AMENDMENT TWENTY-EIGHT
to the
SACRAMENTO INDEPENDENT HOTEL, RESTAURANT AND TAVERN EMPLOYEES WELFARE PLAN

Recitals

WHEREAS, the Board of Trustees of the Sacramento Independent Hotel, Restaurant and Tavern Employees Welfare Plan ("Plan") hereby (based on a good faith interpretation) amends the recently restated Plan rules to comply with Division BB of the Consolidated Appropriations Act of 2021, as it relates to the No Surprise Act (Title I) and Transparency (Title II) provisions that have not been delayed under DOL FAQ Part 49 (August 20, 2021), regarding transparency in identification cards, provider directory information, continuity of care, patient protections, independent dispute resolution process, external review as it relates to certain surprise billing items & services, and prohibition against balance billing with respect to out-of-network emergency services, non-emergency services provided by a non-network provider at in-network facility, and out-of-network air ambulance services, effective for the **Plan year beginning on or after July 1, 2022**;

WHEREAS, the Plan is a Non-Grandfathered, self-funded group health plan (with fully-insured HMO options) under the Patient Protection & Affordable Care act and must comply with the CAA provisions;

WHEREAS, the Plan currently has a Joint Administrative Services Agreement with Aetna for its self-funded medical, surgical, mental health and substance abuse benefits and most of these new provisions will also be implemented through Aetna;

WHEREAS, Kaiser and WHA will be responsible for complying and implementing these new provisions for the Plan's insured HMO options with those carriers;

WHEREAS, in response to a U.S. District Court Case in *Texas Medical Association et al v. U.S. Department of Health & Human Services, et al.* (No. 6:21-cv-425 E.D. Tex.) which invalidated portions of the interim final rule governing aspects of the federal Independent Dispute resolution process, the Departments of Health and Human Services, Labor and Treasury jointly released guidance indicating that effective immediately it has withdrawn guidance that refers to the portions of the No Surprise Act that the court invalidated but the Court's order does not affect any of the Departments' other rulemaking under the No Surprises Act, and therefore the Plan rules as it relates to the IDR process will hereinafter comply with this Court case and any applicable forthcoming guidance, regulations issued by the Departments;

WHEREAS, the Board of Trustees of the Plan believes it is in the best interest of its eligible Plan Participants and Dependents to adopt this amendment; and

THEREFORE, the Board of Trustees amends the Plan's rules and regulations (both the Summary Plan Description and Plan Document), as follows:

Amendment

Effective July 1, 2022, Items. "2.", "13.", "18.", "20" and "30." of Article I, DEFINTIONS of the SIHRTE WELFARE PLAN's Summary Plan Description (which is also the Plan Document) is amended and New Items "31." to "34." are added, as follows:

(2) **Allowable Expenses** – means a health care service or expense, including coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Plans covering the person. If you are covered by more than one medical or dental plan, Allowable Expenses under Coordination of Benefits means any necessary reasonable and customary item of medical or dental expense incurred, a portion of which is covered under one of the plans, covering the person for whom the claim is made. If this is the only plan involved, Allowable Expenses are any necessary, reasonable and customary items of medical or dental expense covered by this Plan. In all cases this Plan's maximum benefit is the limit that will be paid by this Plan. The following are examples of expenses and services that are not allowable expenses:

- If person is covered by two or more plans that compute benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
- The amount a benefit is reduced or not reimbursed by the primary plan because a covered person does not comply with the plan provisions (i.e., second surgical opinions, precertification of admissions, preferred provider arrangements) is not an allowable expense

Effective July 1, 2022, for the following Covered Items and Services under the No Surprise Act only: (1) Emergency services, (2) non-emergency services provided by a Non-Contract Provider at a Contract facility and (3) Covered Air Ambulance Services, the Allowable Charge or Allowable Expense or Covered Expense is the "Recognized Charges/Amount" for Covered Items and Services under the No Surprise Act. See definition for "Recognized Charges/Amounts" below.

