AMENDMENT TO THE
SOUTHERN ILLINOIS LABORERS' & EMPLOYERS
HEALTH & WELFARE FUND SUMMARY PLAN DESCRIPTION

SUMMARY PLAN DESCRIPTION A – AMENDMENT #3
SUMMARY PLAN DESCRIPTION C – AMENDMENT #4

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fund may amend the Summary Plan Description ("SPD") pursuant to Article 13 of the Restated Agreement and Declaration of Trust; and

WHEREAS, the Board of Trustees has determined that the following revisions are necessary to clarify and amend provisions of the SPD; and

NOW THEREFORE, effective August 1, 2022, the following language and sections are hereby approved and incorporated into the SPD as follows:

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1. A new subsection entitled "**The No Surprises Act**" is added above the introductory paragraph of the SPD at Article 6 "**Covered Charges**", as follows:

The No Surprises Act

The No Surprises Act, signed into law in December 2020, protects patients who receive Emergency Services at a Hospital, at an Independent Freestanding Emergency Department and from Air Ambulances. In addition, the law protects patients who receive Emergency Services from an out-of-network provider at a network facility. Effective August 1, 2022, Participants and Dependents receiving these services, referred to collectively as No Surprises Act Services, will only be responsible for paying their network cost sharing and cannot be balance billed by the provider or facility for Emergency Services, non-emergency services from an out-of-network provider at a network facility and Air Ambulance services from out-of-network provider, as explained below.

Emergency Services. Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a network provider or a network emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from 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 network deductible or network out-of-pocket maximums applied under the Plan (and the network deductible and 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.

  Cost sharing amount for Emergency Services from out-of-network providers is the lesser of billed charges from the provider, or the Qualified Payment Amount (QPA).

Non-emergency services from an out-of-network provider at a network facility. For non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an out-of-network provider at 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; and
- 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.

When you may be billed for out-of-network providers who work at network facilities. In certain circumstances, you can be billed by an out-of-network provider who works at a network facility. This can occur if you are provided notice, as described below, that the provider is an out-of-network provider and you give your informed consent to be treated by the out-of-network provider. The out-of-network provider must give you notice that:

- is in writing;
- is provided to you at least 72 hours before the day of the appointment or at least 3 hours in advance of services rendered for a same-day appointment;
- states the provider is a out-of-network provider;
- includes the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment;
- includes the names of any network provider at the facility who are able to treat you;

- provides that you may elect to be referred to a network provider; and
- your costs may be greater if you consent to service or treatment from the out-of-network provider.

If you give informed consent to be treated by the out-of-network provider, then the Plan will pay for these services at the out-of-network rate, and the provider can bill you for the balance directly. You may revoke your consent prior to the receipt of services.

This rule does not apply to services provided by hospital-based providers, such as anesthesiologists and radiologists, also referred to as Ancillary Services, or items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished for which an out-of-network provider satisfied the notice and consent criteria described above. For Ancillary Services, your cost-sharing will be based on the Recognized Amount and any cost-sharing payments you make count toward your network deductible and network out-of-pocket maximum in the same manner as those received from a network provider.

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

- The Air Ambulance services received from an out-of-network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a network provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your network deductible and network out-of-pocket maximum in the same manner as those received from a network provider.

Payments to out-of-network providers and facilities. The Plan will make an initial payment or notice of denial of payment for Emergency Services, non-emergency services at network facilities by out-of-network providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the out-of-network provider. A "clean claim" is a claim that is accompanied by all information needed to decide, adjudicate or process the claim. 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 relates to Emergency Services, Non-emergency services from an out-of-network provider at a network facility and Air Ambulance services from out-of-network provider, you cannot be required to pay more than the network cost-sharing under the Plan, and the provider or facility is prohibited from billing a Participant or Dependent of the Plan in excess of the required cost-sharing.

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

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

- 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
- You will be allowed up to ninety (90) days of continued coverage at network cost sharing to allow for a transition of care to a network provider.

As used in this section, a termination does not include a termination of a contract for failure to meet applicable quality standards or for fraud.

External review. If your initial claim for benefits related to an Emergency Service, non-emergency service provided by an out-of-network provider at a network facility, and/or Air Ambulances service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for external review of the determination. See the section of the SPD entitled "External Review of Emergency Service, applicable Non-Emergency Service and/or Air Ambulance Services as required by the No Surprises Act".

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

Complaint process. Effective August 1, 2022, any Participant or covered Dependent, or their authorized representative, may make a complaint or raise a concern relating to the Plan's processing of any of the above-described types of claims. The complaint or concern should be directed to Heather Laughland-Etherton, Welfare Fund Administrative Manager, who is the designated Fund office contact to review all such complaints and concerns and address them in accordance with the requirements of the No Surprises Act and any other applicable law or regulations. Participants and covered Dependents also have a separate and independent right under the No Surprises Act to submit a complaint to the Department of Health and Human Services relating to the processing of the above-described types of

claims. Participants and covered Dependents may also contact the Employee Benefit Security Administration (EBSA) toll free number at 1866-444-3272.

