# SHEET METAL WORKERS LOCAL 104 HEALTH CARE PLAN
## (As revised January 2021)

Amendment 10

Pursuant to the authority set forth in Article VII of the Agreement and Declaration of Trust, the Trustees hereby amend the Sheet Metal Workers Local 104 Health Care Plan as follows:

1. Item 1 in the subsection entitled "Out-Of-Pocket Maximum" under "Medical Benefits" section is revised to read as follows:
    1. Expenses relating to the use of Non-PPO providers except services covered by the No Surprise Act, including:
        - Emergency Services for an Emergency Medical Condition from a Non-PPO Provider or a Non-PPO Facility (unless you received proper notice and consented to the Non-PPO Provider or facility billing rates for post-stabilization services), or,
        - Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility (unless you received proper notice and consented to the Non-PPO Provider billing rates), or
        - Air Ambulance Services from a Non-PPO Provider.

2. A new number 5 is added to the end of the subsection "How to Use the Preferred Provider Network" under "Important Cost Containment Information" section to read:

    5. If you obtain and rely upon incorrect information provided by the Plan about whether a provider is a PPO Provider from the Plan or its administrators, the Plan will apply the PPO Cost-sharing Amount to your claim, even if the provider was a Non-PPO Provider.

3. A new paragraph is added to the end of the subsection "How to Use the Preferred Provider Network" under "Important Cost Containment Information" section to read:

### CONTINUITY OF COVERAGE

If you are a Continuing Care Patient, and the contract with your PPO 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 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 the Contracted Cost-Sharing Amount to allow for a transition of care to a PPO Provider.

4. The following three new paragraphs are added to "Description of Covered Medical Services" section to be incorporated in alphabetical order:

**AIR AMBULANCE SERVICES**

If you receive Air Ambulance services from a Non-PPO Provider that are otherwise covered by the Plan, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO 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 a PPO Provider.

- The Cost-sharing Amount will be calculated as if the total amount that would have been charged for the services by a PPO 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 PPO deductible and PPO out-of-pocket maximum in the same manner as those received from a PPO Provider.

- In general, you cannot be Balance Billed for these items or services.

**EMERGENCY SERVICES**

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided by a Non-PPO Provider;

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

- Without imposing any administrative requirement or limitation on Non-PPO Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO Providers and PPO emergency facilities;

- Without imposing Cost-sharing requirements on Non-PPO Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO Provider or a PPO emergency facility;

- By calculating the Cost-sharing requirement for Non-PPO 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 PPO deductible or PPO Out-of-Pocket Maximums applied under the Plan (and the PPO deductible and PPO 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 PPO Provider or a PPO emergency facility.

In general, you cannot be Balance Billed for these items or services. The Cost-sharing Amount for Emergency Services from Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).

## NON-EMERGENCY ITEMS OR SERVICES FROM A NON-PPO PROVIDER AT A PPO 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 a Non-PPO Provider at a PPO 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 PPO Provider,

- By calculating the Cost-sharing requirements as if the total amount that would have been charged for the items and services by such PPO 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 PPO deductible and PPO out-of-pocket maximums applied under the Plan (and the PPO 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 PPO Provider, and

- In general, you cannot be Balance Billed for these items or services.

Non-emergency items or services performed by a Non-PPO Provider at a PPO facility will be covered based on the Plan's definition of Allowed Charge and forgo the financial protections of the No Surprise Billing Act if:

1. 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 that the provider is a Non-PPO Provider with respect to the Plan, an estimate of the charges for the treatment and any advance limitations that the Plan may put on the treatment, the names of any PPO Providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the PPO Providers listed; and

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

The notice and consent exception for non-emergency items or services performed by a Non-PPO Provider at a PPO facility 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-PPO 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 PPO 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,

- With Cost-sharing for items and services so furnished counted toward any PPO deductible and PPO out-of-pocket maximums, as if such Cost-sharing payments were made for items and services furnished by a PPO Provider, and

- In general, you cannot be Balance Billed for these items or services.

The Cost-sharing Amount for non-emergency services at PPO Facilities by Non-PPO Providers will based on the Recognized Amount, which is, generally, the lesser of the billed charges from the Non-PPO Provider or the Qualifying Payment Amount (i.e., the Plan's median of contracted rates for the item or service in that location).

5. Number 33 is under "Medical Plan Exclusions" is revised to read as follows:

   33. Any **transportation**, other than professional ambulance service or air ambulance service, except as pre-approved by the Plan.

6. A new subsection entitled "**Payments to Non-PPO Providers and Facilities"** is added after subsection "Limitations of Liability" under the Claims and Appeals Procedure section to read:

   PAYMENTS TO NON-PPO PROVIDERS AND FACILITIES

   The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance services within 30 calendar days of receiving a claim from the Non-PPO Provider or Air Ambulance 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 Amount under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required Cost-sharing Amount.

