RAILROAD MAINTENANCE AND INDUSTRIAL HEALTH AND WELFARE FUND

PLAN D – AMENDMENT NUMBER TWO

AMENDING THE SUMMARY PLAN DESCRIPTION (SPD) DATED JANUARY 1, 2021

EFFECTIVE MAY 1, 2022

The Summary Plan Description (SPD) for the **Plan D** participants in the Railroad Maintenance and Industrial Health and Welfare Fund has been amended. Effective with all claims incurred on or after **May 1, 2022,** several changes have been enacted in order for the plan to comply with the "No Surprises Act." As a result, your SPD has been amended to reflect these changes. This is explained below.

(1) Effective **May 1, 2022**, the subsection in the **Schedule of Benefits** beginning with the heading "Except as Specifically Outlined Below, No Charges Incurred with a Non-PPO Provider will be Covered under the Plan" shall be deleted and replaced with the following:

EXCEPT AS SPECIFICALLY OUTLINED BELOW, NO CHARGES INCURRED WITH A NON-PPO PROVIDER WILL BE COVERED UNDER THE PLAN.

The following categories of out-of-network charges will be covered the same as if they were incurred with participating network providers:

- Out-of-Area Provisions. Charges for treatment incurred with an out-of-network provider when it is determined that there is no in-network provider qualified to administer that treatment within 50 miles of your home address or the place where the claim in incurred;

- Charges for Emergency Services;

- Charges for anesthesiology, radiology, pathology, laboratory services and emergency room Physicians when incurred in connection with treatment administered at a participating PPO covered facility, and, if applicable, by a participating PPO attending Physician;

- Charges for covered Dental Benefits;

- Charges for items and services rendered by a nonparticipating provider (out-of-network/non-PPO) with respect to a visit at a participating health care facility if otherwise a Covered Expense, unless the provider has satisfied the notice and consent requirement. The notice and consent exception does not apply with respect to the following: emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, diagnostic services, including radiology and laboratory services, and items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility. The notice and consent exception also does not apply with respect to 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 notice and consent requirements have been satisfied.

    - Notice and Consent Requirement: An exception applies with respect to certain nonparticipating providers at participating health care facilities who have provided notice to you and received informed consent from you with respect to the out-of-network (non-PPO) provider's billing practices. <u>If the exception applies, and informed consent is provided, this generally means that no benefits will provided by the Plan</u>. For the exception to apply, the nonparticipating provider must provide notice that:
        - Is in writing;
        - Is provided 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 an out-of-network (non-PPO) provider;
        - Includes the estimated charges for the treatment and any advance limitations that the Plan may put on the treatment;
        - Includes the names of any in-network providers at the facility who are able to provide treatment;
        - States that you may elect to be referred to an in-network provider; and
        - States that your costs will be greater if you (or your Authorized Representative) consents to the service or treatment.

- Incorrect PPO Provider Information Provision. A list of PPO providers is available to you without charge by visiting www.weclometoUHC.com/uhss 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. If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was out-of-network (Non-PPO).

With respect to claims subject to the No Surprises Act (e.g. Emergency Services provided by out-of-network providers, out-of-network providers at in-network facilities, etc.), the charge allowed by said provider is determined based on the Recognized Amount for the items or services. Cost-sharing requirements for participants shall be determined as if the total amount that would have been charged for the items and services by such provider were equal to the Recognized Amount for the items and services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing. Further, any cost sharing you pay with respect to claims subject to the No Surprises Act will count toward your deductible and out-of-pocket maximum.

For claims subject to the No Surprises Act, 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. The Out-of-Network Rate for this purpose means one of the following: (a) the amount the parties negotiate; (b) the amount approved under the independent dispute resolution (IDR) process; or (c) if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

Finally, if you believe you have been wrongly billed, or otherwise have a complaint under the No Surprises Act, you may contact the Fund Office at (217) 787-2923 or (800) 258-6534. You 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 claims subject to the No Surprises Act. You may also contact the Employee Benefit Security Administration (EBSA) toll free at 1-866-444-3272.