2. The introductory paragraph in the section entitled **"Covered Medical Expenses"** at Article 6 of the Summary Plan Description is amended to read as follows:

   Except in the case of Emergency Services, non-Emergency Services from an out-of-network provider at certain network facilities, and Air Ambulance services by out-of-network providers as described above, the covered charges referred to in this provision are charges incurred for the following services and supplies which are necessary for treatment of an accidental Injury or Sickness and which are Reasonable and Customary as determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned:

3. A new subsection entitled "**Patient Protections**" is added to the **"Preferred Provider Organization"** at Article 2, Section 2.02 of the Summary Plan Description following the **"Newborns' and Mothers' Health Protection Act of 1996"** and such new subsection shall read as follows:

   The Plan does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any network or out-of-network health care provider; however, payment by the Plan may be less for the use of an out-of-network provider.

   You do not need prior authorization from the Plan, BlueCross BlueShield of Illinois, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office.

4. The **Definitions** section at Article 8 of the Summary Plan Description is amended to add the following definitions:

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

   Ancillary Services are, with respect to a network facility:

   - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
   - Items and services provided by assistant surgeons, hospitalists, and intensivists;
   - Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and

- Items and services provided by an out-of-network provider if there is no 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 out-of-network providers, or the cost of items or services that are not covered under the Plan.

Cost Sharing Amount means the Participant's cost-sharing for Emergency Services, Non-emergency Services performed by out-of-network providers at network facilities, and Air Ambulance services to be based on the Recognized Amount.

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

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- 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;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- 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.

A serious and complex condition means:

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

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services means the following:

- 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

- 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).

The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta). Emergency Services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also 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, until:

- The provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation;
- You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any in-Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-Network providers listed; and
- You give informed, written consent to continued treatment by the Out-of-Network provider, acknowledging that the Participant or Dependent understands that continued treatment by the Out-of-Network provider may result in greater cost to the participant or Dependent.

Health Care Facility for non-emergency services means each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent Freestanding Emergency Department means a health-care facility (not limited to those described in the definition of Health Care Facility for non-emergency services) 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).

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

Recognized Amount means, for items and services furnished by an out-of-network provider or out-of-network Emergency Facility, the Recognized Amount is one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

5. The **Definitions** section at Article 10 of the Summary Plan Description is further amended to include the following definition of Allowable Expense(s) Incurred, as follows, and to amend the existing definition of Allowable Expense(s), as follows:

Allowable Expense(s) for all claims except in the case of Emergency Services, non-emergency services from an out-of-network provider at certain network facilities, and Air Ambulance services from an out-of-network providers, means:

- For a network provider, the negotiated fee/rate as stated in the agreement with the participating network provider; or
- For an out-of-network provider, the amount, as determined by the Board of Trustees, that this Plan will pay for a particular service or supply.
- The Board of Trustees has determined Allowable Expense(s) to mean the amount most consistently charged by a licensed Physician or other professional provider for a given service which is not otherwise listed in the "Exclusions" section of the Summary Plan Description. An Allowable Expense refers to a charge that is within the range of usual charges for a given service billed by most Physicians or other professional providers with similar training and experience in a given geographic area. When considering the range of usual charges, the Plan may consider discounted rates allowed by network providers as a basis for Allowable Expense(s).
- The Allowable Expense or the amount paid by the Plan for any claim covered by the No Surprises Act shall be calculated as set forth in the Section of this SPD entitled "No Surprises Act."

Allowable Expenses Incurred (Expenses Incurred) means an Allowable Expense for purchases or services rendered and will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the expense is made. *Please note:* Claims should be filed within 90 days after the occurrence for which claim is being made. If it is not reasonably possible to file a claim within the 90-day period, the claim may be accepted by the Fund Office. However, claims will not be eligible for payment 12 months after the claim was incurred.

6. The following Section is added to Article 11, Section 11.07 the Summary Plan Description section entitled "**Appeal Procedure**" immediately preceding the subsection entitled "Exhaustion of Plan Remedies".

External Review of Emergency Services, applicable Non-Emergency Services and/or Air Ambulance Services as required by the No Surprises Act

I. External Review of Standard Claims

The Summary Plan Description's External Review procedures and Expedited External Review procedures are applicable to claims eligible for External Review as required by the No Surprises Act. Generally, this will pertain to denials related Emergency Service, applicable Non-Emergency Service and/or Air Ambulance Service claims as defined in the section of the Summary Plan Description addressing the No Surprises Act. All other claims (*i.e., claims that are not covered by External Review and Expedited External Review requirements of the No Surprises Act*) are subject to the Appeal Procedures section of the Summary Plan Description.

IN WITNESS HEREOF, this Amendment has been approved by the Board of Trustees and made effective as of August 1, 2022.

Chairman, Southern Illinois Laborers' and Employers Health & Welfare Fund

Secretary, Southern Illinois Laborers' and Employers Health & Welfare Fund