Amendment No. 19
to the
Rules and Regulations Providing Health and Welfare Benefits of the
Brick Masons' Health and Welfare Trust

The Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) are amended, as follows:

Effective for services rendered on or after May 1, 2022:

(1) New sections 9.1 and 9.2 are inserted under **Article** I, entitled "**Definitions.**" Section 9.1 shall be entitled "Emergency Services" and section 9.2 shall be entitled "Medical Emergency" on page 5, as set out below; and

(2) Article III, entitled "Fee-For-Service Major Medical Benefit Plan is modified extensively. Sections 1(c), 2, 2(a)(3), 2(b)(3), 3(a), 3(e), 4, 5, and 6(c) are modified to read, as set out below. The following new sections are inserted in Article III: 1(d) and 2(c)(4), as set out below. Underlined, italicized language reflects insertions; stricken language reflects deletions.

I. **Article I. Definitions.**

Section 9.1. "**Emergency Services**" with respect to a "**Medical Emergency**" means:

1. A medical screening examination that is within the capability of the emergency department of a hospital or a of an independent freestanding emergency department as applicable, including ancillary services routinely available to the emergency department to evaluate a medical emergency; and

2. Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable.

Emergency services also include certain post-stabilization services as part of outpatient observation or an inpatient or outpatient stay during a visit if the items and services would otherwise be covered under the Plan if furnished by a PPO provider or facility unless certain conditions with respect to a participant or beneficiary exist such as that individual is stabilized and able to: (a) travel using non-medical or non-emergency medical transportation, (b) receive appropriate notice; and (c) voluntarily consent. Such conditions here must be satisfied to the extent required by law.

Section 9.2. **Medical Emergency**" means:

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

II. **Article III. Fee-For-Service Major Medical Benefit Plan.**

Section 1. Definitions.

(c) Non-PPO Schedule – The term "Non-PPO Schedule" means a fixed schedule of allowances the Plan will pay for Medically Necessary Covered Expenses received from a Non-PPO Provider, *except to the extent such Covered Expenses will be paid at the Qualified Payment Amount (QPA) as otherwise required pursuant to the Consolidated Appropriations Act of 2021 (CAA)*. The *Non-PPO* schedule is based on the 90th percentile of ~~MDR~~ *Reasonable Charges* for Non-PPO claims incurred prior to October 1, 2010, and the 90th percentile of *Reasonable Charges* ~~Context~~ for Non-PPO claims incurred on or after October 1, 2010, as updated from time to time.

(d) Qualified Payment Amount (QPA) – The QPA is the median of contracted rates for the same or similar item or service by a similar provider in the same geographic area of January 31, 2019, indexed for inflation.

Section 2. *Preferred Provider Organization and* Managed Care Programs.

The Trust contracts with ~~a~~ Health *Maintenance* ~~Management~~ Organizations *(HMOs)* to provide various managed care programs.

(a) Preferred Provider Organization

. . .

(3) In no case will the Fund nor any Eligible Individual be liable for charges or fees for services in excess of the Contracted Rate charged by any provider in the PPO Network for which an established Contracted Rate exists. *For Emergency Services, services at PPO facilities, and for air ambulance services rendered on or after May 1, 2022, an Eligible Individual will not be liable for charges or fees in excess of 80% of the QPA for Covered Expenses charged by a Non-PPO Provider as otherwise required pursuant to the CAA.*

(b) Pre-admission Review.

. . . .

(3) Emergency hospitalization does not require Pre-Admission Review. However, the Health Management Organization must be notified within 48 hours of an emergency admission.

(c) Concurrent Review and Discharge Planning.

(1)
(2)
(3)
(4) *As required by the CAA, the PPO Plan will provide continued benefits under the Plan when a*

PPO Provider or facility terminates its contractual relationship with the Plan or its PPO network for Eligible Individuals who are deemed "Continuing Care Patients" as defined in the CAA. A Continuing Care Patient is an Eligible Individual who is:

- *Undergoing a course of treatment for a serious and complex condition from the PPO Provider or facility;*
- *Undergoing a course of institutional or inpatient care from the PPO Provider or facility;*
- *Scheduled to undergo nonelective surgery from the PPO Provider or facility, including receipt of postoperative care;*
- *Pregnant and undergoing a course of treatment for the pregnancy from the PPO Provider or facility; or*
- *Or was determined to be terminally ill and is receiving treatment for such illness from such PPO Provider or facility.*

If the Eligible Individual elects continued transitional care, the PPO Plan will provide the Eligible Individual with continued benefits under the same terms and conditions as would have applied had the termination of that PPO provider or facility not occurred, with respect to the condition needing continuing care. The PPO Plan will provide these continued benefits for a 90-day period, or until the Eligible Individual is no longer a continuing care patient with respect to the PPO Provider or facility, if earlier.

Section 3. Benefits.

If an Eligible Individual receives therapeutic treatment of an Injury or Sickness, the Plan will, subject to the terms and conditions hereafter stated, pay the following benefits:

(a) Medically Necessary Covered Expenses: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider. The Plan pays 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider. Non-PPO Covered Expenses for anesthesiology claims are based on 85th percentile of ~~HIAA~~ Reasonable Charges *provided the Non-PPO provider satisfies all notice and consent requirements required by CAA and such services are not otherwise required to be paid at the QPA pursuant to the CAA. Notwithstanding the above, when a Non-PPO Provider furnishes Emergency Services, services at PPO facilities, and air ambulance services on or after May 1, 2022, such Covered Expenses will be paid at the QPA as otherwise required pursuant to the CAA*.

. . . .

(e) Emergency Services: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider. *The Plan pays 80% of the QPA for Covered Expenses provided by a Non-PPO Provider.*

Section 4. Deductible.

The Deductible is the amount of Covered Expenses that must be paid by an Eligible Individual before the Plan will pay benefits.

. . .

(d) *For Emergency Services, services at PPO facilities, and for air ambulance services rendered on or after May 1, 2022, an Eligible Individual's cost sharing payments for these services will count towards the Plan's PPO Deductible as if the services were provided by a PPO Provider.*

Section 5. Out-of-Pocket Maximum.

Once an Eligible Individual satisfies their calendar year out-of-pocket maximum, the Plan will pay 100% of Covered Expenses for the remainder of the calendar year. The calendar year out-of-pocket maximum does not apply to premiums, balance billing, or services that are not covered under the Plan.

For Emergency Services, services at PPO facilities, and for air ambulance services rendered on or after May 1, 2022, an Eligible Individual's cost sharing payments for these services will count towards the Plan's out-of-pocket maximum as if the services were provided by a PPO Provider. The calendar year out-of-pocket maximum shall apply to services rendered by a Non-PPO Provider for which the Eligible Individual was provided proper notice and voluntarily consented as set out in the CAA.

The calendar year out-of-pocket maximums are, as follows:

(a) Individual: $2,000
(b) Family: $6,000.

Section 6. Covered Expenses.

. . .

(c) Treatment by a licensed Physician or podiatrist, including assistant surgeon and anesthetist, *which includes in-person and tele-health visits.* Charges for the services of an assistant surgeon will be paid at a maximum of 20% of the amount paid to the primary Surgeon. . . .

Certification of Adoption

The undersigned Trustees of the Brick Masons' Health and Welfare Trust do hereby certify that the foregoing Amendment No. 19 to the Rules and Regulations providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust (Restated June 12, 2007) was duly adopted at a meeting held on March 22, 2022.

Union Trustees

Employer Trustees

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Kenneth J. Tejeda Kenneth J. Tejeda

Dana A. Kemp

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