AMENDMENT NO. 22-3
TO THE
RULES AND REGULATIONS
OF THE
MEBA MEDICAL AND BENEFITS PLAN

At their February 10, 2022 meeting, the Trustees of the MEBA Medical and Benefits Plan (the "Plan") amended the Plan's Rules and Regulations effective January 1, 2022 to conform with the requirements of the No Surprises Act, enacted as part of the Consolidated Appropriations Act, 2021.

1. Article VI, Section 2, shall be amended by adding new subsections (i) through (t), to read as follows:

(i) *"Ancillary Services"* shall mean, with respect to a participating Health Care Facility:

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

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

(3) Diagnostic services, including radiology and laboratory services and subject to exceptions specified by federal regulation; and

(4) Items and services provided by a non-PPO provider if there is no PPO provider who can furnish such item or service at such participating Health Care Facility.

(j) *"Cost Sharing" or "Cost Share"* shall mean the amount an Eligible Employee, Pensioner, or their Dependent(s) (each a, "Covered Individual") is responsible for paying for a Covered Medical Expense 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. Effective January 1, 2022, a Covered Individual's Cost Share applicable to No Surprises Services is based on the lesser of the Qualifying Payment Amount payable for such services or the amount billed by the non-PPO provider. Co-Insurance amounts paid for No Surprises Services will count towards a Covered Individual's PPO Annual Deductible, as detailed in Schedules G and J, and any applicable PPO Out-of-Pocket Maximums, as may apply under Schedule L, but not non-PPO Annual Deductibles or non-PPO Out-of-Pocket Maximums.

(k) *"Independent Freestanding Emergency Department"* shall mean a health-care facility that is geographically separate and distinct from a Hospital under applicable state law and that is licensed under state law to provide Emergency Services.

(l) *"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 the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(m) *"Emergency Services"* shall mean with respect to an Emergency Medical Condition:

(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 Eligible Employee or Dependent (regardless of the department of the hospital in which such further examination or treatment is furnished).

(3) Services provided by an out-of-network provider or facility after the Covered Individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

A. The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;

B. The Covered Individual is 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 treatment and any advance limitations that the Plan may put on such treatment, of the names of any PPO providers at the facility who are able to treat the Covered Individual, and that the Covered Individual may elect to be referred to one of the PPO providers listed; and

C. The Covered Individual gives informed Consent to continued treatment by the non-PPO provider, acknowledging that she or he understands that continued treatment by the non-PPO provider may result in greater cost to the Covered Individual.

(n) *"Health Care Facility"* (for non-Emergency Services) shall mean 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.

(o) *"Qualifying Payment Amount"* (QPA) shall mean generally the median contracted rates of the Plan or issuer for the item or service in the geographic region. This amount is subject to change.

(p) "*Continuing Care Patient*" shall mean:

a Covered Individual who is: (1) undergoing a course of treatment for a Serious and Complex Condition, (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) undergoing a course of institutional or inpatient care from the provider or facility.

(q) *"Serious and Complex Condition"* shall mean 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 harm; or

(2) In the case of a chronic illness or condition, a condition that is the following:

(A) Life-threatening, degenerative, potentially disabling, or congenital; and

(B) Requires specialized medical care over a prolonged period of time.

(r) "*No Surprises Act*" shall mean:

Title I of Division BB of the Consolidated Appropriations Act, 2021, P.L. 116-260

(s) "*No Surprises Services*" shall mean 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, neonatology and diagnostics, when performed by a non-PPO provider at a participating Health Care Facility; and (4) other non-emergency services performed by a non-PPO provider at a participating Health Care Facility with respect to which the provider does not comply with federal Notice and Consent requirements.

(t) "*Notice and Consent*" or "*Consent*" with respect to services provided at a participating Health Care Facility by a non-PPO provider, means: (1) that 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 Covered Individual 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 the Covered Individual's treatment and any advance limitations that the Plan may put on his or her treatment, the names of any PPO providers at the facility who are able to treat the Covered Individual and that he or she may elect to be referred to one of the PPO providers listed; and (2) the Covered Individual gives informed Consent to continued treatment by the non-PPO provider, acknowledging that he or she

understands that continued treatment by the non-PPO provider may result in greater cost. 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.

