

**NORTHERN CALIFORNIA SHEET METAL WORKERS
HEALTH CARE PLAN**

(As restated January 2017)

Pursuant to the authority set forth in Articles VI and VII of the Agreement and Declaration of Trust, the Board of Trustees, acting at its meeting of November 9, 2021, amend the Plan as follows, effective January 1, 2022:

The following language is added to the “Contract (PPO) Hospitals” on p. 17:

If you are admitted to a non-contract hospital and Blue Shield certifies the admission as an emergency admission, the Plan will pay the Qualifying Payment Amount and will not impose any greater cost-sharing for emergency and post-stabilization services than would be applied at a PPO facility.

The following language replaces subsection, “Emergency admissions,” on p. 20 in its entirety:

Emergency admissions are treated and payable as contract hospital admissions. The Plan covers emergency services provided in a hospital emergency room or freestanding independent emergency department without prior authorization. The Plan currently covers 80% of the contract rate for emergency services. Effective January 1, 2022, the Plan has adopted a payment formula required by the No Surprises Act that will pay non-PPO hospitals a Qualifying Payment Amount, as defined in Appendix A. The Plan will not impose greater cost-sharing in a non-PPO facility than it would apply in a PPO facility for the same covered services. The Plan’s payment to the provider of emergency services will usually be 80% of the contract rate (if PPO) or the Qualifying Payment Amount (if not PPO) for those services.

Each time you are discharged from the hospital for more than 24 hours, the next hospitalization will be considered a new admission.

The following language replaces #1 of “Out-of-Pocket Maximum” on p. 21 in its entirety:

1. Expenses relating to the elective use of non-PPO providers, *unless* the benefits paid to non- PPO providers are for emergency and qualifying post-stabilization treatment as defined by the Plan. In addition, expenses relating to the use of non-PPO providers *will* count toward your out-of-pocket maximum if the covered services are performed by a non-PPO provider at a PPO hospital, unless you give informed consent to the non-PPO rates.

The following language replaces the first paragraph of “Medical Supplies and Services” on p. 24:

Except as noted below, the following items are paid at 80% of the contract rate (if PPO), or the Qualifying Payment Amount for non-PPO Emergency Services or non-PPO services at a PPO facility, or of Usual, Customary and Reasonable charges (if non-PPO) as defined by the Plan. Non-PPO charges will *not* count toward the out-of-pocket maximum unless they are for Emergency Services, and for Non-PPO providers at PPO facilities.

The following language is added to “Description of Covered Medical Services”:

Surprise Balance Billing Protections. The following protections apply for dates of service on or after January 1, 2022.

Balance Billing Prohibition. Providers and facilities are prohibited from balance billing you 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.

Cost-Sharing Limits. In addition, for the three above-mentioned categories of items and services 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 are applied to items and services provided by a participating provider. The participant or dependent’s cost-sharing is based on the recognized amount. The recognized amount is the lesser of the billed charge or Qualifying Payment Amount (the median of the contracted rates for the same or similar services in the applicable geographic area and adjusted for inflation in years after 2022).

Non-Emergency Services Provided by Out-of-Network Provider at In-Network Facility. Any cost-sharing for medically necessary non-emergency items, services and visits (which may include equipment, devices, telemedicine, imaging services, lab work, preoperative and postoperative services) performed by an out-of-network provider 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 requirements) will not be greater than the in-network cost sharing amount and will count towards the Plan’s applicable deductible and out-of-pocket maximums as if the non-emergency items and services were provided by a participating provider. Non-emergency health care facilities include hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgical centers.

Participants and dependents can knowingly and voluntarily agree to be balance for non-emergency services provided the following conditions are met:

- (i) The notice and consent form must be provided together and be physically separated from any other documents by Provider/Facility;
- (ii) Notice 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, a good faith estimate for items or services reasonably expected to be provided, a statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and in-network cost sharing rules will apply in such cases).
- (iv) A copy of the signed consent must be provided to patient in the method selected by patient.

Participants and dependents may not consent to balance billing for certain services:

- (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 where no in-network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

Continuity of Care. When a provider or contracted facility is removed from the Blue Shield network, the Plan or Blue Shield will notify participants and eligible dependents who are receiving continuing care for a serious and complex condition 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 the termination not occurred.

For purposes of this section, a 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.

Accuracy of Provider Directory Information. Blue Shield will maintain a public website directory, Find My Doctor, that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information).

If participant or dependent received and relied on incorrect information from the Plan or Blue Shield about a provider's network status prior to a visit, and the item or services would otherwise be covered under the plan if furnished by a participating provider/facility, the Plan will not impose a cost-sharing amount that is greater than would be applied to an in-network item or service and will count any copayment and co-insurance towards the applicable out-of-pocket maximum and in-network deductible.

The following language is added to the beginning of the section “External Review of Claims” on p. 91:

External Review is only applicable in certain cases. You may request further review by an Independent Review Organization (IRO) if your appeal for urgent care, pre-service, or post-service medical benefits was denied on the basis of a medical judgment, or if your coverage was rescinded (retroactively terminated) other than for non-payment of contributions. In addition, you may request external review whether a plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act for the following categories of claims: (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.

Appendix A, Definitions – Emergency Care, is replaced in its entirety with the following:

EMERGENCY CARE

An emergency is defined by the Plan as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 (a) a condition placing the health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Examples of emergency conditions include but are not limited to:

- severe chest pain
- loss of consciousness
- severe shortness of breath
- poisoning
- sudden onset of paralysis and/or slurred speech
- severe burns
- broken bones

- uncontrolled bleeding

Care will not be considered to be for an emergency unless it is sought immediately (usually within 24 hours) after the sudden onset of symptoms. Care will also not be considered to be an emergency unless it is provided within the emergency department of a hospital or an independent freestanding emergency department, or pre-stabilization or post-stabilization care categorized as “emergency care” by the No Surprises Act and its implementing regulations.

Post-stabilization services (*i.e.*, services provided after the patient is moved out of the emergency department and admitted to the hospital) are included in the definition of “emergency services” unless (1) the attending physician determines the patient can travel to an in-network facility using nonmedical transportation and (2) the patient gives informed consent to the out-of-network care.

The following new definition is added to Appendix A:

QUALIFYING PAYMENT AMOUNT

The Qualifying Payment Amount is the median of the contracted rates for the same or similar services in the applicable geographic area.

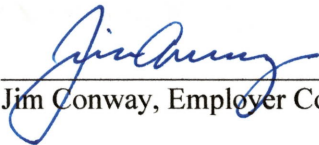
Adopted on November 9, 2021 via videoconference by unanimous consent of the Trustees. The Chairman and Co-Chairman are authorized to execute this Amendment on behalf of the Board of Trustees.



Sal Rotolo, Union Chair

02/22/2022

Date



Jim Conway, Employer Co-Chair

2/22/22

Date