   The Plan will pay a total plan payment directly to the Non-PPO 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.

7. A new number 2 and number 3 are added to subsection "Provisions Under the Affordable Care Act" in the "Claims and Appeals procedure" section. Number 2 – 6 are renumbered accordingly.

    2. The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.

    3. The adverse benefit determination involves a claim subject to the protections of the No Surprises Act for Emergency Services, services of a Non-PPO Provider at a PPO Facility, or Air Ambulance Services.

8. The following terms are added to the "Definition of Terms" section, to be placed alphabetically.

**EMERGENCY MEDICAL CONDITION**

The term "Emergency Medical Condition" means a medical condition, including mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Final determination as to whether services were rendered in connection with an Emergency will be made by the Plan or, where applicable, Independent Review Organization.

**NON-PPO PROVIDER**

The term "Non-PPO Provider" shall mean a Hospital, Physician, or other Health Care Provider that does not contract with the Plan's contracting organizations to provide health care services and supplies at negotiated rates 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.

**AIR AMBULANCE**

The term "Air Ambulance" means medical transport for patients 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.

## ANCILLARY SERVICES

The term "Ancillary Services" means, with respect to services furnished by Non-PPO Providers at a PPO 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 other specialty practitioners as specified by the Secretary; and
- Items and services provided by a Non-PPO Provider if there is no PPO Provider who can furnish such item or service at such facility.

With respect to Hospital Services (Inpatient), Ancillary Services also include services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

## CONTINUING CARE PATIENT

The term "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.

## COST-SHARING/COST SHARING AMOUNT

The term "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 Non-PPO 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 PPO Facilities performed by Non-PPO Providers, and Air Ambulance services from Non-PPO Providers will be based on the Recognized Amount.

## EMERGENCY SERVICES

The term "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 a Non-PPO Provider or Non-PPO Emergency Facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services were furnished, until:

- The attending emergency physician or treating provider determines that the participant or beneficiary is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and

- The participant or beneficiary is supplied with a written notice of the following:

    1. The provider is a Non-PPO Provider with respect to the Plan,

    2. An estimate of the charges for treatment and any advance limitations that the Plan may put on a patient's treatment,

    3. The names of any PPO Providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the PPO Providers listed; and

    4. The patient (or their authorized representative) gives informed voluntary consent to continued treatment by the Non-PPO Provider, acknowledging that the patient (or their authorized representative) understands that continued treatment by the Non-PPO Provider may result in greater cost to the participant or beneficiary.

## HEALTH CARE FACILITY

The term "Health Care Facility" (for non-emergency services) means 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

The term "Independent Freestanding Emergency Department" means 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

The term "No Surprises Act" means the No Surprises Act (Public Law 116-260, Division BB).

## NON-PPO EMERGENCY FACILITY

The term "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.

## NON-PPO RATE

With respect to Emergency Services provided by a Non-PPO Provider, non-emergency services furnished by a Non-PPO Provider at a PPO facility, and Air Ambulance Services by a Non-PPO Provider, the term "Non-PPO Rate" 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.

## OUT-OF-POCKET LIMIT ON MEDICAL PLAN PPO COST-SHARING (ANNUAL OUT-OF-POCKET LIMIT)

The No Surprises Act modifies the definition of Annual Out-of-Pocket Limit provided in the Summary Plan Description for Emergency Services, non-emergency services furnished by a Non-PPO Provider at a PPO facility, and Air Ambulance Services as follows: any Cost-sharing payments (e.g., copayments, coinsurance, and deductibles) made by the participant or beneficiary are counted towards any PPO deductible or Out-of-Pocket Limit.

## QUALIFYING PAYMENT AMOUNT (QPA)

The term "Qualifying Payment Amount" means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the Plan or issuer for the item or service in the area.

## RECOGNIZED AMOUNT

The term "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-PPO Providers, the **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

## SERIOUS AND COMPLEX CONDITION

The term "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—

    - Is life-threatening, degenerative, potentially disabling, or congenital; and

    - Requires specialized medical care over a prolonged period of time.

## TERMINATION

In the context of Continuity of Care, **Termination** includes, with respect to a contract, 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.

This Amendment 10 was adopted by the Board of Trustees on June 15, 2022. The Chairman and Co-Chairman were authorized by the Board of Trustees to execute this Amendment on their behalf. This Amendment 10 may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same Amendment 10.

DocuSigned by:
Rick Werner
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Chairman

Date: 6/22/2022 | 7:13 PM EDT

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Sean O'Donoghue
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Co-Chairman

Date: 6/22/2022 | 4:30 PM PDT