AMENDMENT NO. 4

TO THE OPERATING ENGINEERS LOCAL 501 SECURITY FUND

(SOUTHERN CALIFORNIA)

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

(Effective January 1, 2023)

This is to certify that the Board of Trustees of the Operating Engineers Local 501 Security Fund, have adopted the following Amendment effective January 1, 2023 to the Summary Plan Description and Plan Document. Specifically, the Fund has amended the General Definitions, Indemnity Medical Plan Coverage and External Review Procedures to comply with the No Surprises Act as promulgated by the Consolidated Appropriations Act. Accordingly, the following changes have been made:

Effective January 1, 2023, in **General Definitions** on page 3, the following terms are added:

Allowed Charges Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies.

For Emergency Services, non-Emergency Services provided by Non-Network Providers at Network facilities, and Air Ambulance services, the Allowed Charge is the Recognized Amount.

For all other services, the Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. With respect to a Network provider, the negotiated fee/rate set forth in the agreement between the participating network provider/facility and the network or the Plan; or

2. With respect to a Non-Network provider, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers.

   The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary, and reasonable charge (UCR), prevailing or any similar term.

   The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. Or

3. For an Network Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third-party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an Network claim; or

4. The provider's/facilities actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual

Out-of-Pocket Limit. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan except for Emergency Services, non-Emergency Services furnished by a Non-Network provider at a Network facility, or Air Ambulance.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

Ancillary Services are, with respect to a 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
- Items and services provided by a Non-Network provider if there is no Network provider who can furnish such item or service at such facility.

Cost Sharing means the amount a participant or dependent 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 Non-Network providers, or the cost of items or services that are not covered under the plan.

The **Cost Sharing Amount** for Emergency and Non-emergency Services at Network Facilities performed by Non-Network Providers, and air ambulance services from Non-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.

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-Network 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.

Non-Network Rate with respect to items and services furnished by a Non-Network provider, Non-Network emergency facility or Non-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;
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system; or
- If applicable, if a State law is in effect and applies, the amount determined in accordance with such law.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 45 CFR § 149.140(a)(16).

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 Non-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, dependent, 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.

Effective January 1, 2023, in **General Definitions** on page 5, the term **Emergency** is replaced with the following:

Emergency means the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act) 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 under section 1867 of the Social Security Act to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency services furnished by a Non-Network provider or Non-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 dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or

- The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-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 Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the Network providers listed; and

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

Effective January 1, 2023, in **Network of Providers and Medical (And Mental Health/Substance Abuse Use Disorder) Services Review**, new subsections are added beginning on page 43 as follows:

Non-Network Providers Paid under the No Surprises Act

In certain limited circumstances the Indemnity Medical Plan will pay charges for services provided by a Non-Network physician at the Network Rate under the No Surprises Act. Payment rules may be different for the fully insured HMO.

Emergency Services are covered:

- Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;

- Without regard to whether the health care provider furnishing the Emergency Services is a Network Provider or a Network emergency facility, as applicable, with respect to the services;

- If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility:

  – 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 Network Providers and 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 a Network Provider or a 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 dependent 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 a Network Provider or a Network emergency facility.

Emergency Services furnished by a Non-Network Provider or Non-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes 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 are covered, until:

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

- The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-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 Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the Network providers listed; and

- The participant or dependent is in a condition to receive the written notice, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable State law.

- The participant or dependent gives informed consent to continued treatment that is not considered Emergency Services by the Non-Network provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Network provider may result in greater cost to the participant or dependent and balance billing.

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 a Non-Network provider at a 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 a 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 Network provider were equal to the Recognized Amount for the items and services.

- By counting any cost-sharing payments made by the participant or dependent 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 a - Network Provider.

Non-emergency items or services performed by a Non-Network Provider at a Network facility will be covered based on your out-of-network coverage if:

– 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), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-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; and

– The participant or dependent gives informed consent to continued treatment by the Non-Network Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Network Provider may result in greater cost to the participant or dependent, that the payment of such charge might not accrue toward meeting any limitation of the plan on cost-sharing (such as deductible or out-of-pocket maximum), and that the participant or dependent may be balance billed.

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 Non-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 a Network Provider,

– With cost-sharing requirements calculated as if the total amount charged for the items and services by such Network provider 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 a Network Provider.

Timing Requirement for Payment of Emergency Services, Non-Emergency Services at Network Facilities by Non-Network Providers, and Air Ambulance

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Services at Network Facilities by Non-Network Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-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.

If a Non-Network provider or facility and the plan enter into the Independent Dispute Resolution (IDR) process under the federal No Surprises Act (Public Law 116-260, Division BB) and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service, the allowable amount is the amount of such determination. The participant or dependent has no right nor obligation to participate in any IDR process under the federal No Surprises Act.

Effective January 1, 2023, in **Claims and Appeals Procedures for the Indemnity Medical Plan,** subsection **External Review Process** on page 116, the following section is added:

External Review of Certain Claims for Emergency Services, Non-Emergency Services from Non-Network Provider at Network Facility, and Air Ambulance Services

This voluntary External Review process is intended to comply with the No Surprises Act external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

External Review is only applicable in certain cases. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim is denied and is a claim for emergency services, non-emergency services from a Non-Network provider at a Network facility, or air ambulance.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

Generally, you may only request external review after you have exhausted the Plan's internal claims and appeals process described above. This means that, generally, you may only seek external review after a final determination has been made on your appeal.

Chairman	Secretary
5/2/2024 | 3:07 PM EDT	5/2/2024 | 1:56 PM EDT
Date	Date