DIVISION 1181 A.T.U. - NEW YORK WELFARE FUND
ACTIVE SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Division 1181 A.T.U. – New York Welfare Fund ("Fund") has adopted the following benefit changes under the Division 1181 A.T.U. – New York Welfare Fund's Active Plan of Benefits ("Plan"). These changes to your Plan are designed to comply with changes in federal law under the No Surprises Act, effective January 1, 2022. Other changes are effective as of the dates below. Please review this document and keep it with your Summary Plan Description ("SPD") and your Summary of Benefits and Coverage.

Dental Benefits Changes

Effective October 1, 2021, Section 8 of the SPD is revised to reflect the updated Section attached as Appendix A.

Temporary COVID-19 Related Coverage Changes

Effective January 15, 2022 and continuing through the end of the federally-declared public health emergency, certain COVID-19 diagnostic tests purchased without a prescription ("over-the-counter" or "OTC Tests") are now covered under the Plan's Prescription Drug Benefit. **This benefit is only available for OTC tests obtained for personal diagnostic use and not for any employment related testing purposes.**

You and your covered dependents can order tests may obtain up to eight (8) OTC Tests per person, every 30 (thirty) days, with no out-of-pocket cost (i.e., no deductible or copays) and with no requirement for any prior authorization. A testing kit containing two tests in one box will count as two tests toward this limit. Please note, COVID-19 diagnostic tests performed at a provider's office, hospital, or clinic do not count toward this limit.

There are three options for obtaining OTC tests through this program:

- You may go to any in-network retail pharmacy and obtain an OTC Test for $0 copay by bringing the COVID-19 test to the pharmacy counter and presenting your Express Scripts ID card. **Please note, this no-upfront-cost option is only available if you purchase the OTC Tests at the pharmacy (as in, the checkout area where prescription medication is picked up or purchased) and not through the regular checkout lane.**

- You may order an OTC Test online through Express Scripts Pharmacy by following these steps. (1) Log in at express-scripts.com, (2) click "Order At-Home COVID-19 Tests" on the home page, (3) submit your order, and (4) get the tests shipped directly to you from Express Scripts Pharmacy.

- Alternatively, if you weren't able to purchase your at-home COVID-19 test(s) at the pharmacy counter of an in-network pharmacy and wound up paying out of pocket for them, or you chose to purchase OTC Tests at non-participating pharmacies or other retailers, you may submit manual claims for reimbursement of up to $12 per test online at Express Scripts' COVID-19 Resource Center at www.express-scripts.com/covid-

19/resourcecenter and log in for instructions on how to submit an online reimbursement claim form or download and print a paper claim form that you can mail in to the address on the form for reimbursement. **Consequently, you may be able to save money by obtaining tests from participating Express Scripts pharmacies.**

- **Please note, when submitting a manual claim for reimbursement, you will need to provide a receipt for the COVID-19 test with an NDC or UPC code. Be sure to obtain a receipt when you purchase the OTC tests.**

Important notes:

- Not all COVID tests may be available through point of sale at Express Scripts network pharmacies and COVID tests currently available through this option may change from time and time. If you have any questions on what tests will be covered at the pharmacy, please call the customer service number on the back of your Express Scripts ID card for assistance.

- OTC Test stock may vary widely among Express Scripts pharmacy locations. You may wish to call an Express Scripts location ahead of time to make sure the pharmacy has the tests covered under your Express Scripts benefit in stock. Please note, individual retailers and pharmacies may implement their own limits on at-home COVID-19 test kits you can purchase based on available stock.

Note: Currently, OTC COVID tests are in high demand. As an alternative to obtaining these tests at a pharmacy or retailer, you also can visit www.COVIDtests.gov to order 8 free at-home tests that will be mailed to you from the federal government. There also may be additional options in your local area for obtaining OTC COVID tests at no cost.

No Surprises Act Benefit Changes

The No Surprises Act is a federal law that prohibits balance billing above the Fund's allowed amount when individuals receive certain services from out-of-network hospitals, physicians or other providers. The changes described below implement the following changes of the No Surprises Act:

(1) prohibits surprise medical bills for most emergency services (including treatment necessary to stabilize your condition, regardless of where in the hospital you receive the exam or treatment), out-of-network air ambulance services (not ground ambulances), certain out-of-network "ancillary" (i.e., radiology, pathology, anesthesiology, etc.) services performed at an in-network facility, and certain non-emergency services from out-of-network providers performed at in-network facilities unless you consent to balance billing ("No Surprises Act Services");

(2) provides that any cost-sharing (copays and co-insurance) that you pay for No Surprises Act Services will count towards your in-network annual medical out-of-pocket maximum;

(3) provides participants with certain conditions the ability to elect to continue care with an in-network provider for up to 90 days after they leave the Empire network; and

(4) provides external review rights in connection with denials of No Surprises Act Services, to the extent required under federal law.