2. Article VI, Section 3(e)(11), shall be amended to read as follows:

(11) local use of ambulance service, when medically necessary; effective January 1, 2022, local use of non-PPO air ambulance services that are medically necessary are a No Surprises Service subject to the Plan's applicable Cost Sharing.

3. Article VI, Section 3, shall be amended by adding new subsections (n) and (o), to read as follows:

(n) No Surprises Services.

Effective January 1, 2022, charges for No Surprises Services are covered as required by the No Surprises Act, and subject to applicable Cost Sharing. In addition, if a Covered Individual receives No Surprises Services from a non-PPO provider that the Covered Individual thought was a PPO provider, based on inaccurate information in a current provider directory, then the No Surprises Services provided by that non-PPO provider will be covered as if the provider was a PPO provider.

(o) Emergency Services.

Emergency Services are covered without the need for prior authorization.

4. Article VI, Section 4, shall be amended by replacing the first sentence with the following:

Except to the extent otherwise required by applicable law, the term Covered Medical Expense shall not include expenses for:

5. Article VI, Section 9, shall be amended to read as follows:

9. Preferred Provider Organization.

(a) The Plan will contract for an optional form of coverage with a Preferred Provider Organization ("PPO") through which the Plan will be billed at reduced rates for certain charges received from participating Health Care Facilities and physicians. Effective January 1, 2006: a) All PPO co-pays shall be $20; b) When participating PPO providers are used, the Plan's payment will be 90% for hospital charges and 80% for medical charges, after applicable co-pays, except as provided under Article VI, Section 3(e) (14), (15), (16), and (17) and (28) – (34); and Article VI, Sections 3 (g) (ii) and (h). Effective October 25, 2007, even when a non-PPO provider is used, the Plan's payment will be 80% of Allowable medical charges where a good faith effort is made by the Eligible Employee or Dependent to use a PPO provider.

(b) Continuity of Coverage. Effective January 1, 2022, if a Covered Individual is a Continuing Care Patient and the PPO terminates its contract with a PPO provider or participating Health Care Facility that is treating that Covered Individual, the Plan will do the following:

(1) Notify the Covered Individual in a timely manner of the termination of his or her provider's or facility's contract and inform the Covered Individual of their right to elect continued transitional care from that provider or facility; and

(2) If the Covered Individual elects, allow ninety (90) days of continued coverage and the determination of Cost Sharing for such continuing care services as if that provider or facility continued to be a PPO provider or participating Health Care Facility, to allow for a transition of care to a PPO provider.

6. Article VIII, Section 2 shall be amended by adding the following sentence to the end of the first paragraph:

Notwithstanding anything in this Section 2 to the contrary, No Surprises Services received by a Pensioner or their Dependent(s) will be covered subject to the Plan's applicable Cost Sharing only to the extent otherwise covered for Pensioners and their Dependents or as may be required by the No Surprises Act.

7. Article VIII, Section 2(d) shall be amended to read as follows:

(d) Preferred Provider Organization.

(1) The Plan will contract for an optional form of coverage with a Preferred Provider Organization ("PPO") through which the Plan will be billed at reduced rates for certain charges received from participating Health Care Facilities and physicians. This coverage will not be available to Pensioners and their Dependents who are eligible for coverage under the Federal Medicare Program. Effective January 1, 2006, eligible Pensioners with 20 or more years of pension credit and their Dependents who select health care providers participating in the PPO shall receive benefits as follows: a) All PPO co-pays shall be increased from $10 to $20; b) The Plan's payment will be 90% for hospital charges and 80% for medical charges, after applicable co-pays, except as provided under Article VI, Sections 3 (e)(28) - (34) and Article VIII, Section (2) (b) (2) and (ii). Eligible Pensioners with less than 20 years of pension credit (exclusive of credit for "Prior Maritime Employment" pursuant to Section 3.04 of the MEBA Pension Trust Regulations) and their Dependents will be covered under Section 2(a)(1) of Article VIII, but will be billed at reduced rates if they select health care providers participating in the PPO. Effective October 25, 2007, even when a non-PPO provider is used, the Plan's payment will be 80% of Allowable medical charges where a good faith effort is made by the Eligible Employee or Dependent to use a PPO provider.

