I.U.P.A.T. DISTRICT COUNCIL NO. 51
HEALTH AND WELFARE FUND

Fund Office: Zenith American Solutions, Administrator, 3 Gateway Center, 401 Liberty Ave., Ste. 1200, Pittsburgh, PA 15222-1024
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September 27, 2022

Dear Participant:

This Summary of Material Modifications [SMM] serves as your notice of material changes to the 2019 Summary Plan Description [SPD] of the IUPAT District Council No. 51 Health and Welfare Fund. These changes are effective as outlined below:

1. **No Surprise Billing**

Under existing plan provisions, benefits for services rendered on an emergency basis at a non-network hospital, or by a treating provider who is not a PPO provider, are paid at the higher PPO 80% co-insurance rate based on PPO allowances. This means that the Fund will pay the same percentage co-insurance that it would have paid if the provider or facility were a member of the PPO network. However, because no PPO discount would be given for using an out-of-network provider or facility, your out-of-pocket expenses would be higher than for an in-network provider, even with the increased percentage of co-insurance paid by the Fund.

An amendment to this SPD provision shall be effective October 1, 2022, by adding the following language to the end of the section titled, "NON-PREFERRED PROVIDERS":

> **Effective October 1, 2022, you and your dependents are protected from having to pay greater out-of-pocket costs for emergency services rendered by non-PPO providers and facilities than PPO providers and facilities. Your cost sharing for out-of-network emergency services will be limited to in-network levels, and your cost sharing for these services will count toward in-network deductibles and out-of-pocket maximums. Emergency care providers and facilities will be prohibited from issuing "balance billing" invoices or "surprise bills" to you for any costs billed beyond in-network levels paid by the Plan. These protections will apply to most emergency services, air ambulance services (but not ground ambulance services) from out-of-network providers, and supplemental non-emergency care from out-of-network providers (like anesthesia, pathology, neonatology, radiology and laboratory services) at certain in-network facilities, including in-network hospitals and ambulatory surgical centers.**

2. **Continuity of Care**

Under existing plan provisions, when a network provider terminates its contractual relationship with the Plan or its network, your continued care by such a provider would thereafter be paid under the plan terms for "non-preferred providers." An amendment to the SPD shall be effective October 1, 2022, by adding the following language to the end of the newly added section noted immediately above at Section 1 of this SMM:

> **Effective October 1, 2022, where a network provider terminates its contractual relationship with the Plan or its network, you will be notified that your provider has moved out of network and of your right to elect continuing care for a limited period under the same coverage and terms that apply to in-network services. If you request and sign a Continuity of Care election form, you can elect to get up to 90 days of continued care by the provider at in-network rates while undergoing:**

a course of treatment for a serious and complex medical condition; a course of institutional or in-patient care; a course of treatment for pregnancy; a course of treatment for a terminal illness; or where you are scheduled to undergo non-elective surgery from such a provider (including postoperative care). Under those circumstances, the Plan will continue to pay your continuity of care claims for up to 90 days on plan terms that apply to in-network care (for 90 days from the date the notice of the right to elect continuing care is provided, or until continuing care is no longer needed/elected, whichever is shorter).

Please also note that, on or after October 1, 2022, EOBs will include a separate notice that will provide further information regarding an individual's rights under the No Surprises Act.

3. Maternity-Related Disability Income and Maternity Leave Program

The Trustees are pleased to announce a new Maternity-Related Disability Income and Maternity Leave Program available to female Participants only (not spouses or dependents) effective October 1, 2022. The Program consists of two distinct benefits: a disability income benefit for all maternity-related, pre-birth disabilities and a post-birth Maternity Leave Benefit. The Program does not apply to surrogate-related pregnancies, adoption of a child, or foster care situations.

With regard to both the Maternity-Related Disability Income Benefit and the Maternity Leave Benefit, eligible Participants shall be credited with hours towards eligibility for each hour for which the Participant receives payment of a Benefit under the Program.

A. Maternity-Related Disability Income Benefit

The SPD currently provides a Disability/Loss of Time Benefit that pays Participants only a Weekly Disability Income benefit for non-occupational loss of time for up to 26 weeks per calendar year. The current benefit provides a Weekly Benefit of $400 for the first 13 weeks and $300 for the next 13 weeks.

The new Maternity-Related Disability Income Benefit provides a maximum of 26 weeks of Disability Income beginning the 4th month of pregnancy. The pre-birth benefit may be used intermittently but may not exceed a total of six (6) months of benefits, regardless of whether the Participant is then able to return to work.

The Maternity-Related Disability Income Benefit is equal to 66.67% of the Participant's normal weekly earnings up to a maximum weekly benefit of $800. Weekly earnings are determined to be the hourly wage based on a 40-hour work week. Benefits are calculated at the rate of 1/7 of the weekly benefit for each day of Total Disability when totally disabled for less than a full week.