1. **The following new definitions are added to Section 1 of the SPD:**

Ancillary Services, with respect to an Empire health care facility, means: (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 (in-hospital physicians), and intensivists (critical care physicians); (3) diagnostic services, including radiology and laboratory services; and (4) items and services provided by a non-Preferred Provider not otherwise noted in (1) – (3) if there is no Preferred Provider who can furnish such item or service at such facility.

Emergency Services means the any of the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a Hospital, including Ancillary Services routinely available to the emergency department to evaluate the emergency medical condition;
- 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);
- Services provided by a non-Preferred Provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit until: (1) the provider or facility determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available to an Empire Preferred Provider, and (2) the current Hospital or facility complies with federal notice and consent requirements.

No Surprises Act Services means the following, to the extent covered under the Plan: (1) Emergency Services from a non-Preferred Provider or facility; (2) air ambulance services from a non-Preferred Provider; (3) non-emergency Ancillary Services performed by a non-Preferred Provider at an Empire facility; and (4) other out-of-network non-emergency services performed by a non-Preferred Provider at an Empire facility with respect to which the provider does not comply with federal notice and consent requirements.

Serious and Complex Condition means: (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 life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

2. Under Section 1 of your SPD, the definition of Allowable Charge is amended by adding the following at the end thereof:

For No Surprises Act Services, the ultimate Allowable Charge will be determined by applicable law, but you will not be balance billed for these services.

3. Under Section 1 of your SPD, the definition of Hospital is amended by adding the following at the end thereof:

With respect to claims for Emergency Services, Hospital also means any facility that is geographically separate and distinct from a hospital and is licensed under state law to provide emergency services.

4. In Section 4 Exclusions and Limitations, the first paragraph is amended by adding the following sentence at the end thereof:

To the extent a service listed below is otherwise required to be covered under applicable federal law, it is covered only to the extent necessary to comply with such law.

5. The following is added to the end of Section 5:

I. No Surprises Act Services

The Fund will cover No Surprises Act Services as required by applicable law. You will not be subject to balance billing for No Surprises Act Services. Please visit the Fund's website to view more information about balance billing.

6. In Section 5.B.1. Emergency Treatment and/or Ambulatory Surgery, the last paragraph is deleted in its entirety.

7. The following is added to the end of Section 6:

I. Continuing Care Patients

If a Preferred Provider leaves the Empire network, you may continue to receive such care as if the provider continued to be in-network for up to 90 days if you are considered a "Continuing Care Patient" and you make an election to be so treated. A 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. Therefore, if you are receiving care from a Provider that is leaving the Empire network, and you believe you qualify as a Continuing Care Patient, please contact Empire to understand your rights and make an election to receive this temporary continuation of in-network coverage

for a period of time, which will give you more time to transition to a new Preferred Provider for services.

J. No Surprises Act Services

The Fund will cover No Surprises Act Services as required by applicable law. You will not be subject to balance billing for No Surprises Act Services. Please visit the Fund's website to view more information about balance billing.

8. In Section 11 Annual Out-Of-Pocket Maximums, the last sentence is deleted and replaced with the following:

Any out-of-pocket expenses for non-essential benefits, out-of-network costs, and costs for excluded benefits do not count towards this annual out-of-pocket maximum. However, any copays and co-insurance for No Surprises Act Services will count towards this annual out-of-pocket maximum.

9. In Section 19 General Claims and Appeals Procedures, the following is added at the end of "Post-Service Claims":

However, providers of No Surprises Act Services will receive payment, or a denial, of a post-service claim for No Surprises Act Services within 30 days of the Fund's receipt of all information necessary to adjudicate the claim.

10. In Section 19 General Claims and Appeals Procedures, the first paragraph of "External Review of Denied Claims" is deleted and replaced with the following:

a. ***Standard External Review.*** If you receive an adverse benefit determination that (1) relates to a No Surprises Act Service, (2) is based on a medical judgment decision or (3) is based on a rescission of your coverage, you may appeal the adverse benefit determination to an external independent review organization (IRO). Claim denials for other reasons are not subject to external review.

