LOCAL 272 WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

DECEMBER 1, 2022

This document is a Summary of Material Modification ("SMM") intended to notify you of an important change to the plan of benefits provided by the Local 272 Welfare Fund (the "Fund" or the "Plan"). This summary is intended to satisfy the requirements for issuance of a SMM under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). You should take the time to read this letter carefully and keep it with the copy of the Summary Plan Description ("SPD") that was previously given to you. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact the Fund Office during normal business hours at: 220 East 23rd Street, Room 805, New York, NY 10010, telephone number (212) 726-9730. If there is any discrepancy between the information printed on this insert and the Plan, the Plan will govern. Please keep this SMM and any other documents you receive from your Welfare Fund with your important papers so that you can refer to them when you need to.

The Trustees wish to inform you that the Plan has been amended effective December 1, 2022 for purposes of in-network benefits only to eliminate the 90/10 benefit design. The Plan's out-of-network benefits remain unchanged and subject to the Plan's current rules.

Currently, the Fund pays 10% of all eligible in-network claims over $125,000 annually for medical claims, hospital claims and other medical expenses, less any applicable copayments and/or coinsurance. Also, the Fund pays 10% of all eligible in-network prescription drug claims over $5,000 annually, less any applicable copayments and/or coinsurance.

Beginning as of December 1, 2022, the Fund will cover all eligible in-network claims, less any applicable copayments and/or coinsurance without application of the 10% limit. The Plan's medical necessary requirement and exclusions remain in effect. Again, please note that the Plan's out-of-network benefit rules remain unchanged and may not fully cover the payment for claims that may be incurred using out-of-network providers. Please refer to the SPD for details about your out-of-network benefits. It is you, the participant, who is responsible to make certain that any provider that you use is an in-network provider in order to maximize your Fund benefits. If you have any questions about whether a provider is in-network, please contact the Fund Office at 212-726-9730.

REMINDERS

NOTE: The following information is NOT a change to the Plan, rather, included only as a reminder. In the event that there is any discrepancy between that which is set forth below and the Plan, the Plan's terms will prevail.

Please be advised that the Plan does not cover elective or routine lab tests performed in a hospital. The Plan does not cover elective or diagnostic radiological exams performed in a hospital. However, the Plan will cover eligible tests if they are required while a patient is in a hospital in accordance with the terms of the Plan.

If you have a newborn child, Fund coverage begins as of the date of birth, provided that you must submit to the Plan the required documentation (i.e., birth certificate) within 30 days. If the proper documentation is not received within 30 days of the child's birth, Fund coverage begins on the date the completed documentation is received by the Fund Office. It is important that the parent covered under the Plan has their name on the birth certificate of the child, otherwise the Fund will not cover the child without proper documentation.
Also, please make certain that you report to the Fund Office any changes in your family, such as a newborn or newly adopted child, a marriage, a divorce, a separation or a death.

Please contact the Fund Office with any questions you may have regarding this SMM.

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This SMM is intended to provide you with an easy-to-understand description of certain changes to the Fund. 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 Fund. If any conflict should arise between this SMM and the Fund, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Fund 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 Fund, or any benefits provided under the Fund, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Fund and its related Trust Agreement. The Trust Agreement is available upon request at the above address 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 Fund, or to change any provision of the Fund. 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 Fund and decide all matters arising under the Fund.

IMPORTANT NOTICE REGARDING THE PLAN'S GRANDFATHERED PLAN STATUS

Trustees believe that the Plan is a "grandfathered plan" as such term is defined under PPACA (more commonly known as Health Care Reform). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when Health Care Reform was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the plan may not include certain consumer protections of Health Care Reform that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (i.e., copayments, coinsurance, deductibles). However, grandfathered health plans must comply with certain other consumer protections in Health Care Reform, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26. 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 Plan Administrator during normal business hours at: 220 East 23rd Street, Room 805, New York, NY 10010, telephone number (212) 726-9730. You may also contact the Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.