IMPORTANT NOTICE TO PARTICIPANTS IN THE MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes being made to the plan of benefits (the "Plan") of the Milwaukee Drivers Health and Welfare Trust Fund. You should take the time and 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 414-258-2336 or toll free at 800-255-3340.

The Trustees wish to advise you as to the Plan's coverage for the No Surprises Act (NSA) services requirements, effective July 1, 2022.

The NSA was signed into law in December 2020, as part of the Consolidated Appropriations Act (CAA), 2021. Generally, effective January 1, 2022, the NSA protects patients from balance billing for Emergency Services, certain non-Emergency Services performed by a non-network Provider at a network (PPO) facility, and Air Ambulance Services. This means that patients receiving these services will only be responsible for paying their network cost sharing.

You are still encouraged to use network facilities and network Providers whenever possible. Please review these changes carefully and contact the Fund Office with any questions.

Coverage of Emergency Services, Certain Non-Emergency Services by a Non-Network Provider at a Network Facility, and Air Ambulance Services

1. Emergency Services

   The Plan covers "Emergency Services," as defined below, provided at a non-network facility or by a non-network Provider in the same way as network Emergency Services. This means that you pay the same cost-sharing whether you receive Emergency Services from a non-network facility or Provider or a network facility or Provider. In general, you cannot be balance billed (charged the difference between the non-network Provider's fee and the amount the Plan pays) for these services. Your cost-sharing is based on the "Recognized Amount" payable for the services, which generally means the lesser of billed charges from the Provider or the Plan's median network rate (which is also known as the Qualifying Payment Amount, or QPA).

   Cost-sharing payments for non-network Emergency Services count toward your network deductible and network out-of-pocket maximum in the same way as services received from a network Provider.

   You do not need prior authorization for any Emergency Services, and there are no administrative requirements for non-network Emergency Services that are more restrictive than for network Emergency Services.

2. Non-Emergency Services

   If you receive non-Emergency Services that are otherwise covered by the Plan from a non-network Provider working at a network facility, your cost-sharing is no greater than the cost-sharing that would apply for the services of a network Provider. In general, you cannot be balance billed for these non-Emergency Services, and your cost-sharing is based on the "Recognized Amount" (defined above) payable for these services.

   Cost-sharing payments for these services count toward your network deductible and network out-of-pocket maximum in the same way as services received from a network Provider.

3. Notice and Consent Exception

   In limited circumstances where you provide written informed consent, a non-network Provider working at a network facility may charge you the difference between their fee and the amount the Plan pays for the service (i.e., balance bill you). Specifically, certain non-network Providers may notify you of their status as a non-network Provider, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the network Providers listed.

   If you provide written informed consent to be treated by the non-network Provider after receiving this information, the Plan will pay for the services at the non-network rate, and the non-network Provider can bill you for the balance directly.

   However, this notice and consent exception does not apply to Hospital-based Providers, such as anesthesiologists and radiologists – meaning that you can never be balance billed by a non-network Hospital-based Provider working at a network facility.

4. Air Ambulance Services

   In general, you cannot be balance billed for Air Ambulance Services. The Plan covers Air Ambulance Services that are otherwise covered by the Plan from a non-network Provider with cost-sharing that is no greater than the cost-sharing that would apply if the services had been furnished by a network Provider. The Plan calculates your cost-sharing amount as if the total amount that would have been charged for the services by a network Air Ambulance Services were equal to the lesser of the QPA (defined above) or the billed amount for the services.

   Any cost-sharing payments that you make for covered Air Ambulance Services will count toward your network deductible and network out-of-pocket maximum in the same way as services from a network Provider.

5. For purposes of the NSA, "Emergency Services" means an appropriate medical screening examination within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate the condition. This includes further medical examination and treatment needed to stabilize the patient (regardless of the department of the Hospital where the further examination or treatment is provided), as well as services after a patient is stabilized and as part of outpatient observation or an inpatient or

outpatient stay related to the Emergency Medical Condition, until the Provider or facility determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation.

An "Emergency Medical Condition" means a medical condition, including a mental health condition or substance use disorder, with acute symptoms of sufficient severity (including severe pain) that someone with average knowledge of health and medicine could reasonably expect not receiving immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Continuing Coverage with a Provider Who Leaves the Plan's Network

If you are a "Continuing Care Patient" (defined below) and the Plan terminates its contract with your network Provider or facility, or your benefits are terminated because of a change in terms of the Provider's and/or facility's participation in the Plan, the Plan will notify you in a timely manner that the Provider or facility is no longer network, inform you of your right to elect continued transitional care from the Provider or facility, and allow you ninety (90) days of continued coverage with network cost sharing to allow for a transition of care to a network Provider.

You are considered a Continuing Care Patient for these purposes if you are undergoing a course of treatment for a Serious and Complex Condition or a course of institutional or inpatient care; scheduled to undergo non-elective surgery; pregnant and undergoing a course of treatment for the pregnancy; or determined to be terminally ill and receiving treatment for such illness.

Provider Directory

The Plan's network Provider directory will be updated at least every ninety (90) days. If the Plan informs you (by telephone, electronic, or internet-based inquiry, or you receive information from a print or electronic Provider directory) that a Provider is in-network, but, in fact, the Provider is non-network, and you receive services from the non-network Provider, the Plan charges you cost-sharing that is no greater than network cost-sharing for the service, and applies any out-of-pocket limit as if you received the service from a network Provider.

External Review of Certain Coverage Determinations

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by a non-network provider at a network facility, and/or Air Ambulances 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.

This announcement, which serves as a Summary of Material Modification, contains only highlights of recent changes to the Milwaukee Drivers Health and Welfare Trust Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

A Final Note

If you are married, please share information about COVID-19 vaccine coverage with your spouse.

If you have any questions about COVID-19 vaccine coverage or any of your Plan benefits, contact the Fund Office at 414-258-2336 or toll free at 800-255-3340.

Notice of Grandfathered Health Plan

The Milwaukee Drivers Health and Welfare Trust Fund believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 414-258-2336 or toll free at 800-255-3340. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.