(13) **Emergency Services** – means, with respect to an Emergency Medical Condition—

(a) (a) Effective July 1, 2022, a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and pre-stabilization services and treatment to stabilize an individual (regardless of the department of the hospital in which such examination or treatment is furnished), and

(b) (b) Such further medical examination and treatment (for emergency Services furnished by a Non-preferred provider or Non-preferred emergency facility regardless of the department of the hospital in which such items or services are furnished), to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient 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:

1. The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or
2. The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract 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 Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and
3. The participant or dependent gives informed consent to continued treatment by the Non-Contract provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract provider may result in greater cost to the participant or dependent.

Effective July 1, 2022, the emergency department of a hospital also includes an independent freestanding emergency department which means a health care facility that is geographically separate, distinct, and licensed separately from a hospital and provides emergency services.

(18) **Life Threatening Condition** – Effective July 1, 2022, to comply with the No Surprise Act definition of an Emergency Condition, life threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted, as determined by ~~a health care professional~~ a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in likelihood of death.

(20) **Medically Necessary** – means a procedure, treatment, service, supply, equipment, drug or medicine that a licensed physician, dentist or other medical/mental health practitioner, would provider to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, condition, disease, or its symptoms and that meets generally accepted standards of medical practice. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, and following the standards set forth in clinical policies and applying clinical judgment.

(30) **Recognized Charges/Amounts** – means the negotiated charge contained in an agreement the claims administrator has with the provider either directly or indirectly through a third party**…**

(The following is added after the last paragraph in this section on page 8 of the SPD.)

Involuntary Services and Surprise Bills. There may be times when you unknowingly receive services or do not consent to receive services from an out-of-network provider, when where you try to stay in the network for your covered services. A federal law called the No Surprises Act protects you from surprise bills by limiting cost sharing and prohibiting balance billing by out-of-network providers. Effective July 1, 2022, the following type of claims only for which an out-of-network provider may not bill you for amounts above what is eligible for coverage are: (1) Emergency services, (2) Non-emergency services provided by a Non-Contract Provider at a Contract facility and (3) Covered Air Ambulance Services, the Recognized Charge or Amount means (in order of priority) one of the following:

(i) If applicable, the amount determined by All-Payer Model Agreement under Section 1115A of the Social Security Act;
(ii) If applicable, the amount specified by State law (as applied to plan regulated by state law);
(iii) The lesser of the billed amount charged by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by Non-Contract providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

(31) **Qualifying Payment Amount-** means the amount calculated using the method described in the No Surprise Act regulations under 29 CFR 716-6(c).

(32) **Ancillary Services-** means with respect to a Preferred Provider facility:

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, and intensivists;
3. Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
4. Items and services provided by a Non-Preferred provider if there is no preferred provider who can furnish such item or service at such facility.

(33) **Independent Free Standing Emergency Department** means a health care facility that is geographically separate, distinct, and licensed separately from a hospital under applicable state law and provides emergency services.

(34) **Serious and Complex condition** means with respect to a participant or dependent, one of the following:

(i) 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;

(ii) in the case of a chronic illness or condition, a condition that is a life threatening, degenerative, potentially disabling or congenital; and requires specialized medical care over a prolonged period of time.

Effective July 1, 2022, Section F. "Emergency Services." of Article IX, CLARIFICATIONS OF INDEMNITY PLAN BENEFITS to the SIHRTE WELFARE PLAN's Summary Plan Description (which is also the Plan Document) is amended, as follows:

F. Emergency Services

If you require Emergency Care (see definition of Emergency Care on page 2) and use the services of a non-PPO Hospital emergency facility or comparable facility, no additional Hospital deductible or reduction of benefits will apply to you. However, if you use the services of a non-PPO Hospital emergency facility or comparable facility and the condition for which you received treatment did not

require Emergency Care (that is non-life threatening) (see Definition of Emergency Care and Life-Threatening Condition on pages 2 and 3), an additional $150 Hospital deductible and reduction of benefits will apply. The following benefits are payable from the Indemnity Plans A and B when you obtain services in an emergency facility:

	Indemnity Plan A (High Plan)		**Indemnity Plan B (Low Plan)**	
	PPO PROVIDER	NON- PPO PROVIDER	PPO PROVIDER	NON- PPO PROVIDER
Emergency Treatment	90% of negotiated PPO contracted rater after satisfying Annual Deductible plus $150 co-payment*.	90% negotiated PPO contracted rate after satisfying Annual Deductible plus $150 co-payment*.	80% of negotiated PPO contracted rate after satisfying Annual Deductible plus $150 co-payment*.	80% of negotiated PPO contracted rate after satisfying Annual Deductible plus $150 co-payment*.
Non-Emergency Treatment (not life threatening)	60% of the UCR Rate after satisfying Annual Deductible and an additional $150 deductible penalty.	60% of the UCR Rate after satisfying Annual Deductible and an additional $150 deductible penalty.	50% of the UCR Rate after satisfying Annual Deductible and an additional $150 deductible penalty.	50% of the UCR Rate after satisfying Annual Deductible and an additional $150 deductible penalty.
Out of Country Emergency Claims OUTSIDE OF THE UNITED STATES OF AMERICA, ITS TERRITORIES AND ITS PROTECTORATES	90% of the Sacramento, California UCR Rate after satisfying his or her Annual Deductible plus $150 co-payment. If a UCR Rate cannot be determined, the claim will be paid at 90% of billed charges, not to exceed $500 per day.		80% of the Sacramento, California UCR Rate after satisfying his or her Annual Deductible plus $150 co-payment. If a UCR Rate cannot be determined, the claim will be paid at 80% of billed charges, not to exceed $500 per day.	
Out of Country Non-Emergency Claims OUTSIDE OF THE UNITED STATES OF AMERICA, ITS TERRITORIES AND ITS PROTECTORATES	60% of the Sacramento, California UCR Rate after satisfying his or her Annual deductible. If a UCR Rate cannot be determined, the claim will be paid at 60% of billed charges, not to exceed $500 per day.		50% of the Sacramento, California UCR Rate after satisfying his or her Annual deductible. If a UCR Rate cannot be determined, the claim will be paid at 50% of billed charges, not to exceed $500 per day.	

*Copayment is waived if admitted to the Hospital at the time of visit for emergency care. For emergency treatments with Non-PPO Provider, must transfer to a PPO hospital as soon as it is determined medically feasible.

It will save you money and it will save the Trust money if you use the emergency room only for conditions that require Emergency Care.

Effective July 1, 2022, **Emergency Services** (as defined in the Definitions section) will be covered:

(i) without prior authorization regardless of whether received in-network or out-of-network;
(ii) without regard as to whether provider furnishing the emergency service is a contract provider or a contract emergency facility, as applicable, with respect to the services,
(iii) without conditions such as denials based on final diagnosis codes,
(iv) without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, any permissible waiting periods or applicable cost-sharing requirements,
(v) without administrative requirements or limitations that are more restrictive than those applied to in-network emergency services and facilities,
(vi)Any cost-sharing for out-of-network emergency items and services will not be greater than the in-network cost sharing amount that would apply had the items and services been provided by a participating provider or participating emergency facility,
(vii) Any cost-sharing payments made by the participant or dependent will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider or participating emergency facility,
(viii) Covered services include services to evaluate and stabilize an emergency medical condition in a hospital emergency room,
(ix) Coverage for Emergency Services will continue until the following conditions are met: (a) Participant or Dependent is evaluated and condition is stablilized; and (b) Attending physician determines participant or dependent is medically able to travel or to be transported, by non-medical or non-emergency transportation to another provider if you need more care. If the conditions are met and you continue to stay in the hospital (emergency admission) or receive follow-up care, Aetna does not consider this emergency services and different benefits and requirements apply.

If you go to an emergency room for what is not an emergency medical condition, the Plan may not cover your expenses.

If you have any questions about using your medical plan, call the Trust Fund Office at (925) 398-7044 or (877) 893-1500.