To be eligible for the new benefit, Participants must submit certification of their pregnancy from a medical doctor verifying that they are unable to perform the duties of the trade due to physical limitations arising from their pregnancy, which shall include miscarriage. The Fund may require re-certifications of continued inability to work from time to time from the Participant's medical doctor during pregnancy. Participants must be further eligible for coverage under the DC 51 Health and Welfare Fund on the date of their disability, and they must not have used this benefit within the past 24 months.

Where the existing Disability/Loss of Time Benefit provides a greater weekly benefit than the Maternity-Related Disability Income Benefit, disabled female Participants may access the existing benefit. Participants may not access both the Maternity-Related Disability Income Benefit and the existing Disability/Loss of Time Benefit for the same period of disability (i.e., no pyramiding of benefits).

This benefit is available for pre-birth disabilities beginning on and after October 1, 2022.

B. Maternity Leave Benefit

Female Participants are also entitled to up to six (6) weeks of paid Maternity Leave after the birth of their child, with an additional two (2) weeks available for Cesarean deliveries (a total of eight (8) weeks).

The amount of the Maternity Leave Benefit is calculated in the same manner as the Maternity-Related Disability Income Benefit: 66.67% of the Participant's normal weekly earnings up to a maximum weekly benefit of $800.00. However, the Maternity Leave Benefit is available regardless of whether the Participant had a pre-birth disability or received a pre-birth Maternity-Related Disability Income benefit.

The Maternity Leave Benefit is available for all births on and after October 1, 2022. The Maternity Leave Benefit is not available to a Participant who has obtained this benefit within the past 24 months. Participants must be otherwise eligible for coverage under the Fund as of the newborn's date of birth.

Please contact the Fund Office at 1-800-242-8923 if you have any questions or to request a Maternity Leave Benefit application.

4. COVID-19 Antiviral Medication

Under existing plan provisions, COVID-19 antiviral therapeutics are covered under the Retail (pharmacy) prescription drug co-pays: Generic - $0; Preferred/Formulary - $45; and Non-Preferred/Non-Formulary Brand - $75.00.

To provide optimal support in navigating the ongoing COVID-19 pandemic and effective July 1, 2022, the Plan will cover COVID-19 antiviral medications, which currently include Paxlovid and Monlupiravir, at no cost to you - $0 co-pay.

5. Amendment of section, "DEPENDENT ELIGIBILITY"

The current SPD provides that your children are eligible for full dependent coverage from birth until their 26th birthday.

Effective October 1, 2022, this section shall be amended to add the following additional text:

You have a right to opt out of dependent coverage for any child who is Medicaid eligible, to the extent permitted by law, by providing written notice to the Fund Office.

6. Amendment of section, "REIMBURSEMENT AND SUBROGATION"

The current SPD provides that the Plan has a right of reimbursement and subrogation should you receive plan benefits arising from an injury, illness or other condition that results in a monetary recovery against a third party; in the event of such third-party recovery, the Plan must be fully and promptly reimbursed for the amount of benefits advanced by the Plan.

The current SPD further provides that you and your eligible dependents (if appliable) must cooperate with the Plan in order to protect the Plan's reimbursement and subrogation rights. Cooperation includes, among other things, the requirement that you, your eligible dependents (if appliable) and your legal counsel fully and timely execute any subrogation and reimbursement agreement, along with other relevant paperwork and information, as requested by the Plan.

The subsection titled, "THE PLAN'S REIMBURSEMENT RIGHTS" is hereby amended by adding a new eighth (8th) paragraph that reads as follows:

> **The subrogation and reimbursement agreement must be fully executed by you, your eligible dependent (if applicable) and your legal counsel and received in writing by the Fund office within one year after the accident or event giving rise to the Plan's reimbursement and subrogation claim. You must also submit within this one-year deadline all other requested paperwork and information, such as information regarding your personal injury insurance. If the fully executed agreement, along will all other requested paperwork and information, are not received by the Fund office within one year, your claim will be denied.**

This subsection titled, "THE PLAN'S SUBROGATION RIGHTS", is hereby amended by adding a new sixth (6th) paragraph that reads as follows:

> **The subrogation and reimbursement agreement must be fully executed by you, your eligible dependent (if applicable) and your legal counsel and received in writing by the Fund office within one year after the accident or event giving rise to the Plan's reimbursement and subrogation claim. You must also submit within this one-year deadline all other requested paperwork and information, such as information regarding your personal injury insurance. If the fully executed agreement, along will all other requested paperwork and information, are not received by the Fund office within one year, your claim will be denied.**

All other rules of the Plan remain unchanged and are more fully described in the SPD dated January 2019.

Please keep this Notice with your copy of the 2019 SPD, which is available on Zenith's Participant Edge website **(https://edge.zenith-american.com)** and at **https://iupatdc51.com**, for future reference.