SETTLEMENT AGREEMENT AND RELEASE

THIS AGREEMENT AND RELEASE (the "Agreement") is made and entered into by and between the United States Department of Labor, Employee Benefits Security Administration ("EBSA") and the Boilermakers National Health & Welfare Fund (the "Fund"). EBSA and the Fund are referred to collectively as the "Parties." The Agreement is effective as of the date it is signed by the last Party to execute the Agreement (the "Effective Date").

WHEREAS, the Fund is an ERISA-covered Taft-Hartley multiemployer health plan that provides benefits for members of the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers, and Helpers, and their families;

WHEREAS, on August 4, 2021, EBSA requested a comparative analysis and supporting documentation (the "Comparative Analysis") regarding the Fund's application of the following non-quantitative treatment limitation: "standards for provider admission to participate in a network, including reimbursement rates, for in-network inpatient and in-network outpatient services" (the "NQTL") pursuant to section 712(a)(8)(B) of ERISA, 29 U.S.C. § 1185(a)(8)(B);

WHEREAS, the Fund produced a Comparative Analysis and supporting documentation in response to EBSA's request;

WHEREAS, the Fund, as of the Effective Date of this Agreement, contracts with Cigna Health and Life Insurance Company ("Cigna") to provide in-network healthcare services to its participants and beneficiaries;

WHEREAS, EBSA issued an Initial Determination Letter (the "IDL") on January 24, 2023, determining that the Fund failed to comply with ERISA § 712(a)(3), 29 U.S.C. § 1185(a)(3), with respect to the NQTL, because (1) the Fund, through Cigna, uses different, non-comparable processes and evidentiary standards to evaluate the adequacy of its medical/surgical ("M/S") and

mental health/substance use disorder ("MH/SUD") networks; (2) the Fund, through Cigna, does not respond comparably to identified deficiencies in its M/S and MH/SUD Networks; and (3) the Fund's own practices for addressing deficiencies in its Network are not applied comparably to M/S and MH/SUD benefits. EBSA also found that the Fund failed to produce a statutorily sufficient Comparative Analysis, in violation of ERISA § 712(a)(8)(A), 29 U.S.C. § 1185(a)(8)(A) (collectively, the "IDL Violations");

WHEREAS, the Fund neither admits nor denies the IDL Violations, has responded to EBSA in a letter dated March 10, 2023, and has agreed to resolve the alleged IDL Violations, as described in this Agreement;

WHEREAS, EBSA is concerned about the adequacy of Cigna's MH/SUD Network and the Fund's disparate rate of out-of-network ("OON") utilization for MH/SUD services as compared to M/S services;

WHEREAS, the Parties have engaged in good-faith negotiations, including the submission of proposed Corrective Action Plans;

WHEREAS, the Fund is committed to ensuring that its plan participants and beneficiaries have comparable access to in-network MH/SUD benefits as they have to in-network M/S benefits, and is committed to working with its Network Administrator towards making its MH/SUD Networks as robust and accessible as its M/S Networks;

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, it is agreed as follows:

I. Definitions. The following definitions apply to the terms of this Agreement:

A. **"Collaborative Care Model" ("CoCM")** means an integrated approach that involves the collaboration between patients and primary care physicians within physician groups that

include care for mental health conditions and substance use disorders, particularly including the addition of two key services to the "usual" primary care: (1) care management support for patients receiving behavioral treatment; and (2) regular psychiatric inter-specialty consultation to the primary care team, especially for patients whose conditions are not improving;

B. **"Monitoring Period"** means an 18-month period of time starting on the Effective Date of this Agreement;

C. **"Network"** means the facilities, providers, and suppliers contracted to provide healthcare services;

D. **"Network Administrator"** means an entity which has established a Network and which offers that Network to health plans for a fee;

E. **"Network Gap"** refers to a deficiency of in-network provider(s), facilities, or suppliers within the MH/SUD Network as compared to the M/S Network;

F. **"Preferred Facility"** is defined in Paragraph 107 of Article 28 of the 2023 Boilermakers Summary Plan Description;

G. **"Request for Information" ("RFI")** means the process outlined on page 8 of the Fund's updated Corrective Action Plan, dated June 16, 2023; and

H. **"Substance Abuse Treatment Program"** means the program described in Section 4.17 of the 2023 Boilermakers Summary Plan Description.

