AMENDMENT NO. 7

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA

PLAN RULES AND REGULATIONS

The Cement Masons Health and Welfare Trust Fund For Northern California Active and Retired Cement Masons Plan Rules and Regulations (Amended and Restated March 1, 2015) (the "Plan"), are amended as follows, effective September 1, 2022:

1. **Article I, Definitions, a new Section 2.00 is added, and all Sections re-designated accordingly, stating as follows:**

   Section 2.00 The term **"Air Ambulance"** means medical transport by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605, for patients.

2. **Article I. Definitions, Section 3.00 (formerly Section 2.00) is amended by adding the text in underline below, as follows:**

   Section 3.00 The term **"Allowed Charge", "Allowed Amount"** or **"Allowable Charge"** means the amount the Fund allows, subject to all Plan provisions, for eligible Medically Necessary services or supplies. Except as required by the No Surprises Act, the Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

   a. For a **Participating Provider**, the negotiated contract rate set forth in the agreement between the participating provider and Anthem Blue Cross.

   b. For a **Non-Participating Provider**, the schedule of fees that lists the dollar amounts the Fund has determined it will allow for eligible Medically Necessary services or supplies unless subject to the No Surprises Act. The Fund's Allowed Charge amount list is not based on nor intended to reflect fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charges (UCR), prevailing or any similar term. The Fund reserves the right to have the billed amount reviewed by an independent medical review organization to assist in determining the amount the Fund will allow for the submitted claim; **or**

   c. The provider's actual charge.

   The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even if the Eligible Individual has paid the applicable Plan Year Deductible, Copayment and/or coinsurance. This is because the Plan covers only the **"Allowed Charge"** for health care services or supplies.

   Any amount in excess of the **"Allowed Charge"** does not count towards the Plan Year Out-of-Pocket Maximum. The Eligible Individual is responsible for amounts that exceed the **"Allowed Charge"** determined by the Plan.

   In accordance with federal law, with respect to emergency services performed in a Non-Participating Hospital **E**mergency **R**oom (ER), the Plan's allowance for ER visit facility fees is to pay the **greater of:**

   (a) The Participating Hospital's negotiated rate;

(b) 100% of the Plan's Allowed Charge formula reduced for applicable cost sharing; **or**

(c) When such database is available, the amount that Medicare Parts A or B would pay reduced for cost-sharing.

3. Article I, Definitions, a new Section 5.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 5.00 The term **"Ancillary Services"** means, with respect to a Participating health care facility:

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

b. Items and services provided by assistant surgeons, hospitalists, and intensivists;

c. Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of Health and Human Services; and

d. Items and services provided by a Non-Participating Provider if there is no Participating Provider who can furnish such item or service at such facility.

4. Article I, Definitions, a new Section 13.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 13.00 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 non-elective surgery from the provider, 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.

5. Article I, Definitions, a new Section 14.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 14.00 The term **"Cost-Sharing"** means the amount a participant or dependent is responsible for paying for a covered item or service 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-Participating Providers, or the cost of items or services that are not covered under the Plan.

6. Article I, Definitions, a new Section 15.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 15.00 The term "**Cost-Sharing Amount"** means for Emergency Services, non-Emergency Services at Participating Facilities performed by Non-Participating Providers, and Air Ambulance services from Non-Participating Providers will be based on the Recognized Amount.

7. Article I. Definitions, Section 16.00 (formerly Section 12.00) is amended by adding the text in underline below, as follows:

Section 16.00 The term **"Covered Charges"** as it relates to Article V., Subsections 4.b. and 4.e., inpatient Hospital expense at a Non-Participating Hospital means: Room, board and routine nursing charges up to an amount equal to the Hospital's lowest rate charged for semi-private or intensive care room accommodations, or 80% of the lowest rate charged for private room accommodations unless subject to the No Surprises Act.

