Amendment 1 to the
United Food and Commercial Workers
Unions and Employers Calumet Region Insurance Fund

The Trustees of the United Food and Commercial Workers Unions and Employers Calumet Region Insurance Fund ("Plan") amended and restated January 1, 2020, hereby amend the Plan, effective December 1, 2022, to comply with the No Surprises Act as follows:

1. A new Section 2.03, *Ancillary Services*, is added to Article 2, *Definitions*, with the subsequent Sections renumbered accordingly to read as follows:

Section 2.03. Ancillary Services

Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by a PPO provider at a non-PPO Health Care Facility, Ancillary Services means the following:

(a) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner,

(b) Items and services provided by assistant surgeons, hospitalists, and intensivists;

(c) Diagnostic services, including radiology and laboratory services;

(d) Item and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and

(e) 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.

2. Section 2.22 (formerly 2.21), *Emergency Medical Condition*, under Article 2, *Definitions*, is amended to read as follows:

Section 2.22. Emergency Medical Condition

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 an average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in:

- The patient's health (or with respect to a pregnant woman, the health of her unborn child) being placed in serious jeopardy;
- Serious impairment of bodily function; or
- Serious dysfunction of a bodily organ or part.

3. Section 2.23 (formerly 2.22), *Emergency Services*, under Article 2, *Definitions*, is restated in its entirety to read as follows:

Section 2.23. Emergency Service(s)

Emergency Service(s) means:

(a) An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department meaning, a Health Care Facility that is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(b) 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).

(c) Emergency Services furnished by a non-PPO provider or at a non-PPO Hospital (regardless of the department of the Hospital in which such items or services are furnished) or an independent freestanding emergency department 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 related to the Emergency Medical Condition, until:

(i) The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and

(ii) The patient or their representative is supplied with a written notice, as required by federal law, that the provider is a non-PPO provider with respect to the Plan, an estimate of the charges for 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

(iii) The patient or their representative gives informed written voluntary consent to continued treatment by the non-PPO provider, acknowledging that the patient understands that continued treatment by the non-PPO provider may result in greater costs to the patient.

4. A new Section 2.29, *Health Care Facility*, is added to Article 2, *Definitions*, with the subsequent Sections renumbered accordingly to read as follows:

Section 2.29. Health Care Facility

Health Care Facility (for non-Emergency Services) means each of following:

(a) A Hospital (as defined in section 1861(e) of the Social Security Act);

(b) A Hospital outpatient department;

(c) A critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

(d) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

5. A new Section 2.45, *No Surprises Act and No Surprises Act Services*, is added to Article 2, *Definitions*, with the subsequent Sections renumbered accordingly to read as follows:

Section 2.45. No Surprises Act and No Surprises Act Services

The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 27, 2020, as part of the Consolidated Appropriations Act of 2021. The term "No Surprises Act Services" means the following, to the extent covered under the Plan: (1) non-PPO Emergency Services, (2) non-PPO Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a non-PPO provider at a PPO facility; and (4) other non-PPO non-Emergency Services performed by non-PPO provider at a PPO facility with respect to which the provider does not comply with written federal notice and consent requirements.

6. A new Section 2.48, *Out-of-Network (Non-PPO) Rate*, is added to Article 2, *Definitions*, with the subsequent Sections renumbered accordingly and to read as follows:

Section 2.48. Out-of-Network (Non-PPO) Rate

With respect to No Surprises Act Services, the term "Out-of-Network (Non-PPO) Rate" means one of the following in order of priority:

(a) If the state has an All-Payer Model Agreement, the amount that the state approves under that system;

(b) Applicable state law;

(c) The amount parties negotiate; or

(d) The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

7. A new Section 2.60, *Qualifying Payment Amount*, is added to Article 2, *Definitions*, with the subsequent Sections renumbered accordingly and to read as follows:

Section 2.60. Qualifying Payment Amount

Qualifying Payment Amount (QPA) 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 geographic region.

8. A new Section 2.61, Recognized Amount, is added to Article 2, Definitions, with the subsequent Sections renumbered accordingly and to read as follows:

Section 2.61. Recognized Amount

Recognized Amount means (in order of priority) one of the following:

(a) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

(b) An amount determined by a specified state law; or

(c) The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by a non-PPO provider, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

9. Section 2.69 (formerly 2.63), *Usual and Customary Charge*, under Article 2, *Definitions*, is amended to read as follows:

Section 2.69. Usual and Customary Charge

(a) Except as otherwise required by the No Surprises Act, with respect to a provider outside of the geographic area served by the PPO, the charge for Medically Necessary services or supplies will be determined by the Plan Sponsor or its designee to be the lowest of:

(i) The usual charge by the Health Care Provider for the same or similar service or supply; or

(ii) No more than 85% of the "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply; or

(iii) The Health Care Provider's actual charge.