II. The Fund agrees to complete the following actions (the "Negotiated Corrections"):

A. **Measurement and Improvement of the Network Administrator's Network**

1. Within 90 days of the Effective Date, the Fund will:

a. Define "High-Volume Specialists" as the top five categories of M/S specialists and the top five categories of MH/SUD specialists (as measured by claims

volume) used by the Fund's participants and beneficiaries;

b. Define "High Impact Specialists" by using the Fund's claims and cost data to identify the top five M/S and the top five MH/SUD specialists treating conditions that either have a high mortality/morbidity rate or require significant resources (i.e., cost of treatment exceeds $10,000);

c. The Fund will use the definitions of "High-Volume Specialists" and "High-Impact Specialists" in evaluating the Network Administrator's Network adequacy standards applied to M/S and MH/SUD specialists.

d. Provide EBSA with documentation of the Fund's evaluation noted in 1.c above.

e. Provide EBSA with documentation to demonstrate the changes noted in 1.a and 1.b above.

2. On a quarterly basis during the Monitoring Period, the Fund will evaluate the comparative adequacy of its Network Administrator's Network as applied to M/S and MH/SUD providers generally, as well as the adequacy of the Network with respect to "High-Volume Specialists" and "High Impact Specialists" in particular. The Fund will identify any Network Gaps, and will work with its Network Administrator to take affirmative, documented steps that are reasonably designed to close the gaps within the Monitoring Period.

3. The Fund will perform six quarterly reviews of its Network Administrator's Network during the Monitoring Period. In each quarterly review, the Fund will collect and evaluate the following data and measurements, in addition to any other information the Fund elects to consider, to identify Network Gaps:

a. *Out-of-Network Utilization*: These measurements require the collection and completion of the data elements and calculations set forth in Attachment A,

Table 1. The data used in this measurement should be based on the claims incurred date, breaking the data out by year and by category, for the previous two years prior to each quarterly review.

i. The Fund will also request and review, on a quarterly basis, reports from the Fund's Network Administrator addressing Network Gaps. For example, it will request and review Cigna's "Gaps in Care" and Medical Snapshot Report ID 068. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that EBSA can take appropriate action to protect the interests of Fund participants and beneficiaries.

ii. The Fund will also request from its Network Administrator and review, on a quarterly basis, a list of all provider specialties and sub-specialties for which participants and beneficiaries submitted claims for OON MH/SUD services. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that EBSA may take appropriate action to protect the interests of the Fund's participants and beneficiaries.

b. *Network Providers Actively Submitting Claims:* These measurements require the collection and completion of the data elements and calculations specified in Attachment A, Table 2, for the six months prior to each quarterly review. Providers not actively submitting claims will be removed from the data provided. These measurements may be based on the Network Administrator's

book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same Network for the Fund as for other benefit plans or group policies, and the Fund has no reason to believe that data based on the Network Administrator's book of business is unrepresentative of the Fund's experience.

c. *Wait Times for New and Existing Patients:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 3. These measurements may be based on the Network Administrator's book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same network for the Fund as for other benefit plans or group policies, and the Fund has no reason to believe that data based on the Network Administrator's book of business is unrepresentative of the Fund's experience.

d. *Time and Distance Measurements:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 4. The Fund will request that the Network Administrator identify the actual number of providers that are counted in the standard measured, not just whether the standard was met or the percentage meeting the standard. The standards will not be treated as meeting the requirements of this Agreement if they contemplate greater times or distances for MH/SUD claimants than for M/S claimants. These measurements may be based on the Network Administrator's book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same network for the Fund as for other benefit plans or group policies, and the Fund has no reason to believe that data based

on the Network Administrator's book of business is unrepresentative of the Fund's experience. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that it can take appropriate action to protect the interests of the Fund's participants and beneficiaries.

e. *Provider-To-Member Ratios:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 5. The Fund will request that the Network Administrator identify the actual number of providers that are counted in the standard measured, not just whether the standard was met or the percentage meeting the standard. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that EBSA can take appropriate action to protect the interests of the Fund's participants and beneficiaries. If unable to obtain this data from the Network Administrator regarding the Network Administrator's book of business, the Fund will collect and utilize the Fund's data to the best of its ability (i.e., relying on all claims data and reporting capabilities available to the Fund) as related to the Fund's Network.

f. *Retention and Loss of Network Providers:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 6, for the two years preceding each quarterly review. These measurements may be based on the Network Administrator's book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same network for the Fund as for other benefit plans or

group policies, and the Fund has no reason to believe that data based on the Network Administrator's book of business is unrepresentative of the Fund's experience.

g. *Telehealth:* The Fund will perform quarterly monitoring of the following aspects of telehealth utilization during the Monitoring Period:

   i. average wait times for appointments,

   ii. gaps in telehealth Network, and

   iii. member complaints.