And

(2) Effective with all claims incurred on or after May 1, 2022, the term **Emergency Medical Condition,** as defined below, shall replace the defined term Life-Threatening Emergency as found in **Definitions,** and elsewhere, of the Summary Plan Description:

> **Emergency Medical Condition:** "Emergency Medical Condition" means a medical condition manifesting itself 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 medical attention to result in (1) placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, or (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

And

(3) Effective with claims incurred on or after May 1, 2022, the following definitions shall be added to the **Definitions** of the Summary Plan Description:

Emergency Services: "Emergency Services" means the following:

1. An appropriate medical screening examination (as required under Section 1867 of the Social Security Act) 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 (as required under Section 1867 of the Social Security Act) 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 a 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:

   a. The provider or facility determined you are able to travel using nonmedical transportation or nonemergency medical transportation;
   b. 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
   c. You give informed consent to continued treatment by the out-of-network provider, acknowledging that the participant or beneficiary understands that continued treatment by the out-network provider may result in greater cost to the participant or beneficiary.

Qualifying Payment Amount (QPA) means generally the amount calculated using the methodology described in 29 CFR 2590.716-6(c).

Recognized Amount means for items or services furnished by an out-of-network (non-PPO) provider or out-of-network emergency facility, one of the following (in order of priority):

a. An amount determined by an applicable All-Payer Model Agreement under section 1114A of the Social Security Act;
b. An amount determined by a specified state law; or
c. The lesser of the amount billed by a provider or facility or the Qualifying Payment Amount (QPA).

(4) Effective with all claims incurred on or after May 1, 2022, the following **Continuity of Care** language shall be added to the **Rules of Eligibility** of the Summary Plan Description, following **Eligibility for Maternity Benefits**:

(a) Ensuring continuity of care with respect to terminations of certain contractual relationships resulting in changes in provider network status. -

1. In the case of an individual with benefits under a group health plan and with respect to a health care provider or facility that has a contractual relationship with such plan for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility –

   A) Such contractual relationship is terminated (as defined in paragraph (b));
   B) Benefits provided under such plan with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or
   C) A contract between such group health plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility; the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

2. Requirements. The requirements of this paragraph are that the plan or issuer -

   A) Notify each individual enrolled under such plan who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;
   B) Provide such individual with an opportunity to notify the plan of the individual's need for transitional care; and
   C) Permit the patient to elect to continue to have benefits provided under such plan, under the same terms and conditions as would have applied

and with respect to such items and services as would have been covered under such plan had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of –

(i) The 90-day period beginning on such date; or
(ii) The date on which such individual is no longer a continuing care patient with respect to such provider or facility.

(b) Definitions. In this section:

1. Continuing care patient. The term "continuing care patient" means an individual who, with respect to a provider or facility –

A) Is undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
B) Is undergoing a course of institutional or inpatient care from the provider or facility;
C) Is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;
D) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
E) 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.

2. Serious and Complex Condition. – The term "serious and complex condition" means, with respect to a participant or beneficiary under a group health plan –

A) 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; or
B) In the case of a chronic illness or condition, a condition that –

(i) Is life-threatening, degenerative, potentially disabling, or congenital; and
(ii) Requires specialized medical care over a prolonged period of time.

3. Terminated – The term "terminated" 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.

and

(5) Effective with all claims incurred on or after May 1, 2022, the following shall be added to section 1. Claims Subject to Review of the subsection **Claimant's Right to External Review of an Adverse Benefit Determination** of the **Appeal Procedures** of the Summary Plan Description:

(e) Emergency Services claims and non-emergency services claims performed by nonparticipating providers at certain participating facilities subject to "Surprise" billing and cost-sharing protections under the "No Surprises Act."

IN WITNESS WHEREOF, the Trustees have caused this instrument to be executed on this 12th day of April, 2022.

MANAGEMENT TRUSTEES

LABOR TRUSTEES