SDC-LEAGUE Health Fund
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SUMMARY OF MATERIAL MODIFICATIONS

SDC-LEAGUE HEALTH FUND

Changes to Medical Benefits Under Option A Pursuant to the No Surprises Act

Effective September 1, 2022

The following summary describes changes to the SDC-League Health Fund's plan of benefits that will take effect September 1, 2022. This summary is intended to satisfy the requirements for issuance of a Summary of Material Modification (SMM) under the Employee Retirement Security Act of 1974, as amended ("ERISA"). You should take time to read this material carefully and keep it with a copy of the Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, or if you need another copy of the SPD, please contact Caitlin Higgins or Suzette Porte at the Fund Office at 321 W. 44th Street, Suite 804, New York, NY 10036, or by telephone at 212-869-8129, or by email at CHiggins@SDCweb.org or SPorte@SDCweb.org.

The Board of Trustees of the SDC-League Health Fund ("Fund" or "Plan") is pleased to announce the following changes to medical benefits provided to participants and their covered dependents, in accordance with the federal No Surprises Act. These changes are effective September 1, 2022. Please note the changes discussed in this SMM pertain to the Option A medical plan benefits under Aetna Managed Choice and Kaiser Permanente Plans as applicable.

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, where permitted, 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, and the full amount charged for a service. "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) will be 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 provisions regarding

payment determined in accordance with the Act. To locate an In-Network medical provider, visit https://www.aetna.com/individuals-families/find-a-doctor for the Aetna Managed Choice network or https://healthy.kaiserpermanente.org/doctors-locations for the Kaiser Permanente.

Capitalized terms used in this notice, such as "No Surprise Services" and "Emergency Services," are defined in the Glossary at the end of this notice.

BENEFIT CHANGES

Emergency Services

As required by the Act, the Plan will cover Emergency Services that qualify as No Surprise Services, in accordance with the following requirements:

1. No Prior Authorization Requirement. The services will be covered by the Plan 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. 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;

5. Cost-Sharing Calculations (Use of "Recognized Amount"). The Plan will calculate the participant cost-sharing requirement (such as any applicable co-insurance) 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 (not the higher billed amount).

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 In-Network deductible and out-of-pocket limit in the same manner as those received from an In-Network Provider.

In light of the Act's 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 cannot be balance billed for these Emergency Services.

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

As required by the Act, the Plan will cover Non-Emergency Services performed by an Out-of-Network provider at an In-Network Health Care Facility in accordance with the following requirements (to the extent that those Non-Emergency Services qualify as No Surprise Services):

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 participant cost-sharing requirement (such as any applicable co-insurance) 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 such items and services (not the higher billed amount).

3. Deductibles and Out-of-Pocket Maximums. The Plan will count any cost-sharing payments you make toward any deductible and out-of-pocket limits applied under the Option A Aetna and Kaiser Permanente Plans 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 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 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 Option A Aetna and Kaiser Permanente Plans 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 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 the Act's new 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 the notice and consent exception applies and is satisfied. Moreover, unless that exception applies and is satisfied, Out-of-Network providers cannot balance bill you for No Surprise Services, 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

As required by the Act, the Plan will cover Out-of-Network air ambulance services (to the extent covered by the Plan) 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 Out-of-Network air ambulance services. The Act does not apply to ground ambulances, which are subject to the normal terms of the SPD.

Continuing Care Patients

If you are a Continuing Care Patient and either the Option A Aetna or the Option A Kaiser Permanente Plans terminate its 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 (provided you remain enrolled in the Plan's coverage).

External Review for No Surprise Services Claims

Currently, the Plan provides that after you exhaust your internal appeals, you can file a request for external review with the Plan under certain circumstances. Beginning September 1, 2022, external review will also be available for adverse benefit determinations based on compliance with the surprise billing protections under the Act or its implementing regulations. Where your benefits are provided through Aetna Managed Choice or Kaiser Permanente, the Board of Trustees has delegated to Aetna or Kaiser primary responsibility with respect to administration of your benefit claims, and any request for additional review will be handled by these companies, as the duly authorized designees of the Board of Trustees. Please contact Aetna or Kaiser Permanente for a copy of the Plan's External Review procedures for claims covered by the Act.

Provider Directory

To help you find care from In-Network Providers and facilities, Aetna and Kaiser Permanente maintain a provider directory. Aetna and Kaiser Permanente are responsible for updating these directories every ninety (90) days as required by the No Surprises Act. If you receive inaccurate information from Aetna or Kaiser Permanente about a provider or facility's network status, you will be liable only for In-Network cost-sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the provider or facility that you have selected is In-Network at the time you receive services.

GLOSSARY

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

Ancillary Services means 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) is 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 with respect to an Emergency Medical Condition:

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. Post-Stabilization Services, which are 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) 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 to an available participating provider or facility located within a reasonable travel distance; and

    b. You are supplied with a written notice, as required by the Act, that the provider is an Out-of-Network Provider with respect to the Option A Aetna and Kaiser Permanente Plans, of the good faith estimated charges for your treatment and any advance limitations that the Health Fund 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 Surprise Services means the following, to the extent covered under the Option A Aetna and Kaiser Permanente Plans:

1. Out-of-Network Emergency Services;

2. Out-of-Network air ambulance services;

3. Non-emergency Ancillary Services for anesthesiology, pathology, radiology, neonatology 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 the Act's notice and consent requirements.

Recognized Amount means 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 or issuer 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 you have any questions about these changes, or about any aspect of the Fund, please contact the Fund Office by calling 212-869-8129 or emailing Health@SDCweb.org.

This SMM is intended to provide you with an easy-to-understand description of certain changes to 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. Except to the extent that this SMM modifies the Plan, if any discrepancy 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 document 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 arising under the Plan.