4. For each of the six quarterly reviews conducted during the Monitoring Period, the Fund will provide the following documentation to EBSA within 90 days after the end of the quarter (with the final quarterly submission due 90 days after the end of the Monitoring Period):

   a. Data specified in Attachment A, Tables 1-6, in Excel format;

   b. Explanation of methodologies used to identify inputs into Attachment A, Tables 1-6;

   c. Summary of any analysis of the data;

   d. Identification of any Network Gaps and explanation of how they were identified;

   e. Any action plans prepared in response to the Network Gaps identified, and the basis for concluding that the action plans will close the Network Gaps within the Monitoring Period; and

   f. If requested by EBSA, underlying data and supporting documentation used to derive the data specified in Attachment A, Tables 1-6.

5. After completion of the Monitoring Period, the Fund will continue to monitor the

adequacy of its Network Administrator's Network at least annually thereafter. Until such time as specific statutory or regulatory requirements for measuring provider networks supersede the requirements set forth herein, the Fund will continue to use the measurements specified in II.A.3 above, but will not be required to automatically report to EBSA on a quarterly basis as required during the Monitoring Period.

6. For any Network Gap identified during the Monitoring Period and in any of its own subsequent annual reviews of the adequacy of its Network:
    a. The Fund will take affirmative steps that are reasonably designed to close the Network Gaps within the Monitoring Period.
    b. The Fund will define and document all steps taken to close identified Network Gaps, including Network Gaps identified by the Fund or identified by the Network Administrator.
    c. The Fund will measure progress toward closing Network Gaps using the same data-based measures it used to identify the Network Gaps.
    d. The Fund or its Network Administrator will review MH/SUD OON claims to identify providers for recruitment to join the Network.
    e. The Fund or its Network Administrator will engage efforts to recruit new MH/SUD providers to the Network.
    f. The Fund or its Network Administrator will document these recruitment efforts and their outcome. This documentation will include sufficient detail to identify whether and when either of the following considerations resulted in the failure of new providers to join the Network:
        i. Insufficient reimbursement rates; or
        ii. Administrative burdens.

g. The Fund will request information from the Network Administrator regarding its efforts to contract with new MH/SUD providers. The Fund will request from the Network Administrator copies of the corresponding executed contracts with new MH/SUD providers that resulted from efforts to expand the Network based on identified gaps. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, and nothing in this Agreement shall prevent EBSA from taking appropriate action to protect the Plan's participants and beneficiaries. If the Fund determines it is reasonable and appropriate to pursue direct contracting, the Fund will provide copies of its efforts and agreements to EBSA during the Monitoring Period.

7. The Fund will provide to EBSA, within 90 days after the end of each quarter during the Monitoring Period, documentation of the following in connection with its efforts to close any identified Network Gap:
    a. Documentation noted in 6.b. above;
    b. Documentation noted in 6.f. above;
    c. Any new or amended contracts between the Fund and the Network Administrator as it relates to efforts to close Network Gaps;
    d. Any policies or procedures the Fund implements related to its Network Administrator's Network adequacy or the measurement thereof;

B. **Request for Information**

1. At least once during the Monitoring Period, the Fund will send an RFI to other Network Administrators to evaluate the adequacy of its Network as compared to Networks

offered by competing Network Administrators. The RFI will include data requests sufficient to evaluate parity with respect to MH/SUD and M/S providers.

2. For any RFI comparing the adequacy of the Network Administrator's Network that occurs during the Monitoring Period, the Fund will provide EBSA documentation of the RFI analysis within 90 days after completion of the analysis, but in no event later than 90 days after the end of the Monitoring Period.

C. **Supplemental Network for the Fund**

1. The Fund or Network Administrator will review and identify additional facilities that are candidates for the Network Administrator to contract with as Preferred Facilities for participation in the Substance Abuse Treatment Program.
2. The Fund will review and consider implementation of a Preferred Facilities program for the treatment of acute mental illnesses.
3. The Fund will ensure that any Substance Abuse Treatment Program hotlines offered to the Fund's participants and beneficiaries are directing individuals with mental health conditions to available resources.
4. Within 90 days after the end of each quarter during the Monitoring Period, the Fund will provide EBSA with documentation of its review, identification, and recommendations performed pursuant to Section II.C. of this Agreement. This will include meeting minutes and any other documentation used in the decision-making process.