(2) Continuity of Coverage. Effective January 1, 2022, if a Covered Individual is a Continuing Care Patient and the PPO terminates its contract with a PPO provider or participating Health Care Facility that is treating that Covered Individual, the Plan will do the following:

(1) Notify the Covered Individual in a timely manner of the termination of his or her provider's or facility's contract and inform the Covered Individual of their right to elect continued transitional care from that provider or facility; and

(2) If the Covered Individual elects, allow ninety (90) days of continued coverage and the determination of Cost Sharing for such continuing care services as if that provider or facility continued to be a PPO provider or PPO facility, to allow for a transition of care to a PPO provider.

8. Article XVI, Section 3, is amended to add the following new paragraph at the end of that section:

Notwithstanding the above, a non-PPO provider of No Surprises Services will receive an initial payment or notice of denial of payment for No Surprises Services within 30 calendar days of the Plan's receipt of the billed charges and all information necessary to adjudicate the claim.

9. Article XVI, Section 7A, is amended to add a new subsection G, to read as follows:

G. External Review

Effective January 1, 2022, if a claimant receives an adverse benefit determination that relates to a No Surprises Service, the claimant may be entitled to appeal the decision to an external independent review organization (IRO) within four months of the receipt of the adverse determination on appeal. External review is limited to claims involving whether the Plan is complying with the surprise billing and cost sharing protections under No Surprises Act. No other denials will be reviewed by an IRO unless otherwise required by law. Requests for external review are filed with the Plan Office.

All such external review requests shall, within five business days following the receipt of the external review request, receive a preliminary review to determine whether: the claimant is or was covered under the Plan at the time the health care item or service was provided; the request for external review concerns payment for No Surprises Services; the claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeal process; and the claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Fund Office will issue a written notification of its determination to the claimant, including, if applicable, the reason for the request's ineligibility for external review or a description of any information or materials necessary to perfect the request for external review. If additional information or materials are necessary, the claimant shall have until the later of the four-month filing period or 48 hours following receipt of the written notification to provide the additional information or materials.

Upon completion of a preliminary review that determines that the matter is eligible for external review under these procedures, the Plan Office shall refer the matter to an IRO.

The determination of the IRO shall be binding except to the extent that other remedies may be available under Federal law. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination on appeal, the Plan shall immediately provide payment for the No Surprises Service claim.

10. Schedule F shall be amended to read as follows:

SCHEDULE F

MAJOR MEDICAL EXPENSE COVERAGE FOR ELIGIBLE

EMPLOYEES AND DEPENDENTS

Co-Insurance

The Eligible Employee shall be responsible for Covered Medical Expenses, as described in Article VI, to the extent of 40% for non-PPO providers, except as described in Article VI, Sections 3(n) and 9(b). When participating PPO providers are used, and as described in Article VI, Sections 3(n) and 9(b), when non-PPO providers provide certain services, the Eligible Employee shall be responsible for 10% of hospital charges and 20% of medical charges, after applicable co-pays. Notwithstanding anything in this Schedule to the contrary, No Surprises Services received by an Eligible Employee will be covered subject to the Plan's applicable Cost Sharing.

11. Schedule I shall be amended to read as follows:

SCHEDULE I

MAJOR MEDICAL EXPENSE COVERAGE FOR

PENSIONERS AND DEPENDENTS

The Pensioner shall be responsible for Covered Medical Expenses, as described in Article VIII, to the extent of 40% for non-PPO providers, except as described in Article VI, Section 3(n) and Article VIII, Section 2(d)(2), when non-PPO providers provide certain services. When participating PPO providers are used, the Pensioner shall be responsible for 10% of hospital charges and 20% of medical charges after applicable co-pays. Notwithstanding anything in this Schedule to the contrary, No Surprises Services received by a Pensioner will be covered subject to the Plan's applicable Cost Sharing only to the extent otherwise covered for Pensioners and their Dependents or as may be required by the No Surprises Act.

Adopted in Principle: December 28, 2021
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Language Approved: February 10, 2022

Adam Vokac, Chairman

Edward Hanley, Secretary