Appendix A

SECTION 8
DENTAL BENEFITS

The Fund pays up to a maximum of $2,000 per year for Dental expenses incurred by Participants and/or Dependents age 19 or over in accordance with the Schedule of Dental benefits; however, there is no annual limit on dental benefits for Dependent children age 18 and under if required by law. Dental claims and questions should be directed to the Fund Office.

Procedures: When you go to a DDS, Inc. Panel Dentist, the Panel Dentist will accept the Fund's allowance rate as full and final satisfaction of the bill for services and you will not be responsible for any costs, up to the annual maximum noted above. If you go to a Dentist that is not a DDS, Inc. Panel Dentist, you will have to pay the difference between the Fund allowance below and what the Dentist charges. With that in mind, you can elect to either have (1) the Fund pay the Fund allowance listed below for the service and have the Dentist balance-bill you for the rest **or** (2) you can pay the full Dentist charge, file a claim for reimbursement with the Fund Office, which will in turn you directly the Fund Allowance for the service. Please contact the Fund Office for a copy of the latest DDS, Inc. Panel.

SCHEDULE OF DENTAL BENEFITS

DESCRIPTION OF PROCEDURE	FUND ALLOWANCE
DIAGNOSTIC	
Oral Examination	
Consists of charting, completion of forms and oral examination (twice per year)	$ 30.00
Radiographs	
Complete intra-oral series (consists of 14 periapical and four bite-wing films once every three years)	$ 50.00
Intra-oral single first film (periapical)	$ 5.00
Intra-oral each additional periapical film	$ 4.00
Four regular bite-wing films	$ 15.00
Two regular bite-wing films	$ 10.00
Single regular bite-wing film	$ 5.00
Panorex (once every 3 years)	$ 50.00
Occlusal films (usually used in edentulous cases) each.	$ 15.00
* Note: Total of individual films may not exceed allowable number for complete series.	
PREVENTIVE	
Oral Prophylaxis (twice per year)	
Adults (age 12 and over)	$ 30.00
Children (under age 12)	$ 15.00
Scaling, curettage, and root planning	$30.00

per quadrant / $480.00 maximum per year

Fluoride treatments - ages 4 to 14 years: Topical application of stannous fluoride - two treatments annually ..... $ 20.00

Sealants - ages 4 to 14 on posterior permanent teeth ..... $ 15.00

DESCRIPTION OF PROCEDURE	FUND ALLOWANCE

Space Maintainers

Fixed unilateral ..... $ 90.00

Fixed bilateral ..... $ 100.00

RESTORATIVE

Amalgam Restorations

Amalgam - one surface ..... $ 25.00

Amalgam - two surfaces ..... $ 35.00

Amalgam - three surfaces or more ..... $50.00 maximum

Composite Restorations or similar accepted materials (per restoration)

One surface ..... $ 35.00

Two surfaces ..... $ 45.00

Three surfaces ..... $ 55.00

Four surfaces or more ..... $ 75.00

Inlays

One surface ..... $ 80.00

Two surfaces ..... $ 90.00

Three surfaces ..... $ 110.00

Recementing inlay (must be serviceable) ..... $ 15.00

Reinforcement pins

Each pin ..... $ 20.00

Crowns (single restoration only)

Stainless steel crown ..... $ 50.00

(To be used on deciduous teeth or where permanent restoration on permanent tooth is not feasible due to age of patient or enlarged pulp. Three surfaces of tooth must be involved.)

Porcelain fused to metal crown $350.00

Laminate $250.00

Full Cast gold crown $250.00

Resin veneer crown $250.00

Porcelain jacket crown $250.00

Three quarter crown ..... $ 75.00

Recement Crowns (must be serviceable) ..... $ 20.00

Palliative Treatment (emergency treatment of dental pain with no other treatment in same visit) ..... $ 20.00

PERIODONTAL SURGICAL PROCEDURES

Osseous surgery – Requires Prior Approval 1-3 teeth.....$250
Osseous surgery – Requires Prior Approval.....$300.00 per quadrant
Gingivectomy .....$100.00 per quadrant

DESCRIPTION OF PROCEDURE **FUND ALLOWANCE**

MAXIMUM ALLOWANCE FOR PERIODONTAL SURGERY.....$1,200.00
Periodontal maintenance.....$ 50.00

ENDODONTICS

Pulpotomy

Limited to deciduous teeth only - If tooth is not ready to be exfoliated.....$ 50.00

Root Canal Therapy Pre- and post-operative x-rays are required.

