MASON TENDERS' DISTRICT COUNCIL WELFARE FUND

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IMPORTANT NOTICE
REGARDING PROTECTIONS OF THE FEDERAL NO SURPRISES ACT

To: Fund Participants and Covered Family Members

From: Board of Trustees
Mason Tenders' District Council Welfare Fund

Date: May 2023

This is a Summary of Material Modifications ("SMM" or "Notice") intended to notify you of important changes to the medical benefits provided by the Mason Tenders' District Council Welfare Fund (the "Fund" or "Plan"), in accordance with the federal No Surprises Act, which became effective January 1, 2022. You should take the time to read this SMM carefully and keep it with the 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.

Capitalized terms used in this notice, such as "No Surprise Services" and "Emergency Services," are defined in the Definitions section at the end of this notice, or in the Summary Plan Description.

Overview of Changes Effective January 1, 2022 (See "Background and Details" Section starting on page 3 for detailed Plan changes):

Emergency Services

- Emergency Services are covered without Prior Authorization whether In-Network or Out-of-Network (this is not a Plan change);
- Coverage of Out-of-Network Emergency Services are not more restrictive or subject to more limitations than In-Network Emergency Services;
- Cost-sharing requirements for Out-of-Network Emergency Services are the same as In-Network Emergency Services (this is not a Plan change);
- Cost-sharing calculations for Out-of-Network Emergency Services are made using the "Recognized Amount" for such services; and
- Your cost-sharing payments for Out-of-Network Emergency Services count towards your deductible and out-of-pocket maximum in the same way as payments for In-Network Emergency Services (this is not a Plan change).

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

- Cost-sharing requirements are the same as if performed by an In-Network Provider;
- Cost-sharing calculations are made using the "Recognized Amount" for such services; and
- Your cost-sharing payments count towards your deductible and out-of-pocket maximum in the same way as payments for services performed by an In-Network Provider.

There are exceptions to these rules. Please see "Notice and Consent Exception" on page 5 for more details.

Out-of-Network Air Ambulance Services

- Cost-sharing requirement is the same as if provided by an In-Network Air Ambulance provider;
- Cost-sharing calculations are made using the lesser of the "Qualifying Payment Amount" or the amount billed by the Out-of-Network Air Ambulance provider; and
- Your cost-sharing payments count towards your deductible and out-of-pocket maximum in the same way as payments for services performed by an In-Network Provider.

Continuity of Coverage

If you are a Continuing Care Patient and the Plan terminates its contract with the In-Network Provider or facility providing services to you, or if the In-Network Provider or facility leaves the Plan's network, you will be:

- Notified of the contract termination (or end of participation) and of your right to continued transitional care from the Provider or facility; and
- Given ninety (90) days of continued coverage at the In-Network cost-sharing.

Provider Directory

A list of In-Network Providers, updated at least every 90 days, is available to you without charge by visiting the Aetna website www.aetna.com/docfind or by calling the phone number on your ID card.

If you receive services from an Out-of-Network Provider who you believe is In-Network because of inaccurate information in a Provider directory, such services will be covered as if the Provider was In-Network to the extent required by law.

Complaint Process

You may contact the federal government with complaints or about being billed improperly. See "Complaint Process" on page 7 for contact information).

External Review Process for No Surprise Services Claims

If you are still dissatisfied after you exhaust the Plan's internal claims and appeals process for claims related to Emergency Services, you may be eligible for an independent External Review of your claim. See "External Review Process for No Surprise Services Claims" on page 7 for instructions.

Background and Details

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 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 under its fee schedule, and the full amount charged for a service. This amount is likely more than In-Network costs for the same service and does not count toward the Plan's annual out-of-pocket limit. "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) are 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 fee schedule determined in accordance with the Act. Note, however, that receiving care from In-Network facilities and participating providers when possible is still likely to cost you less. To locate an Aetna medical provider, visit www.aetna.com/docfind.