Effective July 1, 2022, New Item. "12." is added to Section C. "Other Covered Indemnity Plan Benefits" of Article IX, CLARIFICATIONS OF INDEMNITY PLAN BENEFITS to the SIHRTE WELFARE PLAN's Summary Plan Description (which is also the Plan Document) is amended, as follows:

(12) **Non-Emergency Services Provided by Out-of-Network Provider at In-Network Facility.** Effective July 1, 2022, medically necessary Non-Emergency items, services and visits that are otherwise covered by the Plan (which may include equipment, devices, telemedicine, imaging services, lab work, preoperative and postoperative services) performed by Non-contract providers at In-network facilities (for which the participant or

dependent has not knowingly and voluntarily provided consent pursuant to the No Surprise act patient consent and notice requirements) are covered by the Plan as follows:

(i) Cost-sharing will not be greater than the in-network cost sharing amount that would apply if the non-emergency items and services had been provided by a contract provider,
(ii) Any cost-sharing payments made by the participant or dependent will count towards, if any, the Plan's applicable deductible and out-of-pocket maximums as if the non-emergency items and services were provided by a contract provider, and
(iii) **Non-emergency Health Care Facilities** include hospitals (as defined in the Social Security Act Section 1861(e)), hospital outpatient department, critical access hospitals (as defined in the Social Security Act section 1861(mm)(1)) and ambulatory surgical centers (as defined in the Social Security Act Section 1833(i)(1)(A)).

Participants and dependents can knowingly and voluntarily agree to be balance billed including waiving the protections that limit cost-sharing for **Certain Non-emergency services** and **Post-stabilization services** provided the following informed Patient consent and Notice requirements under CAA Section 2799B-2(d) are met:

(i) Notice and consent must be provided together and be physically separate from any other documents by Provider/Facility;
(ii) Must be provided at least 72 hours prior to the scheduled appointment, or if same day no later than 3 hours prior to appointment;
(iii) Notice and consent must list provider's name, good faith estimate for items or services reasonably expected to be provided, statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and in-network cost sharing will apply in such cases), and must be available in 15 most common languages in the geographic region; and
(iv) Copy of signed consent must be provided to patient (via in-person or through mail or email) method selected by patient.

However, providers/facilities **cannot** ask participants and dependents to give up protections not to be balance billed for:

(i) Emergency services;
(ii) Air ambulance services;
(iii) Ancillary services at in-network hospital or ambulatory surgical center, such as emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeon care, hospitalists, intensivists and diagnostic care such as radiology and lab work; and
(iv) Non-emergency services, if no in-network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

The Board of Trustees has added NEW Section. (3) CONSOLIDATED APPROPRIATIONS ACT to ARTICLE VII. "OTHER FEDERAL MANDATES" of the SIHRTE WELFARE PLAN's Summary Plan Description (which is also the Plan Document), as follows:

(3) CONSOLIDATED APPROPRATIONS ACT OF 2021 ("CAA")

Effective July 1, 2022, the Plan rules have been amended to comply with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA.

1. **Identification Cards (CAA Section 107).** The Indemnity Plan and the Insurer's Identification Cards (physical or electronic) issued to participants or eligible dependents will include:
   (a) the amount of the in-network and out-of-network (if any) deductible and out-of-pocket maximums,
   (b) telephone number and website address to seek further consumer assistance.

2. **Ensuring Continuity of Care/Keeping a Provider or Facility You Go To Now (CAA Section 113).** You may have to find a new provider when you newly join the plan and the provider or facility you have now is not in the network or the provider/facility stops being in your network while you are a current participant or dependent. When a medical/mental health/substance abuse provider or contracted facility is removed from the Plan or Insurer's coverage, following termination of the provider/facility contract between the Indemnity Plan and/or Insurer and the Provider/Facility, the Indemnity Plan (through Aetna) and the respective Insurers (ex. Kaiser and WHA) for the insured HMO policies, will timely notify participants or their eligible dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that: (a) the Provider/Facility is no longer part of the Plan's network and (2) the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had termination not occurred. You should submit a request to keep going to your current provider or facility to Aetna if you are under the self-funded indemnity plan or to Kaiser or WHA directly if you are enrolled in the HMO plan options.

