BRICK MASONS TRUST FUNDS

Bricklayers Local No. 4 Southern California

Date: December 2022

To: All Employees covered under the Fee-for-Service Medical Plan of the Brick Masons' Health and Welfare Trust Fund

From: Board of Trustees

Surprise/Balance Billing Protections

On December 27, 2020, the Consolidated Appropriations Act of 2021 (CAA) was signed into law. This law includes various provisions to increase cost transparency and protect you from surprise/balance billing for out-of-network (OON) medical services. Surprise/balance billing occurs when OON providers bill you for the difference between what the Brick Masons' Health and Welfare Trust Fund (Fund) agreed to pay and the full amount charged for the service.

Pursuant to these new rules in the CAA, since **May 1, 2022**, you have been protected from balance billing for the following covered services that are medically necessary:

- Emergency services[1] provided at out-of-network (OON) facilities
- Certain non-emergency services provided by OON providers at in-network facilities (unless the provider gives advance notice and obtains your consent); and
- Air ambulance services

In these situations where balance billing is not permitted, you will have the following additional protections:

- You will only be responsible for paying your share of the cost that you would pay if the provider was in-network (20% coinsurance for emergency and air ambulance services). The Fund will pay out-of-network providers and facilities directly.
- The Fund generally must:
    - Cover emergency services without requiring prior authorization

[1] Medical emergency 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 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 individuals (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy."

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- Cover emergency services by out-of-network providers
- Base your cost sharing on what the Fund would pay an in-network provider or facility and show that amount in your explanation of benefits
- Include any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Note that these balance billing protections only apply in circumstances as described above. For OON charges where you consent to being balance billed, you would be responsible for such payment.

Previously, if you visited an OON provider under circumstances as described above, you would have been responsible for a higher coinsurance (i.e. 40% of the Non-PPO Schedule)for emergency care), plus you could be balanced billed for the amount in excess of 40% of the Non-PPO Schedule.

See Table 1 below for your cost sharing for the aforementioned services prior to May 1, 2022:

Table 1

If you go to a HealthSmart Provider	**If you go to a Non-HealthSmart Provider**
Plan pays Provider: 80% of the Contracted Rate (defined as the established rate between the Fund and each participating provider)	**Plan pays You:** 60% of the Non-PPO Schedule (defined as 90th percentile of Reasonable Charges for Non-PPO claims)
You owe Provider: 20% of the Contracted Rate (coinsurance) You do not owe any amount above the Contracted Rate.	**You owe Provider:** The Total Charges which includes the Plan payment (60% of the Non-PPO Schedule), your coinsurance (40% of the Non-PPO Schedule) and any amount above the Non-PPO Schedule.

On or after May 1, 2022, the cost sharing shown in Table 2 below will apply:

Table 2

If you go to a HealthSmart Provider	**If you go to a Non-HealthSmart Provider for Services that Qualify for Balance Billing Protections**	**If you go to a Non-HealthSmart Provider for Services that do not Qualify for Balance Billing Protections**
Plan pays Provider: 80% of the Contracted Rate (defined as the established rate between the Fund and each participating provider) Any remaining charges.	**Plan pays Provider:** 80% of the QPA,* plus any amount in excess of the QPA* that the Plan is required to pay the Provider by law.	**Plan pays You:** 60% of the Non-PPO Schedule (defined as 90th percentile of Reasonable Charges for Non-PPO claims)

You owe Provider:	**You owe Provider:**	**You owe Provider:**
20% of the Contracted Rate (coinsurance) You do not owe any amount above the Contracted Rate	20% of the QPA*. You do not owe any amount above the QPA*.	The Total Charges which includes the Plan payment (60% of the Non-PPO Schedule), your coinsurance (40% of the Non-PPO Schedule) and any amount above the Non-PPO Schedule.

*Effective May 1, 2022, the qualifying payment amount (QPA) shown in the table above is equal to the median in-network rate for similar procedures performed in similar geographic areas as of January 31, 2019, increased using the Consumer Price Index for Urban Consumers, as defined under the CAA and related regulations.

For any OON services where the provider gives advance notice and obtains your consent, the cost sharing shown in Table 1 above will continue to apply.

Covered Expenses Include Tele-Health Visits

Also, since May 1, 2022, the Plan's Covered Expenses include treatment by a licensed Physician or podiatrist, whether in- person or via tele-health.

Continuity of Coverage

If you are a Continuing Care Patient (as set out in the CAA), and the contract with your PPO provider or facility terminates, or your benefits under the Plan are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at PPO cost sharing to allow for a transition of care to a PPO provider

Summary of Material Modifications

This Summary of Material Modification (SMM) modifies some of the information contained in the Summary Plan Description of the Brick Masons' Health and Welfare Trust Fund. For example, this SMM modifies some of the provisions set out on pages 1, 2, 4, and 16 of the SPD. In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM will govern. You should take the time to read this SMM carefully and keep it with the SPD and SMMs that were previously provided to you.

If you have any questions, please contact the Fund at (877) 516-0586.

This document has been uploaded and is available on the participant website at www.socalbrickmasonsbenefits.org.