8. Article I. Definitions, Section 25.00 (formerly Section 21.00) is amended by adding the text in underline and deleting text in strikethrough, as follows:

Section 25.00 The term **"Emergency Medical Condition"** means a medical condition, including mental health condition or substance use disorder, manifested by ~~involving~~ acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in serious jeopardy to the health of the individual or a pregnant woman, her unborn child or serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

9. Article I. Definitions, Section 26.00 (formerly Section 22.00) is restated in its entirety by adding text in underline and deleting text in strikethrough as follows:

Section 26.00 ~~The term **"Emergency Services"** means a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.~~

- ~~The term **"to stabilize"** means, to provide medical treatment of the 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).~~

~~**The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.**~~

The term **"Emergency Services"** means the following:

a. 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 an Emergency Medical Condition;

b. 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 patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

c. Post stabilization services which are additional services covered under the Plan that are furnished by a Non-Participating Provider or Non-Participating emergency facility (regardless of the department of the hospital in which such items or services are furnished)

after a patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay, with respect to the visit in which the services described in subsections a. and b. are provided, until:

(1) The provider or facility determines that the participant or dependent is (i) stable; (ii) able to travel using nonmedical transportation or nonemergency medical transportation to an available Participating Provider or Participating Facility within a reasonable travel distance, taking into account the individual's medical condition; and (iii) in a condition to receive the information and provide informed consent, as described herein;

(2) The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Participating Provider with respect to the Plan, of the estimated charges for the treatment and any advance limitations that the Plan may put on such treatment, of the names of any Participating Providers at the facility who are able to provide such treatment, and that the participant or dependent may elect to be referred to one of the Participating Providers listed; and

(3) The participant or dependent gives informed consent to continued treatment by the Non-Participating Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or dependent.

10. Article I, Definitions, a new Section 33.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 33.00 The term **"Health Care Facility"** (for non-Emergency Services) means each of the following:

a. A hospital (as defined in section 1861(e) of the Social Security Act);

b. A hospital outpatient department;

c. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

d. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

11. Article I, Definitions, a new Section 39.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 39.00 The term **"Independent Freestanding Emergency Department"** means a health care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct and licensed separately from a hospital under applicable State law and provides Emergency Services.

12. Article I, Definitions, a new Section 43.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 43.00 The term **"No Surprises Act"** means the federal No Surprises Act (Public Law 116-260, Division BB).

13. Article I, Definitions, a new Section 44.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 44.00 The term **"No Surprises Act Services"** means the following, to the extent covered under the Plan: (1) Non-Participating Emergency Services, (2) Non-Participating Air Ambulance

Services; (3) non-emergency Ancillary Services performed by a Non-Participating Provider at a Participating Health Care Facility; and (4) other Non-Emergency Services performed by a Non-Participating Provider at a Participating Health Care Facility with respect to which the provider does not comply with the applicable written federal notice and consent requirements.

14. Article I, Definitions, a new Section 45.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 45.00 The term **"Non-Participating Emergency Facility"** means an emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service under the Plan.

15. Article I, Definitions, a new Section 49.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 49.00 The term **"Out-of-Network Rate"** with respect to No Surprises Act Services furnished by a Non-Participating Provider, Non-Participating Emergency Facility or Non-Participating Provider of ambulance services, means one of the following:

a. the amount negotiated by the Plan and provider or facility;

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

16. Article I, Definitions, a new Section 63.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 63.00 The term **"Qualifying Payment Amount" (QPA)** means the amount calculated using the methodology described in 45 CFR § 149.140(c), which is generally the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

17. Article I, Definitions, a new Section 64.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 64.00 The term **"Recognized Amount"** means (in order of priority) one of the following:

a. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

b. An amount determined by a specified state law; or

c. The lesser of: (1) the amount billed by the provider or facility or (2) the Qualifying Payment Amount (QPA)

Notwithstanding the above, for Air Ambulance services furnished by Non-Participating Providers, the **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

18. Article I, Definitions, a new Section 68.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 68.00 The term **"Serious and Complex Condition"** means with respect to a participant, dependent, or enrollee under the Plan one of the following:

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—

(1) is life-threatening, degenerative, potentially disabling, or congenital; and

(2) requires specialized medical care over a prolonged period of time.