D. **Collaborative Care Model Providers**

1. The Fund will provide directions on its website for participants and beneficiaries to locate CoCM providers through the Network Administrator. The directions shall be written and presented in a culturally and linguistically appropriate manner calculated

to be understood by the average participant, beneficiary, or enrollee.

2. The Fund will confirm with the Network Administrator that there is only one provider directory available for the Fund's participants and beneficiaries. If a secondary provider directory exists, the Fund will request all directories be modified to identify CoCM providers, as needed.
3. The Fund will modify the Summary Plan Description ("SPD") to define CoCM providers[1], identify the types of practitioners that may participate in a collaborative care program, and explain how to locate CoCM providers. The SPD shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
4. The Fund will request that the Network Administrator update its customer service scripts to describe the available CoCM benefits for the Plan participants and beneficiaries. The Fund will inform the Network Administrator that scripts shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
5. Within 90 days of the Effective Date, the Fund will send a letter to all Plan participants and beneficiaries with 2021, 2022, and 2023 claims associated with a CoCM provider or facility and provide them with information regarding CoCM. The letter shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.

[1] Effective January 1, 2024, the SPD was amended to include the following definition of Collaborative Care: Collaborative care is a team-based, comprehensive model of patient treatment. It brings together numerous physicians and caregivers to consider a patient as a whole person, rather than just as a body or disease. This model aims to improve patient outcomes through inter-professional cooperation. It combines general and behavioral medical practices and involves various health practitioners, including primary care physicians, mental health practitioners, and other specialists. Collaborative care provides holistic care by delivering both medical and mental health care in primary care settings. When you visit a Provider who participates in the Collaborative Care Program, the Provider can refer you to a primary care physician, mental health practitioner, or other specialist to collaboratively address your health care needs.

6. Within 90 days of the Effective Date, the Fund will provide EBSA with the following documentation:
    a. A screenshot of the current Fund website confirming that it includes directions to locate CoCM providers through the Network Administrator.
    b. Written confirmation that there is only one provider directory available to the Fund's participants and beneficiaries or, alternatively, that the Fund has requested that all relevant directories be modified to identify CoCM providers.
    c. Documentation of the Fund's request that the Network Administrator update its customer service scripts as required in Section II.D. of this Agreement.
    d. An example of the letter sent to participants and beneficiaries as required in Section II.D. of this Agreement and an attestation under penalty of perjury that to the best of the Fund's knowledge, based upon the Fund's data, the letter was mailed to all Plan participants and beneficiaries with 2021, 2022, and 2023 claims associated with a CoCM provider or facility.
7. Within 90 days of the Effective Date, the Fund will provide EBSA with an amendment to the SPD as required in Section II.D. of this Agreement.

E. **Expansion of Summary Plan Description Section Titled "When Out-of-Network Services are Payable at the In-Network Level"[2]**

1. If a Network Gap is identified, the Fund will amend the SPD Section titled "When Out-of-Network Services are Payable at the In-Network Level" to cover MH/SUD services as if they were in-network, in geographic areas where the Fund's MH/SUD Network does not meet the Fund's Network adequacy standards. Upon identification of such

[2] In 2018, this was Section 4.4. In the 2023 SPD, this is Section 3.4.

geographic areas, the Fund will change the SPD to allow for, and set clear parameters regarding when OON services will be treated as in-network services (for purposes of coverage and cost-sharing). The SPD shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.

2. The Fund acknowledges that it is aware of and will continue to comply with the Consolidated Appropriations Act's provisions regarding continuity of care plans.
3. The Fund will add phone numbers for participants and beneficiaries to call and obtain additional information regarding when OON services are payable at the in-network level to the Fund's website. Additionally, the Fund has requested and will review any customer service scripts from its Network Administrator regarding this section of the SPD. The Fund will inform the Network Administrator that the scripts shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
4. If an amendment is required, as set forth in Section II.E.1 above, the Fund will provide a copy of the amendment to EBSA.
5. Within 90 days of the Effective Date, the Fund will provide documentation that the Fund's website has been updated with the phone number for beneficiaries to call as required in Section II.E. of this Agreement.

