AMENDMENT #9
to the
ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND
Summary Plan Description (SPD)/Plan Rules and Regulations
for Active Employees and Non-Medicare Retirees

Amended, restated and effective June 1, 2018

Effective June 1, 2022, the Summary Plan Description/Plan Rules and Regulations are amended as noted below:

In the Quick Reference Chart, the following section is amended to add the following new language in italics:

Medical Network • Network Preferred (OAP) Providers. **The network is called the Open Access Plus or OAP network.** • Free Online Directory of Network OAP Providers in the State of Arizona. With the OAP network you have access to CIGNA Medical Group facilities, CIGNA urgent care centers located in the Phoenix metro area and the Lifesource Programs of Excellence locations for transplants. • Download the **CIGNA app** to your smartphone for easy access to network providers	**CIGNA** 1-800-244-6224 Online Directory of OAP Network Providers: www.cigna.com. Then click on "Find a Doctor." Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price. *Note: If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network*. **CAUTION:** Use of a **non**-OAP network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. (See definition of "balance billing" in the Definition Article of this document). **Your lowest out of pocket costs will occur when you use CIGNA Network OAP providers**. *Note: Balance billing does not apply to emergency services in a non-network hospital or Independent Freestanding Emergency Department center, non-emergency services by non-network providers at network facilities, or air ambulance services*.

Article I: General Definitions, Section 4, the following section is amended to add the following new language in italics:

Section 4: The term **"Balance Billing"** means a bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged. Amounts associated with Balance Billing are not covered by this Plan, even if the Plan's Out-of-Pocket Limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Note that amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket Limit and may result in Balance Billing by the provider to you. Typically, Network providers do not Balance Bill except in situations of third-party liability claims. **Out-of-Network Health Care Facilities or Practitioners commonly engage in Balance Billing a Plan Participant for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid Balance Billing by using Network providers.** *Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, non-emergency services by Out-of-Network providers at network facilities, or air ambulance services.*

Article XVI: Medical Plan Benefits chapter, the introductory section is amended to add the following new language in italics:

IMPROVEMENTS TO BENEFITS FOR CERTAIN SERVICES FROM OUT-OF-NETWORK PROVIDERS

Effective June 1, 2022

The No Surprises Act was signed into law in December 2020. This Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive non-emergency services from an Out-of-Network provider at an In-Network facility. Effective June 1, 2022, beneficiaries receiving these services will only be responsible for paying their In-Network cost sharing, and cannot be balance billed by the provider or facility for emergency services.

Effective June 1, 2022, the Plan is implementing a number of improvements to comply with the No Surprises Act.

Emergency Services

Emergency Services are covered:

- *Without the need for a prior authorization determination, even if the services are provided out-of-network;*
- *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 the services;*
- *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;*

- *Without imposing 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 an In-Network emergency facility;*
- *By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and*
- *By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any In-Network deductible or In-Network out-of-pocket maximums applied under the plan (and the In-Network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by an In-Network provider or an In-Network emergency facility.*

Your cost sharing amount for Emergency Services from Out-of-Network Providers will based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

Non-Emergency Items or Services from an Out-of-Network Provider at an In-Network Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an Out-of-Network provider at an In-Network facility, the items or services are covered by the plan:

- *With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network provider,*
- *By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Out-of-Network provider were equal to the Recognized Amount for the items and services.*
- *By counting any cost-sharing payments made by the participant or beneficiary toward any In-Network deductible and In-network out-of-pocket maximums applied under the plan (and the In-Network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network provider.*
- *Non-emergency items or services performed by an Out-of-Network provider at an In-Network facility will be covered based your out-of-network coverage if:*
  - *At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is 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 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*
  - *The participant or dependent gives informed consent to continued treatment by the Out-of-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or beneficiary.*
- *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, and therefore these services will be covered:*

- *With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network provider,*
- *With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the recognized amount for the items and services, and*

- *With cost-sharing counted toward any In-Network deductible and In-Network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an In-Network provider.*

Your cost sharing amount for Non-emergency Services at In-Network Facilities by Out-of-Network Providers will based on the lessor of billed charges from the provider or the QPA.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from an Out-of-Network provider, those services will be covered by the Plan as follows:

- *The Air Ambulance services received from an Out-of-Network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network provider.*

- *In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.*

- *Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network provider.*

Payments to Out-of-Network Providers and Facilities *The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at In-Network Facilities by Out-of-Network Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Out-of-Network provider. The 30 day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.*

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the Out-of-Network provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by an Out-of-Network provider at an In-Network facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your In-Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. *You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and*
2. *You will be allowed up to ninety (90) days of continued coverage at In-Network cost sharing to allow for a transition of care to an In-Network provider.*

Incorrect In-Network Provider Information

A list of In-Network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is an In-Network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact Cigna or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

Repeal of Emergency Department Payment Rules

The Plan provision concerning payment for Emergency Room services, as required by the Affordable Care Act, is repealed for services provided on or after June 1, 2022, and replaced with the No Surprises Act requirements.

