SHEET METAL WORKERS' UNION LOCAL 33
CLEVELAND DISTRICT HEALTH BENEFITS PLAN

THIRD SUMMARY DESCRIPTION OF MATERIAL MODIFICATION OF THE SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT AS AMENDED AND RESTATED AUGUST 2020

I. INTRODUCTION

The Board of Trustees of the Sheet Metal Workers' Local 33 Cleveland District Health Benefits Plan (hereinafter "Plan") has amended the Plan to comply with the requirements of the No Surprises Act portion of the Consolidated Appropriations Act of 2020. This document is designed to describe modifications to the Plan. Information contained in this Summary Description of Material Modification (hereinafter "Summary Description") supersedes what is contained in the SPD.

II. NO SURPRISES ACT CHANGES

On December 27, 2020, the No Surprises Act (hereinafter "Act") was signed into law as part of the broader Consolidated Appropriations Act of 2021. The purpose of the No Surprises Act is to reduce the prevalence of surprise "balance billing," in which Participants are required to pay the difference between what the Plan pays and what an out-of-network provider charges in emergency situations and when receiving care from out-of-network providers at network facilities. ***This means that effective May 1, 2022, in most instances you will be charged the network cost-sharing rates when receiving emergency treatment or when receiving treatment from an out-of-network provider at a network hospital or other facility.*** In some cases, Participants may still be "balanced billed" if they provide consent in compliance with the Act, or if they use services or Providers not covered under the Act.

The Board of Trustees has amended the Plan to meet these requirements, which become effective May 1, 2022, and the following changes have been made to your SPD:

1. The chart in Article III, Section A, subsection 1, is amended by deleting the column titled Emergency Room Visits and replacing it with the following:

Medical Benefits	Deluxe Plus Plan		Classic Plus Plan		Basic Plus Plan	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Emergency Services at Emergency Room	You pay $50 Co-Pay		You pay $175 Co-Pay		You pay $200 Co-Pay	
Ambulance Services****	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible

2. The paragraph marked (**) at the end of the chart in Article III, Section A, Subsection 1 is deleted in its entirety.

3. The following paragraph marked (****) is added to the end of the chart in Article II, Section A, Subsection 1:

**** Effective May 1, 2022, Out-of-Network Providers of air ambulance services for Emergency Services are covered at the same rate as Network Providers (i.e., Coinsurance rate, Copayment schedule) and costs must count towards the Network deductible and maximum out-of-pocket limits.

4. Article VI, Section B is deleted in its entirety and replaced with the following:

B. ***STEPS TO TAKE WHEN YOU NEED TO SEE A DOCTOR***

When You or Your Dependent needs to see a doctor, You should:

1. Contact Your doctor ahead of Your visit to determine if he or she is a Network Provider, or contact the Plan's PPO Provider, using the contact information found in Article II – Plan Information.

2. Call to make an appointment.

3. Write down any questions You may have before Your appointment so You do not forget to ask Your doctor important questions during the appointment.

4. Make a list of any medications You're taking. Be sure to note how often You take the medications.

5. Show Your ID card when You go to Your appointment.

6. You typically will not need to file a claim if You visit a Network Provider. However, if a claim is not filed by Your Provider, it will be Your responsibility to do so (see Article XIII). You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.

7. You may be billed by Your Network Provider(s) for any Non-Covered Services You receive or when You have not followed the terms of the Plan. However, Your consent is required in some cases before a Provider can bill You for amounts the Plan does not Cover. If the consent meets federal requirements, you will be billed the difference between the Maximum Allowed Amount and what the Provider charges.

5. Article VI, Section D, Subsection 1, Subsection b is deleted in its entirety and amended to read as follows.

b. Out-of-Network Providers – You are not restricted to using the service of Network Providers to receive benefits for Covered Services. When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are Covered at the out-of-network level, unless otherwise indicated in this Summary Plan Description. For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments (in some cases, Your consent is required before being treated if an Out-of-Network Provider is to charge You the difference between their bill and the Plan's Maximum Allowed Amount);
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);

- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done.

In addition, an Out-of-Network Provider may be treated as a Network provider under the Plan if the Board of Trustees determines, in their sole and absolute discretion, that the Out-of-Network Provider provides medical treatment that no Network Provider Facility in the surrounding area provides. Participants may appeal to the Trustees to treat such Non-Network Providers as Network Providers, and a determination will be made on a case by case basis to treat the Provider as a Network Provider if the Board determines that the treatment provided to the Participant could not have been obtained by a Network Provider in the surrounding area.

If you receive services at an in-network facility, providers, including but not limited to, pathologist, radiologist, emergency room physician, and anesthesiologist, you will be reimbursed at the in-network level of benefits regardless of the provider being an Network or Out-of-Network provider.

6. Article VI, Section D, Subsection 4, Subsection a is amended to add the following:

Effective May 1, 2022, Out-of-Network Providers of air ambulance services for Emergencies are covered at the same rate as Network Providers (i.e., Coinsurance rate, Copayment schedule) and costs must count towards the Network deductible and maximum out-of-pocket limits.

7. Article VI, Section D, Subsection 4, Subsection j is deleted in its entirety and replaced with the following:

j. **Emergency Services** - Coverage is provided for Medically Necessary Emergency Services needed to treat an Emergency Medical Condition. Continuation of care beyond that needed to evaluate or stabilize Your Emergency Medical Condition will continue to be Covered under the Plan's emergency benefit coverage or according to Your Schedule of Benefits, as applicable.

8. Article XVI, Section UU is deleted in its entirety and replaced with the following:

UU. EMERGENCY MEDICAL CONDITION

"Emergency Medical Condition" or "Medical Emergency" means a medical Condition, including a mental health Condition or substance abuse disorder, manifesting itself by acute symptoms of sufficient severity, including severe pain, so 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 an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;

b. result in serious impairment to the individual's bodily functions; or

c. result in serious dysfunction of a bodily organ or part of the individual.

9. Lastly, the following Section HHHH is added to the end of Article XVI of the SPD:

HHHH. EMERGENCY SERVICES

"Emergency Services" or "Emergency Care" means:

1. A medical screening examination as required by Federal Law that is within the capability of the emergency department of the 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. Such further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient; and

3. The terms "Emergency Services" or "Emergency Care" as used herein, shall also mean items and services – (1) for which benefits are provided or Covered under the Plan; and (2) that are 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 Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the services described in paragraphs 1. or 2. of this section are furnished.

III. CONCLUSION

This document should be read in conjunction with the Summary Plan Description/Plan Document (hereinafter "SPD") which was provided to you previously and dated August 2020. These modifications reflect changes to the medical benefits available to you. However, this Summary Description changes only the provisions to which it specifically refers, and any other provisions in the SPD remain the same. These modifications are effective May 1, 2022. If you have any questions regarding these changes, please contact the Fund Office.

The Board of Trustees of the
Sheet Metal Workers' Local 33 Cleveland District Health Benefits Plan