3. **Accuracy of Provider Directory Information (CAA Section 116).**
   (c) ***Verification Process.*** Not less frequently than once every ninety (90) days the Indemnity Plan (through Aetna) and Insurer (through Kaiser and WHA) will verify and update its provider directory information included on the Indemnity Plan and Insurer's database. Providers are required to submit regular updates to the plan to assist with the verification and update process, including notice of material changes to their provider directory information. The database of provider directories must then be updated within two (2) business days of the plan receiving such data from the providers.
   (d) ***Response Protocol.*** The Indemnity Plan or Insurer (for the Kaiser and WHA options) will respond to a participant or dependent's request (whether by telephone, electronic, web-based or internet-based), within one (1) business

day of the request, about a provider's network status. The Plan must also retain communication records for two (2) years.

(e) ***Database.*** The Indemnity Plan or Insurer (for the Kaiser and WHA options) will maintain a public website directory that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections and appropriate federal and state agency contacts to report violations.

(f) ***Cost-Sharing for Services provided Based on Reliance on Incorrect Provider Network Information.*** If participant or dependent provides documentation (ex. received through database, provider directory or response protocol) that he/she received and relied on incorrect information from the Indemnity Plan or Insurer (for the Kaiser and WHA options) about a provider's network status prior to the visit and the item or services would otherwise be covered under the plan if furnished by a participating provider/facility, the Indemnity Plan or Insurer (for the Kaiser and WHA options) cannot impose cost-sharing amount greater than in-network rates and it must count towards the participant or dependent's in-network out-of-pocket maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of the in-network cost-sharing amount and the enrollee pays, the provider must refund that excess amount with interest.

4. <u>Surprise Billing Protections (CAA Sections 102 and 105).</u>

(a) ***Balance Billing Prohibition.*** Participants and dependents are prohibited from being balance billed for (1) **out-of-network emergency services**, (2) **non-emergency services performed by an out-of-network provider received at in-network facility**, and (3) **out-of-network air ambulance services**. Providers are prohibited from holding patients liable for excess amounts not covered by the Plan.

(b) ***Cost-Sharing Limits.*** In addition, for the three above-mentioned surprise items and services (#1, #2 and #3) any cost-sharing (such as copayment, coinsurance or deductible) must not be greater than the in-network cost sharing amount and must count towards the Plan's in-network deductible and out-of-pocket maximums, as of the items and services were provided by a participating provider. The participant or dependent's cost-sharing is based on the recognized amount. By statute, the recognized amount is (in order of priority) for only out-of-network emergency services and non-emergency services provided by an out-of-network provider at participating facilities:

(1) Amount determined by All-Payer Model Agreement, if applicable;

(2) Amount under specified state law (as applied to plans regulated by state law);

(3) The lesser of the billed charge or **Qualifying payment amount** (is the median of the contracted rates for similar services in a particular geographic area-based on the metropolitan statistical area adjusted by the consumer price index for inflation for items or services furnished during 2023 or subsequent years).

For out-of-network air ambulance bills the cost-sharing limit must be calculated by using the lesser of the: (1) billed charge or (2) qualifying payment amount.

(c) ***Determination of Out of Network Rates.*** By statute, the total amount to be paid to a provider/facility must be based on (less any cost-sharing from participant or dependent) the following out-of-network rate, in order of priority:

(1) Amount determined by All-Payer Model agreement, if applicable (does not apply to this Plan),

(2) Amount under specified state law (as applied to plans regulated by state law and does not apply to this Plan);

(3) Amount agreed upon by Plan/Insurer and Provider/Facility; and

(4) Amount determined by Independent Dispute Resolution Entity.