(b) With respect to a PPO provider and any other provider within the geographic area served by the PPO, the Usual and Customary Charge means the charges set forth in the agreement between the PPO provider and the PPO or the Plan.

(c) Except as otherwise required by the No Surprises Act, the "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Fund Administrator who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.

(d) No provision of this Plan requires the Plan to pay benefits based on the charges submitted by a proprietary provider of a medical supply or service, except as required by the No Surprises Act.

(e) With respect to Dental Services provided to an individual under the age of 19 or to an Eligible Dependent under the age of 19, the Usual and Customary Charge is the usual charge determined by the standards of generally accepted dental practice made by most Dentists for the same or similar service.

10. Section 6.08, *Initial Determinations of Benefit Claims*, under Article 6, *Claims and Appeals*, is amended to add the following paragraphs to the beginning of the Section and to read as follows:

Section 6.08. Initial Determinations of Benefit Claims

For No Surprises Act Services claims, the non-PPO provider will receive an initial payment or denial of payment from the Plan for No Surprise Act Services within 30 days receipt of all information necessary to adjudicate the claim.

If a claim is subject to the No Surprises Act, the Eligible Employee or Eligible Dependent cannot be required to pay more than the cost-sharing amount under the PPO Plan and the provider or facility is prohibited from billing the Participant or Eligible 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 (Non-PPO) Rate for these services exceeds the cost-sharing amount for the services, less any initial payment amount.

11. Section 6.17, *Claims Eligible For The External Review Process*, under Article 6, *Claims and Appeals*, is amended to read as follows:

Section 6.17. Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

(a) 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.

(b) The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

(c) The denial involves surprise billing and/or cost-sharing protections under the No Surprises Act for Emergency Services, Air Ambulance services, and non-Emergency Services provided by a non-PPO provider at a PPO Health Care Facility.

12. Section 11.04(c) under Article 11, *Comprehensive Medical Expense Benefit*, is amended to read as follows:

(c) **Non-PPO Hospital Deductible**

The Non-PPO Hospital Deductible is the amount specified in the Schedule of Benefits of inpatient non-PPO Hospital expense the Eligible Employee or Eligible Dependent must pay for each Confinement in a non-PPO Hospital. It does not apply to Emergency Services.

13. Section 11.07(c) under Article 11, *Comprehensive Medical Expense Benefit*, is amended to read as follows:

(c) Emergency Services with respect to an Emergency Medical Condition (defined below), which means an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency

department meaning, a Health Care Facility that is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services, as applicable, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are 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).

(i) 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).

(ii) 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 an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency Services furnished by a non-PPO provider or at a non-PPO Hospital (regardless of the department of the Hospital in which such items or services are furnished) or an independent freestanding emergency department 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 related to the Emergency Medical Condition, until:

(i) The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and

(ii) The patient or their representative is supplied with a written notice, as required by federal law, that the provider is a non-PPO provider with respect to the Plan, an estimate of the charges for 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

(iii) The patient or their representative gives informed written voluntary consent to continued treatment by the non-PPO provider, acknowledging that the patient understands that continued treatment by the non-PPO provider may result in greater costs to the patient.

14. A new Section 11.09, *No Surprises Act Services*, under Article 11, *Comprehensive Medical Expense Benefit*, is added and to read as follows:

Section 11.09 No Surprises Act Services

(a) Air Ambulance Services

Air ambulance services are 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. The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

(i) Air Ambulance Services from a non-PPO provider are 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;

(ii) 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;

(iii) Any cost-sharing payments the Eligible Employee or Eligible Dependent makes 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 an PPO provider; and

(iv) In general, an Eligible Employee or Eligible Dependent cannot be balance billed for these Air Ambulance Services.

(b) Continuing Care Patients

If an Eligible Employee or Eligible Dependent is a Continuing Care Patient and the Plan terminates its contract with a PPO provider or a PPO facility or Hospital, or benefits are terminated because of a change in terms of providers' and/or facilities' participation in the Plan, the Plan will do the following:

(i) Provide notice of the Plan's termination of its contracts with the PPO provider or facility and inform the patient or their representative of the patient's right to elect continued transitional care from the provider or facility; and

(ii) Allow the patient (90) days of continued coverage at the PPO cost sharing to allow for a transition of care to a PPO provider or facility.

A Continuing Care Patient is an individual who is: (a) receiving a course of treatment for a Serious and Complex Condition, (b) scheduled to undergo non-elective surgery (including any post-operative care); (c) pregnant and undergoing a course of treatment for the pregnancy; (d) determined to be terminally ill and receiving treatment for the illness; or (e) is undergoing a course of institutional or inpatient care from the provider or facility.

