HOLLOW METAL TRUST FUND
HOLLOW METAL PENSION FUND

UNION TRUSTEES
Paul Capurso
Michael Cavanaugh
Andrew Mucaria
Robert Villalta

Denise Ortiz
Executive Director
395 Hudson Street
New York, NY 10014
Telephone: (212) 366-7880/7881 Fax: (212) 366-7556
Email: HollowMetal@nyccbf.org Website: www.hollowmetalfunds.org

MANAGEMENT TRUSTEES
Vincent Gallo
Edmund Greco
Michael Gallo

SUMMARY OR MATERIAL MODIFICATIONS
HOLLOW METAL TRUST FUND

June 29, 2022

TO: All Active Participants in the Hollow Metal Trust Fund (Plans A & B)

FROM: Board of Trustees

RE: Medical Benefit Changes Under the No Surprises Act Effective January 1, 2022

This Summary of Material Modifications ("SMM") describes changes that were made to certain medical benefits under Plans A & B of the Hollow Metal Trust Fund (the "Plan") effective January 1, 2022 to comply with the No Surprises Act (the "NSA"). As described in more detail below, the NSA is a new Federal law designed to protect you from surprise billing or balance billing when you receive non-network emergency care and certain types of non-emergency care from an out-of-network provider. Please read this SMM carefully and keep it with the Summary Plan Description ("SPD") that was previously provided to you.

APPLICABLE BENEFITS

The changes described in this SMM only apply to certain medical benefits that are subject to the NSA for active employees and their eligible dependents in the Plan, as described below. No provision in this SMM will be interpreted to require the Plan to provide additional, different, or more favorable coverage or benefits beyond the applicable requirements set forth under the NSA or accompanying regulations.

The protections described in this SMM apply to claims incurred for No Surprises Services on and after January 1, 2022.

BACKGROUND

The NSA was signed into law in December 2020, and is intended to protect patients (such as eligible participants and their eligible dependents under the Plan) 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" as defined under the NSA rules) (collectively "No Surprise Services").

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in the Plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with the Plan. Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay under its fee schedule, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit under the Plan. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like 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, active participants and their dependents receiving No Surprise Services will only be responsible for paying their in-network cost sharing. The Plan will not permit the provider to balance bill you 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. Accordingly, the Plan has been amended to implement the no-surprise billing protocols and requirements under the NSA in order to prevent surprise billing or balanced billing for its participants (and eligible dependents) when using an out-of-network provider or facility for certain services.

You are still strongly encouraged to use in-network facilities and participating providers and pay the applicable cost-sharing requirements under the Plan whenever possible.

Please review these changes carefully and contact the Fund Office with any questions that you may have.

NSA Defined Terms

See the Glossary section at the end of this SMM for the complete definitions of "No Surprise Services," "Emergency Services," and other NSA terms used in this SMM.

NSA BENEFIT CHANGES – ACTIVE PARTICIPANTS AND DEPENDENTS

Coverage of Emergency Services

The NSA requires Emergency Services to be covered as follows, to the extent that those Emergency Services qualify as No Surprises Services:

1) No Prior Authorization. Without the need for any prior authorization determination, even if the Emergency Services are provided on an out-of-network basis.

2) Coverage Regardless of Network Status. Without regard to whether the health care provider furnishing the Emergency Services is an in-network provider or an in-network emergency facility, as applicable, with respect to such services.

3) Administrative Requirements/Limitations. Without imposing 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. Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if such services were provided by an in-network provider or in-network emergency facility.

5) Cost-Sharing Calculations (Use of "Recognized Amount"). By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for such Emergency Services were equal to the Recognized Amount for the services.

6) Deductibles and Out-of-Pocket Maximums. By counting 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.

In light of these new 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 can't be balance billed for these "surprise" Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

The NSA requires Non-Emergency Services performed by an out-of-network provider at an in-network Health Care Facility to be covered as follows (to the extent that those Non-Emergency Services qualify as No Surprises Services):

1) Cost-Sharing Requirements. With 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"). By calculating the cost-sharing requirements as if the total amount that would have been charged for the Non-Emergency Services and related items by such in-network provider were equal to the Recognized Amount for such items and services.

3) Deductibles and Out-of-Pocket Maximums. By counting any cost-sharing payments made 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.

4) Notice and Consent Exception. Non-Emergency Services or related items performed by an out-of-network provider at an in-network facility will be covered based on your out-of-network coverage (i.e., at the out-of-network rate and rules) 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 federal law, that the provider is an out-of-network provider with respect to the Plan, the good faith estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and 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.

    The "notice and consent" exception does not apply to "Ancillary Services" and items or services furnished as a result 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 these new rules under these cases, the most those out-of-network providers may bill you is the Plan's in-network cost-sharing amounts. Generally speaking, this applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Such out-of-network providers who fail to comply with the requirements under the NSA cannot balance bill you, and may not ask you to give up your protections not to be balance billed after the fact. If you receive other

services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections under the NSA.

Out-of-Network Air Ambulance Services

The NSA requires out-of-network Air Ambulance Services (to the extent covered by the Plan) to be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if such services had been furnished by an in-network provider. In general, you cannot be balance billed for these out-of-network Air Ambulance Services.

Continuing Care Patients

If you are a Continuing Care Patient (see the Glossary at the end of this SMM) and the Plan terminates its in-network contract with an in-network provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan's network, you will be:

1) Notified in a timely manner of the termination of those contracts with the in-network provider or facility 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

The Independence Blue Cross provider directory will be updated at least every ninety (90) days. If you are informed of or receive inaccurate information from a provider directory indicating that a 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.

External Review for No Surprises 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 see the SPD for a description of the Plan's External Review procedures.

Plan Payments to Providers

The references to Recognized Amount and QPA in this SMM are used solely for purposes of describing the Plan's requirements under the No Surprises Act and are not intended to otherwise change the Plan's methodology for calculating payments to in-network or out-of-network providers. Except as otherwise required by the NSA, such as regarding provider negotiations and "independent dispute resolution" of payments to providers for

No Surprises Services, the Plan's existing methodology for determining amounts paid to providers will not change.

GLOSSARY OF NSA TERMS

The following additional definitions apply for purposes of the NSA changes described in this SMM:

"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 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, with respect to a pregnant woman, her unborn child) in serious jeopardy.

"Emergency Services" means the following services, to the extent that those services qualify as No Surprises 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, 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); and

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 (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 provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and

    b. You are supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the good faith estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and

    c. 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.

"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 Services" means the following services, to the extent that those services are both covered under the Plan and subject to the NSA 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 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 federal notice and consent requirements.

"Qualifying Payment Amount or QPA" means generally the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR § 716-6(c).

"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) An amount determined by a specified state law; or

3) The lesser of the amount billed by the provider or facility or the QPA.

For air ambulance services furnished by out-of-network providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

"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.

REMINDER

As a reminder, under the NSA, you are never required to give up your protections under the law from balance billing. You also are not required to get care from an out-of-network provider or facility. You can choose a provider or facility in the Plan's network. If you believe you have been wrongly billed by an out-of-network Provider, you may contact the Fund Office by calling the number listed below.

QUESTIONS

If you have any questions, please call the Fund Office at (212) 366-7880.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the program of benefits offered under 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. If any conflict should arise between this SMM 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, 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. As in all cases, the Board of Trustees of the Fund reserves the right to modify benefits at any time, in accordance with applicable law. This letter serves as an SMM of your benefits, as required by law.