F. **Expansion of Telehealth**

1. The Fund will review and identify additional MH/SUD telehealth providers to ensure access to MH/SUD telehealth providers is comparable to and no more restrictive than access to M/S telehealth providers, and the Fund will amend the SPD to reflect the changes to the MH/SUD telehealth coverage as needed. The SPD shall be written and

presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.

2. The Fund will contact Cigna to determine whether the Network Administrator's provider or facility contracts require patient contact after an inpatient stay.
3. The Fund will ensure that a participant's or beneficiary's search for a telehealth provider only produces results for providers licensed in the state where the patient is located unless the participant or beneficiary specifically seeks providers located in another state. The Fund will also ensure that if a participant seeks to search for providers located in another state, that the search capabilities are able to produce those results.
4. The Fund will, within the annual telehealth mailer, define or explain Plan telehealth benefits available relating to eligible provider types, face-to-face visits, and audio-only visits as appropriate, and the reimbursement of the same. The annual telehealth mailer shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
5. Within 90 days of the Effective Date, the Fund will provide EBSA with the following:
    a. Documentation of review, recommendations, and decisions made regarding the addition of MH/SUD telehealth providers to its Network.
    b. Documentation confirming that searches for telehealth providers only produce results for providers licensed in the state where the patient is located, and that participants and beneficiaries also have the ability to search for providers in other states.
6. During the Monitoring Period, within 90 days of the end of the quarter in which the Fund sends its annual telehealth mailer, the Fund will provide EBSA with a copy of the

mailer and an attestation under penalty of perjury that the mailer was sent to all Fund participants and beneficiaries.

G. **Additional Assistance for Participants and Beneficiaries Seeking Mental Health or Substance Use Disorder Treatment**

1. The Fund will send a mailing to all Plan participants and beneficiaries identified during the OON utilization review, as outlined in item A.3.a, with inpatient and outpatient OON MH/SUD claims to remind them about the benefits of using in-network providers, give them the Network Administrator's telephone number to use for participant assistance in finding a provider, and further explain the benefits of the CoCM. The mailing shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.

2. Within 90 days of the Effective Date, the Fund will provide EBSA with a copy of the mailing sent to participants and beneficiaries as required under Section II.G. of this Agreement and an attestation under penalty of perjury that to the best of the Fund's knowledge, based upon the Fund's data, the mailer was sent to all Plan participants and beneficiaries.

III. **Release**

A. By EBSA. Except as necessary to enforce the rights and obligations in this Agreement, EBSA and its agents, attorneys, representatives, assigns, predecessors and successors-in-interest, acting in their official capacities, do hereby release, waive, and forever discharge any and all claims, demands, actions, causes of action, liabilities, penalties, and fines that they have against the Fund relating to the alleged IDL Violations, between August 4, 2021 and the Effective Date (the "Released Claims"). EBSA shall not institute or maintain

any investigation relating to the Released Claims, nor shall it refer any issue relating to the Released Claims for litigation. Nothing herein shall preclude any action to enforce the terms of this Agreement.

B. By the Fund. Except as necessary to enforce the rights and obligations in this Agreement, the Fund hereby releases, waives, and forever discharges any and all claims, demands, causes of action, liabilities, penalties, and fines, including those claims arising under the Equal Access to Justice Act or any other statute, rule, or regulation, that the Fund may have against EBSA and its agents, attorneys, representatives, assigns, predecessors and successors-in-interest ("EBSA Releasees") that related in any manner to the investigation of the NQTL by EBSA or the settlement that is the subject of this Agreement between August 4, 2021 and the Effective Date. The Fund agrees not to institute, maintain, or prosecute any action or legal proceeding against the EBSA Releasees relating to the investigation of the NQTL, or the settlement that is the subject of this Agreement. Nothing herein shall preclude any action to enforce the terms of this Agreement.

IV. Other Provisions

A. Headings. The headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

B. Scope. This Agreement is limited to the NQTL defined in this Agreement and addressed by the Negotiated Corrections, described herein. This Agreement does not affect, in any manner, or for any purpose, EBSA's claims with respect to any other issues, nor shall it affect the relief EBSA may obtain in relation to those issues and is not binding on any governmental agency other than EBSA.