5. <u>Patient Protections Disclosure Requirements Against Balance Billing</u>

The Indemnity Plan or Insurer (for the Kaiser and WHA options) are required to make publicly available, by posting on the website of the Plan or Insurer and including on each Explanation of Benefits for an item or service as it relates to:
(1) emergency services or
(2) non-emergency services provided by non-participating provider at in-network facility, balance billing and patient protections in certain circumstances and appropriate government agency contact information if the participant or dependent believes the provider/facility has violated the No Surprise Act provisions.

6. <u>Out-of-Network Rate Independent Dispute Resolution Process for Certain No Surprise Act Items and Services (CAA Section 103).</u>

A federal Independent Dispute Resolution ("IDR") process (also known as an arbitration procedure) is required for disputes involving out-of-network rates between the Plan/Insurer and Out-of-Network provider/facility ("**disputing parties**") as it relates only to: (1) out-of-network emergency services, (2) non-emergency services provided by a non-network provider at an in-network facility and (3) out-of-network air ambulance services. Not all items and services are eligible for the federal IDR process. But, before initiating the IDR process, the disputing parties must first initiate a 30-day open negotiation period (meaning must engage in open negotiations within 30 days of receiving initial payment or denial) to settle an out-of-network payment rate for covered items and services under the No Surprise Act. However, the Trust Fund reserves the right at any time in its sole discretion to settle a claim by agreement with a

Non-Contract Provider, provided that, if the settled Claim is covered by the No Surprise Act the settlement does not result in higher participant or dependent cost-sharing as permitted under the No Surprise Act. If any federal court case including, government guidance, regulations, and/or subsequent law invalidates any portion of the IDR process, as it relates to the No Surprise Act, then the invalidated portions will also not apply to this Plan.

In case of a failed open negotiation period, either party may initiate the federal IDR process as follows:

Independent Dispute Resolution	**Timeline**
Initiate **30 business day** open negotiation period	**30 business days** starts on date of initial payment or notice of denial of payment
Initiate IDR process following failed open negotiation	**4 business days** starts the business day after open negotiation period ends
Mutual Agreement on certified IDR entity selection	**3 business days** after IDR initiation date
Departments select certified IDR entity in the case of no conflict-free selection by the parties	**6 business days** after the IDR initiation date
Submit payment offers and additional information to certified IDR entity	**10 business days** after date of certified IDR entity selection
Payment determinations made (*certified IDR issue binding determination selecting one of the parties' offers as the payment amount)*	**30 business days** after the date of certified IDR entity selection
Payment submitted to the applicable party	**30 business day**s after the payment determination

Both parties are responsible for an administrative fee and the non-prevailing party is responsible for the certified IDR entity fee for the use of this process. The 2022 administrative fee and allowable IDR entity fee ranges is available at: Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov)

Batched Items and Services. Batching means multiple items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the federal IDR process. Batching is also allowed for claims submitted within a 30-day period that meet the following criteria:

- Services furnished by the same provider or facility
- Services provided to participants and dependents under the same plan
- Services for treatment of similar conditions.

The party that initiated the IDR process cannot initiate a new IDR process with the same party and for same services for 90 days. However, on the 90 day period is up, the party may submit (appropriately batched) claims from that 90-day period to IDR.

Factors Considered by IDR Entity.
When making a payment determination, the certified IDR entities must begin with the presumption that the Qualifying Payment Amount is the appropriate out-of-network amount. If a party submits additional information that is allowed under the statute, then the certified IDR entity must consider the information if it is credible. For the IDR entity to deviate from the offer closest to the Qualifying Payment Amount, any information submitted must clearly demonstrate that the value of the item or services is materially different from the QPA.

Within 30 days, the IDR entity selects one of the offers submitted and must consider:
• Offers by both parties; and
• Qualifying payment amount for the same service in the same geographic region.

