FOURTH SUMMARY DESCRIPTION OF MATERIAL MODIFICATION OF THE PAINTING INDUSTRY INSURANCE FUND SUMMARY PLAN DESCRIPTION DATED JANUARY 1, 2019

NOTICE OF CHANGES TO YOUR HEALTH PLAN

This document is called a Summary of Material Modifications ("SMM"). An SMM is designed to describe modifications to the Painting Industry Insurance Fund Summary Plan Description ("SPD") previously sent to you effective January 1, 2019. This SMM discusses three changes to the Painting Industry Insurance Fund ("Plan").

No Surprises Act Changes Effective January 1, 2022

The Plan has been changed to (1) comply with the provisions of a the new "No Surprise Act" provisions which prohibit the Plan from applying out-of-network cost sharing for emergency room visits or for services performed by an out-of-network provider while you are treated in an in-network provider facility. These changes take effect January 1, 2022.

New Maternity Leave Benefits Effective August 26, 2021

The Plan was also amended to add a Maternity Leave Benefit for plan participants only (not for pregnant Spouses or Dependents), which will provide participants six weeks of leave pay following giving birth up to a maximum of eight hundred dollars $800 per week. In the event the participant gives birth through a surgical procedure such as caesarean section, then the Maternity Leave Benefit will last eight weeks following delivery. In addition, if a participant becomes disabled and unable to work during pregnancy (as certified by the participant's physician), then the Plan will also pay a weekly disability benefit of the participant's regular weekly pay up to a maximum of eight hundred dollars per week for up to six months of the participant's pregnancy. These changes are effective August 26, 2021.

Early Retiree Subsidy Termination for Working in Disqualifying Employment

Lastly the Plan was also amended to terminate the early retiree subsidy payments for participants that engage in disqualifying employment after they retire and commence receiving early retiree subsidy payments. These changes are effective August 26, 2021.

Accordingly, the following changes have been made to the SPD you received in January 2019.

1. Effective January 1, 2022, Article III, Section C entitled "Schedule of Benefits: Comprehensive Major Medical Plan Schedule of Benefits," is hereby amended by removing the schedule for "Emergency Care, Urgent Care, and Ambulance Services" (located on page 19 of the SPD) in its entirety and replacing it with the following new schedule for "Emergency Care, Urgent Care, and Ambulance Services" to read as follows:

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD.		
Emergency Care, Urgent Care, and Ambulance Services If an emergency visit is rendered in an office setting, the $20 Primary Care, Specialist, or Physician Copayment will apply.		
Emergency Room Visit Medical Emergency (per visit) Copayment/Coinsurance	$100	$100
All other services (Copayment waived if admitted).	20%	20%
Emergency room visit for a Non-Emergency (per visit)		
All other services	20%	40%
Urgent Care Clinic Visit (per visit) Copayment/Coinsurance	20%	40%
All other services	$35	40%
Ambulance Services (when Medically Necessary)	20%	40%
Land/Air/Water	20%	40% (See below for air ambulance costs in medical emergencies)
Note: Care received Out-of-Network for a Medical Emergency will be provided at the Network level of benefits if the following conditions apply: A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. Care may also be approved as an Authorized Service.		

2. Effective January 1, 2022, Article III, Section C entitled "Schedule of Benefits: Comprehensive Major Medical Plan Schedule of Benefits," is hereby amended by removing the schedule for "Hospital Inpatient Services – Precertification Required" (located on page 20 of the SPD) in its entirety and replacing it with the following new schedule for "Hospital Inpatient Services – Precertification Required":

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD.		
Hospital Inpatient Services – Precertification Required		
Room and Board (Semiprivate or ICU/CCU)	20%	40%

Hospital Services and Supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical therapy, etc.)	20%	40%
Pre-Admission Testing	20%	40%
Physician Services		
• Surgeon	20%	40%
• Anesthesiologist	20%	40%
• Radiologist	20%	40%
• Pathologist	20%	40%
Note: Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. That includes many services rendered by an out-of-network provider at an in-network facility. However, you could be responsible for the difference between the Maximum Allowed Amount and the amount the Provider charges if the charges are (1) not included in this exception, (2) are provided at an out-of-network facility, or (3) you provide written consent to the out-of-network treatment (as required under federal law). For additional information, please contact the Plan Administrator**.**		