C. Entire Agreement. This Agreement constitutes the entire agreement between the Parties

and supersedes any prior agreement or understanding, whether oral or in writing, regarding the subject of the Agreement. This Agreement may not be amended or modified except by a writing signed by all Parties.

D. Waiver. No relaxation, forbearance, delay, or indulgence by a Party in enforcing its rights hereunder or the granting of time by such Party will prejudice or affect its rights hereunder. A provision of this Agreement may be waived only by an instrument in writing executed by the waiving Party and specifically waiving such provision. The waiver of any provision of this Agreement by any Party shall not be deemed to be construed as a continuing waiver or a waiver of any other provision of this Agreement.

E. Authority. The undersigned representatives each expressly acknowledge and represent that they are authorized and empowered to execute this Agreement on behalf of the Parties represented.

F. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. An executed copy of this Agreement delivered by facsimile and/or email shall be deemed to be as effective as an original signed copy.

G. Notices. Any notice required or permitted to be given pursuant to this Agreement shall be sent to the following person/address:

If to EBSA:

Kansas City Regional Office
Mark F. Underwood, Regional Director
c/o Casey Branning, Investigator
2300 Main Street, Suite 11093
Kansas City, MO 64108-2415
Phone: 816-285-1834
Email: branning.casey.a@dol.gov

If to the Fund:

Boilermakers National Health & Welfare Fund
c/o [redacted] Chief Legal Officer and Managing Director
12200 N. Ambassador Drive, Suite 326
Kansas City, MO 64163
Phone: [redacted]
Email: [redacted]

FOR THE SECRETARY OF LABOR:

Dated: February 8, 2024

Mark Underwood

Mark F. Underwood
Regional Director
Kansas City Regional Office
Employee Benefits Security Administration

FOR THE BOILERMAKERS NATIONAL HEALTH & WELFARE FUND:

Dated: February 8, 2024

[redacted]

By: [redacted]

Title: Chief Legal Officer & Managing Director

Attachment A

Table 1: OON Utilization

OON categories to track separately:

1. Inpatient vs. outpatient
2. MH vs. SUD vs. med/surg
3. Professional vs. facility, and specific provider types within those-
   a. MH and SUD professional: psychiatrist (not including child/adolescent psychiatrists), child/adolescent psychiatrist, psychologist (not including child/adolescent psychologists), child/adolescent psychologists, physician board- certified in addiction medicine, behavioral health non-MD prescriber, master's level providers, non-master's level professional providers
   b. Med/surg professional: PCP/family practice, pediatrician, OB/GYN, all other specialty
   c. MH and SUD outpatient facility: IOP, child/adolescent, all other
   d. MH and SUD inpatient facility: acute, PHP, residential, child/adolescent
   e. Med/surg facility: child/adolescent, all other
4. Total billed amount
5. Total allowed amount
6. Total paid amount
7. Total claim lines

Table 1 (sample chart format)

		INN Claims (Service by Participating Providers)				OON Providers (Services by Non-Participating Providers)			
		Total Billed Amt	Total Allowed Amt	Total Paid Amt	Total# Claim Lines	Total Billed Amt	Total Allowed Amt	Total Paid Amt	Total# Claim Lines
Outpatient Services	Med/Surg professional • PCP/family practice • Pediatrician •OB/GYN • All Other								
	MH professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BHNPw/Rx Capability • All other								
	SUD professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BH NPw/Rx capability								

	• All other								
	Med/surg facility • Child/adolescent • All other								
	MH Facility • IOP • Child/adolescent • All other								
	SUD Facility • IOP • Child/adolescent • All other								
Inpatient Services	Med/Surg professional • PCP/family practice • Pediatrician • OB/GYN • All Other								
	MH professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BH NPw/Rx Capability • All other								
	SUD professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BH NPw/Rx Capability • All other								
	Med/surg facility • Child/adolescent • All other								
	MH Facility • IOP • Child/adolescent • All other								
	SUD Facility • IOP • Child/adolescent • All other								

Table 2: Network Providers Actively Submitting Claims

Data to report for Network providers actively submitting claims and accepting new patients. For each of the requests below, break out in-person providers vs. telehealth providers.