In the case of an acute illness, a Serious and Complex Condition is 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 Serious and Complex Condition that is a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

(c) Emergency Services

The No Surprises Act requires Emergency Services to be covered as follows:

(i) Without the need for any prior authorization determination, even if the services are provided on a non-PPO basis;

(ii) Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO facility, as applicable, with respect to the services;

(iii) 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 facilities;

(iv) 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 facility;

(v) 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;

(vi) By counting cost-sharing payments you make with respect to non-PPO Emergency Services toward your PPO provider Deductible and PPO provider out-of-pocket maximum in the same manner as those received from a PPO provider; and

(vii) In general, Eligible Employees and Eligible Dependents cannot be balance billed for these Emergency Services.

(d) Non-Emergency Services

The No Surprises Act requires non-Emergency Services performed by a non-PPO provider at a PPO Health Care Facility to be covered as follows:

(i) 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;

(ii) 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; and

(iii) By counting any cost-sharing payments made toward any PPO provider Deductible and PPO provider out-of-pocket maximums applied under the Plan (and the PPO provider 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.

(iv) In general, Eligible Employees and Eligible Dependents cannot be balance billed for these items or services.

Notice and Consent Exception

Non-emergency items or services provided or performed by a non-PPO provider at a PPO Health Care Facility will be covered based on the Plan's non-PPO provider benefits and forgo the financial protections of the No Surprises Act if:

(i) At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the patient (or their representative) is provided with a written notice, as required by federal law, that the provider is a non-PPO provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on treatment, the names of any PPO providers at the facility who are able to provide treatment, and that the patient may elect to be referred to one of the PPO providers listed; and

(ii) The patient gives written informed consent to continued treatment by the non-PPO provider acknowledging that the patient understands that continued treatment by the non-PPO provider result in greater expenses.

(iii) The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-PPO provider satisfied the notice and consent criteria and, therefore, these services will be covered as follows:

(A) 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;

(B) 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; and

(C) By counting any PPO provider Deductible and PPO provider out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider.

(D) In general, Eligible Employees and Eligible Dependents cannot be balance billed for these items or services.

(e) Provider Directory

The provider directory will be updated at least every ninety (90) days. If an Eligible Employee or Eligible Dependent is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic provider directory that a provider is a PPO provider, but, in fact, the provider is a non-PPO provider and services are furnished by the non-PPO provider, the Plan will:

(i) Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was a PPO provider; and

(ii) Apply the out-of-pocket limit, if any, as if the services were provided by a PPO provider.

15. Item (x) under Article 17, *General Plan Exclusions and Limitations*, is amended to read as follows:

(x) Amounts in excess of Usual and Customary Charges, except as required by the No Surprises Act.

16. The first paragraph of Section 18.03, *Allowable Expense*, is amended to read as follows:

"Allowable Expense" means any necessary, usual and customary expenses incurred by an Eligible Employee or Eligible Dependent during a Calendar Year and while eligible under this Plan, for medical care or treatment, part or all of which would be covered under any Other Plan, except as provided below or otherwise required by the No Surprises Act.

17. The *Medical Out-of-Pocket (OOP) Maximum* under the Schedule of Benefits is amended to read as follows:

Medical Out-of-Pocket (OOP) Maximum:

Single $3,000

Family $9,000

Non-PPO Deductible (applies to each Non-PPO Hospital Confinement, except as otherwise required by the No Surprises Act)..... $550

Non-Compliance Deductible (applies to each inpatient confinement, surgery, advanced diagnostic testing, or other service where Pre-authorization is required for which Pre-authorization is not obtained, except as otherwise required by the No Surprises Act) $100

18. The *Emergency Room Care* under the Schedule of Benefits is renamed *Emergency Services* and amended to read as follows:

Emergency Services:

PPO ..... 90% after Deductible*

Non-PPO ..... 90% after Deductible*

**Services outlined in the Schedule of Benefits that are subject to the Non-Compliance Deductible, except as otherwise required by the No Surprises Act*

19. The Schedule of Benefits *Emergency Medical Transportation* is amended to read as follows:

Emergency Medical Transportation:

PPO ..... 80% after Deductible

Non-PPO ..... 80% of a discounted fee after Deductible, except 80% after Deductible for Air Ambulance Services

IN WITNESS WHEREOF, the Plan is amended as of _____, 2022.

Employee Trustees		**Employer Trustees**	
_____	_____ Date	_____	_____ Date
_____	_____ Date	_____	_____ Date
_____	_____ Date	_____	_____ Date