Benefit Changes

Emergency Services

As required by the Act, the Plan covers Emergency Services (emergency care that qualifies as No Surprise Services) as follows:

1. No Prior Authorization Requirement The services will be covered by the Plan without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis (the Plan already operated in this manner prior to the Act's effective date);

2. 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;

3. 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;

4. 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 the services were provided by an In-Network Provider or In-Network emergency facility (the Plan already counted your cost-sharing payments in this manner prior to the Act's effective date);

5. Cost-Sharing Calculations (Use of "Recognized Amount") The Plan will calculate the participant 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. 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 deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider (the Plan already counted your cost-sharing payments in this manner prior to the Act's effective date).

In light of the Act's 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. This includes services you may get after you are in stable condition unless you give written consent and give up your right not to be balanced billed for the post-stabilization services.

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

As required by the Act, the Plan covers Non-Emergency Services performed by an Out-of-Network Provider at an In-Network Health Care Facility as follows:

1. 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;

2. Cost-Sharing Calculations (Use of "Recognized Amount") The Plan will calculate the cost-sharing requirements 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 the items and services; and

3. Deductibles and Out-of-Pocket Maximums The Plan will count any cost-sharing payments you make toward any deductible and out-of-pocket maximums 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 the Out-of-Network coverage (rate and 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 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

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.

This "notice and consent" exception does not apply to Ancillary Services or to items and services furnished because 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 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 you are provided with the above notice and you consent to the continued treatment, as described above. As noted above, the notice-and consent exception does not apply to Ancillary Services (e.g., emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services). Such Out-of-Network providers who fail to comply with the Act's notice and consent requirements (or where the notice-and-consent exception does not apply to those services) cannot balance bill you, 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

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

1. 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 service had been furnished by an In-Network Provider.

2. 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.

3. Any cost-sharing payments you make with respect to covered Air Ambulance services will count towards 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 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.

Provider Directory

A list of In-Network Providers is available to you without charge by visiting the Aetna website www.aetna.com/docfind or by calling the phone number on your ID card. The provider directory will be updated at least every ninety (90) days. The Network consists of Providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you inadvertently receive services from an Out-of-Network Provider based on inaccurate information in a Provider directory that the Provider is an In-Network Provider, services provided by that Out-of-Network Provider will be covered as if the Provider was an In-Network Provider to the extent required by the Act.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Transparency Rule, you may contact the federal government's NSA Helpdesk at 1-800-985-3059, the Fund Office or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

External Review Process for No Surprise Services Claims

If your initial claim for benefits related to a No Surprise Service (e.g., an Emergency 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. Please contact the Fund Office for a copy of the Fund's External Review procedures for claims covered by the Act or consult the Summary Plan Description.

NSA Definitions

The following definitions apply for purposes of the changes described in this notice and the Summary Plan Description:

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 an Out-of-Network/nonparticipating Provider if there is no In-Network/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) undergoing a course of institutional or inpatient care from the Provider or facility.

Emergency Medical Condition means a medical condition, including a 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 an unborn child in serious jeopardy.

Emergency Services means the following, to the extent that those services qualify as No Surprise Services:

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. 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 attending emergency physician or treating Provider determines that the patient is 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. The patient is supplied with 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 the treatment and any advance limitations that the Plan may put on the treatment, of 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 gives informed 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 cost 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.

No Surprises Service means the following, to the extent covered under the Plan 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 and diagnostics, when performed by an Out-of-Network Provider at an In-Network health care 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 (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. 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 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 there are any questions, please contact the Fund Office at (212) 452-9700.

This Notice is intended to provide you with an easy-to-understand description of certain important changes to the Fund's benefits and rules. While every effort has been made to make this description as complete and accurate as possible, this Notice, of course, cannot contain a full restatement of the terms and provisions of the plan. For a full description of your rights under the Fund, please refer to the plan documents (including the Summary Plan Description). If any conflict should arise between this Notice and the plan documents, or if any point is not discussed in this Notice or is only partially discussed, the terms of the plan documents (including the Summary Plan Description) will govern in all cases.

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Fund, or any benefits provided under the Fund, in whole or in part, at any time and for any reason, in accordance with the amendment procedures established under the plan and the trust agreement establishing the plan. The formal plan documents and trust agreement are available at the Fund Office and may be inspected by you 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 arising under the plan.

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