Tooth with one canal $175.00
Tooth with two canals.....$225.00
Tooth with three or more canals $300.00

Apicoectomy.....$175.00
If more than one root requires apicoectomy, allowance for one root is $175.00; allowance for second and third root is $100.00 each root.
Retrograde Filling – per root.....$ 50.00
Root Resection.....$100.00
Hemisection $100.00

PROSTHODONTICS: REMOVABLE The Fund does not cover temporary or transitional dentures.

Full upper denture.....$350.00
Full lower denture.....$350.00

Immediate full upper or full lower denture shall be considered a final denture.

Bilateral upper or lower partial cast chrome acrylic attachments, cast clasps with rest $375.00
Unilateral partial upper or lower cast chrome acrylic attachments, cast clasps with rest $200.00

Chair side relines rendered in the first three months at no additional fee. **All these procedures require prior approval, except chair side relines.**

Relines or Rebases – Limited to one procedure per year

Upper or full lower dentures, lab processed $125.00
Partial denture relines, lab processed.....$100.00

Denture Repairs

Denture repair.....$ 45.00
Adding tooth or teeth to partial denture replacing extracted tooth or teeth:

Each tooth	$ 40.00
Repair Cast Framework	$ 50.00
Adding clasp to existing partial	$ 50.00
Partial denture repair involving replacement of broken clasp with a new clasp and rest	$ 50.00

DESCRIPTION OF PROCEDURE	FUND ALLOWANCE
Fixed Bridgework	
Porcelain pontic	$400.00
Resin pontic	$300.00
Cast pontic	$300.00
Recement bridge (must be serviceable)	$ 40.00
Porcelain crowns	$400.00
Cast post and core	$150.00
Prefabricated post and core (metal)	$100.00
Crown build-up	$100.00
Maryland abutment	$300.00
ORAL SURGERY	
Routine Extractions per tooth	$ 50.00
Root removal (exposed root)	$ 75.00
Palliative (Emergency) Treatment of Dental	$ 20.00
General Anesthesia (per 15 minutes)	$ 50.00
Incision and drainage	$ 50.00
Frenectomy	$ 50.00
Removal of cyst, lab report required (included in fee)	$150.00
MULTIPLE EXTRACTIONS	
Surgical Extraction	$ 75.00
Soft tissue impaction	$ 75.00
Partial bony impaction	$100.00
Completely bony impaction	$150.00
Alveolectomy	
1-3 teeth	$ 30.00
Per quadrant	$ 90.00

PROCEDURES, LIMITATIONS AND EXCLUSIONS

If prior approval is required for the procedure, and is not obtained, benefits will not be paid.

Covered Persons are required to submit full series of mounted X-rays and invoices, properly charted with treatment plan, to obtain prior approval where required. In edentulous cases, occlusal films must be submitted in order to obtain prior approval.

The Fund will pay $50 annually towards the cost of a consultation with a qualified specialist if requested by the Dentist for each Covered Person before and/or after treatment as the case warrants.

The Trustees have the right, in their discretion, to refer all dental claimants for examination by an independent Dentist before and after treatment.

In addition to the exclusions applicable to all forms of benefits under the Plan (Section 4), dental benefits do not cover:

1. Temporary or transitional dentures;

2. Full mouth, crown and bridge restoration;

3. The replacement of fixed bridges, full or partial dentures, crowns, or any prosthetic appliance if payment toward the cost of original appliance was made by the Fund unless 3 years have elapsed from date of original insertion;

4. Crowns constructed for the purpose of receiving a precision or semi-precision attachment for any prosthetic appliance or for clip on bars;

5. Splinting of periodontally involved teeth with questionable prognosis by means of crowns, inlays or any other appliance, be it during or after treatment;

6. Dental work performed only for cosmetic purposes except to correct a condition resulting from accidental Injury to natural teeth; and

7. Orthodontia. Although the Fund does not cover orthodontic services, as a result of participation with DDS, Inc., dental providers within the DDS network will offer you a courtesy discount rate on orthodontic services. However, as these services are not covered by the Fund, you will be responsible for the full cost of the orthodontic services.