1. Total number of Network providers (do not include single case agreement providers)
2. Total number (and%) of Network providers noted as accepting new patients in

directory

3. Total number (and%) of Network providers who have submitted 0 network claims in the last 6 months
4. Total number (and%) of Network providers who have submitted Network claims for 1-4 unique P/Bs in the last 6 months
5. Total number (and%) of Network providers who have submitted Network claims for 5 or more unique P/Bs in the last 6 months
6. Categories to use in breaking out above numbers should include the following providers, in addition to all provider types the plan or Network has identified as "high volume" or "high impact":
    a. MH/SUD
        i. Psychiatrists (not including child/adolescent psychiatrists);
        ii. Psychologists (not including child/adolescent psychologists);
        iii. Child/adolescent psychiatrists;
        iv. Child/adolescent psychologists;
        v. Master's level MH providers (counselors, marriage and family therapists, independent clinical social workers, advanced social workers);
        vi. Non-master's level MH providers;
        vii. Board certified SUD addiction medicine physicians; and
        viii. Other non-physician SUD professionals.
    b. Med/surg
        i. PCP/family practice (not including pediatricians)
        ii. Pediatrician
        iii. OB/GYN
        iv. Cardiologists
        v. Neurologists
        vi. All other specialty physicians (not otherwise listed);
        vii. Non-physician primary care providers; and
        viii. Non-physician specialty providers

Table 3: Wait Times for New and Existing Patients

Data to report (based on participant/patient surveys) for wait times:

1. Median wait time for new patient appointment
2. Mean wait time for new patient appointment
3. Median wait time for returning patient appointment
4. Mean wait time for returning patient appointment
5. Categories to use should include the following providers, in addition to all provider types the plan has identified as "high volume" or "high impact":
    a. MH/SUD
        i. Psychiatrists (not including child/adolescent psychiatrists);
        ii. Psychologists (not including child/adolescent psychologists);
        iii. Child/adolescent psychiatrists;
        iv. Child/adolescent psychologists;
        v. Master's level MH providers (counselors, marriage and family therapists, independent clinical social workers, advanced social workers);
        vi. Non-master's level MH providers;
        vii. Board certified SUD addiction medicine physicians;
        viii. Other non-physician SUD professionals;
        ix. MH acute facility;
        x. MH subacute facility (such as PHP, residential);
        xi. MH child/adolescent facility (of any level of care);
        xii. SUD acute facility;
        xiii. SUD subacute facility
    b. Med/surg
        i. PCP/family practice (not including pediatricians)
        ii. Pediatrician\

iii. OB/GYN

iv. Cardiologists

v. Neurologists

vi. All other specialty physicians (not otherwise listed);

vii. Non-physician primary care providers;

viii. Non-physician specialty providers;

ix. Acute facility;

x. Subacute facility;

xi. Child/adolescent facility (any level of care).

Wait times survey methodology: If BNF uses a sampling methodology, that methodology must be reasonably designed to survey a sufficient number of each provider type as to constitute an unbiased representative sample of each provider type. The survey must include only providers and facilities who actively submitted one or more claims in the last 6 months.

Table 4: Time & Distance Measurements - (Use the same categories as Table 3 above.)

Methodology:

1. Explain methodology for counting providers for purposes of time/distance metrics. How are the following counted: multi-provider practice groups, single providers with multiple locations, facilities with different patient or bed capacities?

2. They must identify the time/distance metric used and basis of determination.

Data to report on time/distance metrics:

1. Time/distance metrics for each provider category by county type: large metro, metro, micro, Rural, and CEAC.

2. Number and % of these types of counties that meet time/distance standards. When assessing the number and % of these types of counties that meet time/distance standards, BNF must count only providers and facilities who actively submitted one or more claims in the last 6 months.

Table 5: Provider-To-Member Ratios - (Use the same categories as Table 3 above.)

Methodology:

1. Explain methodology for counting providers for purposes of ratios. How are the following counted: multi-provider practice groups, single providers with multiple locations, facilities with different patient, bed capacities or in-person vs. telehealth?

2. They must identify the time/distance metric used and basis of determination.

Data to report on provider-member ratios:

1. Target ratios by category;

2. Actual ratios by category - when calculating actual ratios by category, BNF must count only providers and facilities who actively submitted one or more claims in the last 6 months.

Table 6: Network Retention/Loss Analysis - (Use the same categories as Table 3 above.) Network retention/loss data to report:

1. Number of providers who were part of the Network but left the Network in the last two years;

2. Number of prospective providers who engaged in application process and/or negotiation to join Network, but ultimately did not join Network;

3. Reason for leaving or not joining Network;

4. Explain methodology for counting providers.