3. Effective January 1, 2022, Article III, Section C, entitled "Schedule of Benefits," is hereby amended by removing page 27 in its entirety and replacing it with the following new page 27:

IN ADDITION, MATERINTY BENEFITS ARE NOT COVERED FOR DEPENDENT CHILDREN OF EITHER ACTIVE OR RETIRED PARTICIPANTS

Participants may be responsible for excess charges not covered by the Plan is using Non-Network Providers. Participants risk being balance-billed for charges of the Non-Network providers in excess of the amount payable pursuant to the terms of the Plan.

However, effective January 1, 2022 and as provided under federal law, treatment from an out-of-network provider that that is rendered at an in-network facility will be covered at the In-Network rate. That includes, but is not limited to, charges from Emergency Room Doctors, Anesthesiologists, Pathologists, and Radiologists. That means the claim will be subject to the In-Network deductible, co-insurance rate, co-payment schedule, and out-of-pocket maximum limitation. Further, the Participant will not be balanced billed even though the provider is Out-of-Network.

Please be aware that Participants may, in limited circumstances, voluntarily consent to use an Out-of-Network provider in advance of treatment. If the consent satisfies the requirements set forth in 42 U.S.C. § 300gg-132(d), then the claim will be covered at the Out-of-Network Rate (i.e., out-of-network deductible, co-insurance rate, co-payment schedule, and out-of-pocket maximum limitation). In such an event, the Participant could be responsible for charges in excess of the amount payable under the Plan (i.e., the "balance bill").

1. Emergency Room Treatment at an Out-of-Network Facility

The Plan will also cover at the In-Network Rate emergency medical services that are rendered at Out-of-Network facilities. This includes care received at a hospital emergency room department or an independent free standing emergency department and applies to the claims of both the Eligible Employee and any Eligible Dependents.

For this purpose, "emergency medical services" means the initial care given in a hospital's emergency room or at an independent free standing emergency department immediately after either the sudden and unexpected onset of symptoms or an accident causing injuries that are severe enough to require immediate hospital level of care. See Article XIII Section FFF for the definition of a "Medical Emergency."

The Plan pays Outpatient Emergency claims at 80% in-network and 60% out-of-network. The Plan will pay Outpatient Emergency claims at the Out-of-Network level for treatment received at an Out-of-Network hospital emergency room or independent free standing emergency department if those services do not qualify as "emergency medical services."

4. Effective January 1, 2022, Article III, Section E(1), entitled "Schedule of Benefits: Eligible Benefits – Ambulance Service," is hereby amended to add the following language to the provision:

Out-of-Network Air Ambulance Services for Medical Emergencies (See Article XIII, Section FFF) are covered at the In-Network Rate (i.e., co-insurance rate, co-payment schedule) and costs must count towards the In-Network deductible and maximum out-of-pocket limits.

5. Effective January 1, 2022, Article V Section E, entitled "Medical Claim Procedure: Authorized Services," is hereby amended by replacing that Section in its entirety and replacing it with the new Article V, Section E as follows:

E. AUTHORIZED SERVICES

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. The Plan also will authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services at an Out-of-Network hospital emergency room or independent free standing emergency department. In this circumstance, you are not liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

6. Effective January 1, 2022, Article XIII Section F, entitled "Definitions: Authorized Services," is hereby amended by removing that provision in its entirety and replacing it with the new Article XIII, Section F as follows:

F. AUTHORIZED SERVICE(S)

"Authorized Service(s)" means a Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Participant may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. Federal law will govern payments for Out-of-Network Emergency services. Further, Covered Services rendered by an Out-of-Network Provider at an in-Network facility will be covered at the In-Network rate unless the Participant has consented to the treatment and the consent meets Federal guidelines.

