the No Surprises Act. The No Surprises Act was signed into law in December 2020 and protects patients from "balance billing" for Out-of-Network Emergency Services at hospitals and certain independent freestanding emergency departments, 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").

Effective January 1, 2022, the Plan is hereby amended to reflect the following changes. All other sections of the Plan remain unchanged.

Definitions

The following definitions are added to the SPD:

1. ***"Certified IDR Entity"*** means an entity responsible for conducting and making determinations pursuant to the independent dispute resolution ("IDR") process required by the No Surprises Act and that has been properly certified by the United States Department of Health and Human Services, Department of Labor, and Department of the Treasury.

2. ***"Continuing Care Patient"*** is an individual who, with respect to a provider or facility—
   (a) is undergoing a course of treatment for a Serious and Complex Condition (as defined below) from the provider or facility;

(b) is undergoing a course of institutional or inpatient care from the provider or facility;
(c) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;
(d) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
(e) is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

3. ***"Emergency Medical Condition"*** means a medical condition manifesting itself 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 (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

4. ***"Emergency Services"*** with respect to an Emergency Medical Condition, shall mean
   (a) a 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
   (b) 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).

5. ***"Independent Freestanding Emergency Department"*** means a health care facility that (i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) provides any of the Emergency Services described above.

6. ***"Nonparticipating Emergency Facility"*** or ***"Out-of-Network Emergency Facility"*** is an emergency department of a hospital, or an Independent Freestanding Emergency Department, that does not have a contractual relationship directly or indirectly with the Plan for furnishing such item or service under the Plan.

7. ***"Nonparticipating Provider"*** or ***"Out-of-Network Provider"*** means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the Plan for furnishing such item or service under the Plan.

8. ***"Participating Emergency Facility"*** **or** ***"In-Network Emergency Facility"*** means an emergency department of a hospital, or an Independent Freestanding Emergency Department, that has a contractual relationship directly or indirectly with the Plan with respect to the furnishing of such an item or service at such facility.

9. ***"Participating Provider"*** or ***"In-Network Provider"*** means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the Plan for furnishing such item or service under the Plan.

10. ***"Qualifying Payment Amount"*** means the median of the contracted rates recognized by the Plan or recognized by all plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state All-Payer Claims Database or, if unavailable, any eligible third-party database in accordance with applicable law.

11. ***"Recognized Amount"*** shall mean
    (a) an amount determined under an applicable All-Payer Model Agreement, or if unavailable;
    (b) an amount determined by applicable State law (if applicable); and
    (c) if no such amounts are available or applicable the lesser of a Provider's billed charge or the Qualifying Payment Amount.

12. ***"Serious and Complex Condition"*** means
    (a) 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
    (b) in the case of a chronic illness or condition, a condition that— (i) is life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.

13. ***"Stabilize"*** means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery; or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Emergency Services

The No Surprises Act requires Emergency Services be covered:

1. without the need for any prior authorization determination;
2. whether the health care provider furnishing such services is a Participating Provider or a Participating Emergency Facility;
3. without imposing any requirement under the Plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from Participating Providers and Participating Emergency Facilities;
4. without imposing any cost-sharing requirement greater than the requirement that would apply if such services were provided by a Participating Provider or a Participating Emergency Facility;
5. such that the cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such Participating Provider or Participating Emergency Facility were equal to the Recognized Amount; and
6. such that any cost-sharing payments made by the Participant shall be counted toward any in-network deductible or out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to Emergency Services furnished by a Participating Provider or a Participating Emergency Facility.

Please note, the Plan does not have an in-network deductible.

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 in a Participating Facility be covered:

1. without any cost-sharing requirement for such items and services that is greater than the cost-sharing requirement that would apply under the Plan had such items or services been furnished by a Participating Provider;
2. such that the cost-sharing requirement shall be calculated as if the total amount that would have been charged for such items and services by such Participating Provider were equal to the Recognized Amount; and
3. such that any cost-sharing payments shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the Plan in the same manner as if such cost-sharing payments were with respect to items and services furnished by a Participating Provider.

Please note, the Plan does not have an in-network deductible.

Non-Emergency Services Rendered by a Nonparticipating Provider in a Participating Facility will not be subject to the above (and shall be processed with the Out-of-Network cost-sharing) if:

1. not later than 72 hours prior to the date on which the Participant is furnished such items or services (or, in the case that the Participant makes such an appointment within 72 hours of when such items or services are to be furnished, on such date the appointment is made), the Out-of-Network Provider provides the Participant with a written notice that the provider is out-of-network, a good faith estimated amount that the Participant will be charged, and a list of any Participating Providers at the facility who are able to furnish such items and services;
2. the Out-of-Network Provider obtains from the Participant (or from such an authorized representative) the consent to be treated by an Out-of-Network Provider or Non-Participating Healthcare Facility; and
3. the Out-of-Network Provider provides a signed copy of such consent to the Participant.

Please note, the Plan does not have an in-network deductible.

Continuity of Care

In the event a Participant is a Continuing Care Patient, as defined above, with respect to such provider or facility and the contractual relationship with the provider or facility expires, is not renewed, or terminated for any reason other than the provider's or facility's inability to meet applicable quality standards or for fraud, the Fund shall:

(1) notify each enrolled individual who is a Continuing Care Patient with respect to a provider or facility at the time of a termination affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility;
(2) provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and
(3) permit the patient to elect to continue to have benefits provided under the Plan under the same terms and conditions as would have applied and with respect to such items and services as would have been covered had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a Continuing Care Patient during the period beginning on the date on which the notice of termination is provided and ending on the earlier of (a) the 90-day period beginning on such date; or (b) the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

Incorrect In-Network Provider Information

A list of In-Network providers is available to you without charge by visiting anthem.com or by calling the phone number on your Empire Blue Cross Blue Shield ID card. The network provider directory contains the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which the Plan has a contractual relationship for furnishing items and services.

Empire updates its directories at least every ninety (90) days and will respond to an inquiry about the network status of a provider or facility within one (1) business day.

If you obtain and rely upon incorrect information about whether a provider is an In-Network provider from the Plan, the Plan 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. 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.

External Review Process of Certain Coverage Determinations

If your claim for benefits related to items and services covered under the No Surprises Act has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome after exhausting the Plan's internal claims and appeals process, you may be eligible for External Review of the determination if your appeal relates to whether the Fund is complying with the No Surprises Act.

Complaint Process

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

As always, we encourage you to use a Network Provider to receive the highest level of benefits.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Fund Office.

As always, if you have any questions regarding these Plan changes, please contact the Fund Office at (914) 738-6555

Sincerely,

Local 475 Health Benefit Fund
THE BOARD OF TRUSTEES

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. 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. Except to the extent that this SMM modifies 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 (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 Plan, in whole or in part, at any time and for any reason (with respect to any employee, former employee, spouse, dependent or other individual), in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan documents are at the Fund Office and may be inspected by you free of charge during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. 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 Plan and decide all matters, legal and/or factual, arising under the Plan.