NEW/REVISED DEFINITIONS OF THE PLAN
Effective June 1, 2022

***Air Ambulance** means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.*

***Ancillary services** are, with respect to an In-Network health care facility:*

- *Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,*
- *Items and services provided by assistant surgeons, hospitalists, and intensivists;*
- *Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and*
- *Items and services provided by an Out-of-Network provider if there is no In-Network provider who can furnish such item or service at such facility.*

***Cost sharing** means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Out-of-Network providers, or the cost of items or services that are not covered under the plan.*

Cost Sharing Amount *for Emergency and Non-emergency Services at In-Network Facilities performed by Out-of-Network Providers, and air ambulance services from Out-of-Network providers will be based on the Recognized Amount.*

Continuing Care Patient *means an individual who, with respect to a provider or facility-*

1. *is undergoing a course of treatment for a serious and complex condition from the provider or facility;*
2. *is undergoing a course of institutional or inpatient care from the provider or facility;*
3. *is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;*
4. *is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or*
5. *is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such 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 serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.*

Emergency Services *means the following:*

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).*

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 include 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:

- *The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or*
- *The participant or beneficiary is 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 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*

The participant or beneficiary gives informed consent to continued treatment by the Out-of-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or beneficiary.

Health Care Facility *(for non-emergency services) is each of the 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*

Independent Freestanding Emergency Department *is a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.*

No Surprises Act *means the federal No Surprises Act (Public Law 116-260, Division BB).*

Non-PPO emergency facility *means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively*

Out-of-Network provider *means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.*

Out-of-Network Rate *with respect to items and services furnished by an Out-of-Network provider, Out-of-Network emergency facility or Out-of-Network provider of ambulance services, means one of the following:*

- *the amount the parties negotiate;*
- *the amount approved under the independent dispute resolution (IDR) process; or*
- *if the state has an All-Payer Model Agreement, the amount that the state approves under that system*

Qualifying Payment Amount (QPA) *means the amount calculated using the methodology described in 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 Qualifying Payment Amount (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 Qualifying Payment Amount (QPA).*

Serious and Complex Condition *means with respect to a participant, beneficiary, or enrollee under the Plan 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;*
2. *in the case of a chronic illness or condition, a condition that is—*
   a. *is life-threatening, degenerative, potentially disabling, or congenital; and*
   b. *requires specialized medical care over a prolonged period of time.*

Termination *includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.*

Article XVI: Medical Plan Benefits, "Open Access Plus Medical Plan Benefits" chapter, The Schedule is amended to add the following new rows to proceed Co-Surgeon section, stating as follows:

Co-Surgeon The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.
Out-of-Network Charges for Certain Services *Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.* *The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.* ***Out-of-Network Emergency Services Charges*** *1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.* *2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.* *3. The allowable amount used to determine the Plan's benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.* *The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.*

Article XVI: Medical Plan Benefits, "Open Access Plus Medical Plan Benefits" chapter, the section "Maximum Reimbursable Charge" is amended to delete the text in strikethrough and add the text in italics as follows:

BENEFIT HIGHLIGHTS OF THE OPEN ACCESS PLUS MEDICAL PLAN	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge *The* Maximum Reimbursable Charge *for Out-of-Network services other than those described in the Schedule sections Out-of-Network Charges for Certain Services and Out-of-Network Emergency Services Charges* is determined based on the lesser of the provider's normal charge for a similar service or supply; *or the amount agreed to by the Out-of-Network provider and Cigna, or a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.* ~~A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:~~ ~~• the provider's normal charge for a similar service or supply; or~~ ~~• the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Medical Plan Claims Administrator, CIGNA.~~	Not Applicable	*150%*

Article XVI: Medical Plan Benefits, "Open Access Plus Medical Plan Benefits" chapter, the section "Definitions" is amended to delete the text in strikethrough and add the text in italics as follows:

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount *including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.*

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, *or of an independent freestanding emergency facility*, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply;
- the amount agreed to by the Out-of-Network provider and Cigna; or

- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

This Amendment #9 to the 2018 Arizona Pipe Trades Health & Welfare Trust Summary Plan Description/Plan Rules and Regulations for Active Employees and Non-Medicare Retirees was duly adopted by the Board of Trustees at a meeting held on September 14, 2022.

Chairman

Secretary