7. Effective August 26, 2021, Article III, entitled "Schedule of Benefits," is hereby amended by adding section Y, entitled "Maternity Leave Benefits Program" to read as follows:

Y. MATERNITY LEAVE BENEFITS PROGRAM

All Participants who meet the Eligibility Criteria below and who are pregnant or give birth will be eligible for Maternity Leave Benefits from the Plan, including a Pre-Delivery Disability Benefit and a Post-Delivery Leave Benefit as described below:

a. Post-Delivery Leave Benefit: Participants who give birth naturally are eligible for six (6) weeks of a Weekly Benefit Amount as set forth below. Participants who have given birth by a caesarean section or other surgical procedure will be eligible for up to eight (8) weeks of a Weekly Benefit Amount as set forth below for paid leave. Other leaves occurring while impregnated, but before the birth of a child will be considered on a case-by-case basis. Proper medical documentation and certification will be required to process and approve such leaves. Other leaves include:

b. Pre-Delivery Disability Benefit: If a Participant is certified by a health care provider as being unable to work during their pregnancy, they may receive up to six (6) months of the Weekly Benefit Amount as set forth below *prior* to giving birth.

Weekly Benefit Amount – The Weekly Benefit Amount is equal to sixty-six and sixty-seven tenths' percent (66.67%) of the Participant's regular weekly pay, up to a maximum of eight-hundred ($800.00) dollars per week. Weekly earnings shall be determined to be the regular hourly wage based on a forty (40) hour work week. The Regular Hourly Wage shall be based on the hourly wage rate (excluding benefit contributions) under the Collective Bargaining Agreement that the Participant was working under at the time the Participant became pregnant. Benefits shall be 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. The following formula shall be used to calculate benefit payments:

66.67% of Regular Hourly Wage × 2080 ÷ 52 = weekly benefit ($800 cap)

Eligibility Criteria:
In order for the Plan to be reimbursed for the Participant's use of this benefit, the following criteria must be met:

a. The Maternity Leave Program Benefits Program is available only to a Participant on whose behalf Contributions are made to this Plan. This benefit does not extend to pregnant Spouses or pregnant Children; and
b. The Participant must have worked at least one-hundred (100) hours over the past three (3) months and be currently eligible for coverage under the Plan on the date of pregnancy and disability; and
c. The Participant has not previously received maternity leave benefits from this Plan within the past twenty-four (24) months; and
d. For Pre-Delivery Disability Benefits only, the Participant must submit certification of their pregnancy from their medical doctor verifying they are unable to perform the duties of their trade due to physical limitations arising from the pregnancy.

The Maternity Leave Benefits Program is not available to Canadian residents.

Re-Certification of Continued Inability to Work – The Plan shall require re-certifications of continued or prolonged inability to work, from time to time by the Participant's medical doctor during the pregnancy.

8. Effective August 26, 2021, Article IV, Section C, entitled "Early Retiree Subsidy" is hereby amended by adding the following language to the end of that section:

Termination of Early Retiree Subsidy for Working in Disqualifying Employment: The Early Retiree Subsidy shall terminate, and no further subsidies will be paid on behalf of any Early Retiree who works in Disqualifying Employment. Disqualifying Employment includes any of the following:

- Employment with any Contributing Employer; or
- Employment in the same or related business as any Contributing Employer; or
- Self-employment in the same or related business as any Contributing Employer; or
- Employment or Self-Employment in any business which is or may be under the jurisdiction of the International Union of Painters and Allied Trades ("IUPAT"). For this purpose, Employment or self-employment which is or may be under the jurisdiction of the IUPAT includes, but is not limited to:
    - Work covered by any IUPAT collective bargaining agreement; or
    - Work within the trade jurisdiction of the IUPAT as described in the IUPAT Constitution; or
    - Work which an Employee has been assigned, referred, or can perform because of his or her skill and training as an Employee under an IUPAT collective bargaining agreement.

Work in a related business does not have to be union work under an IUPAT collective bargaining agreement nor in the area in which the Participant worked before retirement in order for it to be considered Disqualifying Employment terminating further Early Retirement Subsidy benefits.

This Summary Description of Material Modification should be read in conjunction with the SPD. Information contained in this Summary Description supersedes what is contained in the SPD. However, this Summary Description changes only the provisions to which it specifically refers and any other provisions in the SPD have not been materially modified. If you have any questions regarding this change, please contact the Plan Administrator.

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PAINTING INDUSTRY INSURANCE FUND