The IDR entity can also consider the following factors:
• Training, experience, quality, and outcomes measurements;
• Market shares of parties;
• Acuity of patients/complexity of cases;
• Teaching status, case mix, scope of services of facility; and
• Good faith efforts by parties to contract and contracting rate history from last four years.
The IDR entity cannot consider:
• Usual and customary rates;
• Billed charges; and
• Payment rates by public payors, including Medicare, Medicaid, CHIP, and Tricare

Effective July 1, 2022, Subsection B.1 of the "EXTERNAL REVIEW FOR INDEMNITY MEDICAL AND DENTAL AND PRESCRIPTION DRUG CLAIMS" of Article XVIII., CLAIMS PROCEDURES to the SIHRTE WELFARE PLAN's Summary Plan Description (which is also the Plan Document) is amended, as follows:

B. Standard External Review of Claims for Benefits

1. Request for External Review. If you receive a notice of denial either at the claim level or any of the mandatory levels of appeal with respect to medical, dental or prescription drug benefits, you or your authorized representative have the option to file a written request for an external review with the Trust Fund Office, provided the request is filed within four months after the date of receipt of the denial notice. (Note: For prescription drugs, the claims administrator is Magellan RX.) If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For

example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Effective July 1, 2022, External review is available only for those claims that involve:

(1) Medical judgment (e.g., a claim that is denied on the basis of medical necessity or because a treatment is experimental or investigational), as determined by the external reviewer; or
(2) Rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time); or
(3) Plan's failure to adhere to its Internal Claims and Appeals Process without meeting an exception ("Deemed Exhaustion Rule"); or
(4) Certain No Surprise Act Claims under CAA Section 110 as discussed below:

External Review of Certain No Surprise Act Claims (CAA Section 110). This External Review process is intended to comply with the No surprises Act external review requirements. The Plan will comply with an applicable external review process, as described in 26 CFR 54.9815-2719(d), 29 CFR 2590.715-2719(d), and 45 CFR 147.136(d) and any subsequent implementing regulations. As such, eligible participants and dependents have the right to request external review after he/she has exhausted the Plan's current internal claims and appeals rules, upon receipt of an adverse benefit determination as it relates to whether the Plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations for certain No Surprise Act claims and services mentioned in this section. This means that, generally, you may only seek external review after a final determination has been made on your appeal. **External Review is available only with respect to the following types of claims (whether urgent, concurrent, pre-service or post-service claim is denied**):

(1) out-of-network emergency services,
(2) non-emergency services provided by a non-network provider at an in-network facility and
(3) out-of-network air ambulance services.

External review is permitted only in certain cases for adverse benefit determinations (including a final internal adverse benefit determination) by the plan or insurer that involves medical judgment, including but not limited to, those based on the plan's or insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, as well as a consideration of whether the plan or insurer is complying with the surprise billing and cost sharing protections under ERISA sections 716 and 717 and §§ 2590.716-4 through 2590.716-5 and 2590.717-1.

To illustrate, the scope of claims eligible for external review include:

(i) Whether a particular item or service constitutes treatment for emergency services.
(ii) Whether services provided by an out-of-network provider at in in-network facility is subject to the No Surprise Act.
(iii) Whether an individual was in a condition to receive Patient protection notice under the No Surprise Act and able to waive the right to those protections.

(iv) Whether a provider has coded the claim correctly, consistent with the treatment the patient actually received.

(v) Whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility.

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.

Approved: _____, 2022

LABOR TRUSTEES

DocuSigned by:
A241FE21D85845D...
Ty Hudson, Chair

DocuSigned by:
Aamir Deen
5915D8637D434A3...
Aamir Deen

DocuSigned by:
331C9DAEB0A84B2...
Regina Longo

DocuSigned by:
651E5615E946405...
Alejandro Rayburn

MANAGEMENT TRUSTEES

DocuSigned by:
Sandra Parker
B4D36B7BEBD9482...
Sandy Parker, Co-Chair

DocuSigned by:
Jeroen Gerrese
15132D7E0BC949F...
Jeroen Gerrese

DocuSigned by:
Marta Rodriguez
2B326C4F710E468...
Marta Rodriguez

DocuSigned by:
GS Walia
F25DBF5DD41E448...
Bobby Walia