19. Article I, Definitions, a new Section 70.00 is added, and all Sections re-designated accordingly, stating as follows:

Section 70.00 The term **"Terminated**" in the context of Continuity of Care, **Termination** includes, with respect to the contractual relationship between the Plan and a provider or facility, 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.

20. Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 1a.(6)(g)(iii) is amended adding language in underline, stating as follows:

(iii) By licensed air ambulance if the Fund determines that the location and nature of the illness or injury made air transportation cost effective or Medically Necessary to avoid the possibility of serious complications or the loss of life, and the charges do not exceed:

1) <u>for Participating Providers, the Allowed Charge; or</u>
2) <u>for Non-Participating Providers, the lesser of the Qualifying Payment Amount or the provider's billed charge.</u>

21. Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 4b. is amended by adding language in underline, stating as follows:

b. Benefits for Confinement in a Non-Participating Hospital

If an Eligible Individual is confined in a Non-Participating Hospital with the approval of the PRO, the Fund will, <u>except as required by the No Surprises Act, and</u> subject to all other Plan provisions, pay 50% of the first $15,000 of **Covered Charges** (as defined in Article I., Section 12.00) and 100% of **Covered Charges** thereafter for all Medically Necessary services including, but not limited to, room, board and routine nursing care.

22. Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 4e. is amended by adding language in underline, stating as follows:

e. Exceptions to the Preferred Provider Plan

(1) If an Eligible Individual **who does not reside** within the Fund's Preferred Provider Plan Service Area is confined in a Non-Participating Hospital with the approval of the PRO, the Fund will, <u>except as required by the No Surprises Act, and</u> subject to all Plan provisions, pay 80% of the first $15,000 of **Covered Charges** (as defined in Article I., Section 12.00) and 100% of **Covered Charges** thereafter for all Medically Necessary services including, but not limited to, room, board and routine nursing care.

(2) If an Eligible Individual **who resides within** the Fund's Preferred Provider Plan Service Area is confined in a Non-Participating Hospital **due to a serious or life-threatening emergency,** the Fund will pay for **Covered Charges** incurred as described in Subsection e.(1) above <u>and as required by the No Surprises Act.</u> The Fund may require the transfer of the Eligible Individual to a Participating Hospital upon the advice of a Physician that it is medically safe to make the transfer.

23. Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 4 h(2)(a) is amended by adding language in underline, stating as follows:

h. **Other Covered Expenses**

(2) For Covered Expenses incurred at a **Non-Participating Provider or the outpatient department of a Non-Participating Hospital**, the Fund will, except as required by the No Surprise Act, and subject to all other Plan provisions, pay the **lesser** amount of the actual charge **or** 50% of the **Allowed Charge**, **except**:

(a) The Fund will pay for **Emergency Services** at 80% of the Allowed Charge for outpatient services within the emergency department of a Non-Participating Hospital. This includes charges made by the Non-Participating Hospital, the Physician's professional fees and professional ambulance services.

(b) **Active Participants and Eligible Dependents:** For Physician Office Visits, the Fund will, subject to all other Plan provisions, pay 50% of the Allowed Charge after a $20 Physician Office Visit Copayment.

(c) **Retired Participants and Eligible Dependents:** For Physician Office Visits, the Fund will, subject to all other Plan provisions, pay 50% of the Allowed Charge after a $20 Physician Office Visit Copayment.

24. Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, is amended by adding a new Section 5, stating as follows:

Section 5.00 No Surprises Act Services

a. Emergency Services

Emergency Services are covered:

(1) Without the need for a prior authorization determination, even if the services are provided out-of-network;

(2) Without regard to whether the health care provider furnishing the Emergency Services is a Participating Provider or a Participating emergency facility, as applicable, with respect to the services;

(3) Without imposing any administrative requirement or limitation on Non-Participating Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Participating Providers and Participating emergency facilities;

(4) Without imposing cost-sharing requirements on Non-Participating Emergency Services that are greater than the requirements that would apply if the services were provided by a Participating Provider or a Participating emergency facility;

(5) By calculating the cost-sharing requirement for Non-Participating Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount (as defined in the Definitions Section) for the services; and

(6) By counting any Cost-Sharing payments made by the participant or dependent with respect to the Emergency Services toward any In-Network deductible or In-Network out-of-pocket maximums applied under the Plan (and the In-Network deductible and In-Network out-of-pocket maximums are applied)

in the same manner as if the cost sharing payments were made with respect to Emergency Services furnished by a Participating Provider or a Participating emergency facility.

Your Cost-Sharing Amount for Emergency Services from Non-Participating Providers will based on the lesser of the billed charges from the provider or the Qualifying Payment Amount .

b. Non-Emergency Services from a Non-Participating Provider at a Participating Health Care Facility

(1) Subject to subsection (2), when non-emergency items or services that are otherwise covered under the Plan are furnished to a participant or dependent by a Non-Participating Provider at a Participating Health Care Facility, such items or services are covered by the Plan:

(a) With a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by a Participating Provider;

(b) By calculating the Cost-Sharing requirements as if the total amount that would have been charged for the items and services by such Participating Provider were equal to the Recognized Amount for the items and services; and

(c) By counting any Cost-Sharing payments made by the participant or dependent toward any in-network deductible and in-network out-of-pocket maximums applied under the Plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such Cost-Sharing payments were made with respect to items and services furnished by a Participating Provider.

(2) **Notice and Consent Exception.** Non-emergency items or services performed by a Non-Participating Provider at a Participating Health Care Facility will be covered based on your Non-Participating coverage, and subsection (1) will not apply to such items or services, if:

(a) At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the Non-Participating Provider supplies the participant or dependent with a written notice, as required by federal law, that the provider is a Non-Participating Provider with respect to the Plan, of the estimated charges for the treatment and any advance limitations that the Plan may put on the treatment, of the names of any Participating Providers at the facility who are able to provide such treatment, and that the participant or dependent may elect to be referred to one of the Participating Providers listed; and

(b) The participant or dependent gives informed consent to continued treatment by the Non-Participating Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or dependent.

Notwithstanding the above, 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-Participating Provider satisfied the notice and consent criteria, and therefore these services will be covered:

(a) With a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by a Participating Provider,

(b) With Cost-Sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and

(c) With Cost-Sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such Cost-Sharing payments were with respect to items and services furnished by a Participating Provider.

Your Cost-Sharing amount for Non-Emergency Services at Participating Health Care Facilities by Non-Participating Providers will based on the lesser of the billed charges from the provider or the Qualifying Payment Amount.

c. Air Ambulance Services

If you receive Air Ambulance services from a Non-Participating Provider, and such services would have been covered as a Covered Expense, those services will be covered by the Plan as follows:

(1) The Air Ambulance services received from a Non-Participating Provider will be covered with a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the services had been furnished by a Participating Provider.
(2) In general, you cannot be balance billed for these items or services. Your Cost-Sharing will be calculated as if the total amount that would have been charged for the services by a Participating Provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the Non-Participating Provider's billed amount for the services.
(3) Any Cost-Sharing payments you make with respect to covered Air Ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from a Participating Provider.

25. Article VIII, Exclusions, Limitations and Reductions, Section 2 is amended by adding language in underline, stating as follows:

Section 2. Limitations

The Fund does not provide benefits for medical services or supplies that are not Medically Necessary as determined by the Plan. Furthermore, the Fund will not provide benefits for medical services or supplies that are in excess of the Allowed Charge or **M**aximum **P**lan **A**llowance (MPA) as determined by the Plan <u>unless subject to the No Surprises Act.</u>

26. Article IX, General Provisions, Section 1 is amended by adding the following after the first paragraph, stating as follows:

For payments to Non-Participating Providers and Facilities for No Surprises Act Services, the Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Participating Facilities by Non-Participating Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the provider. The 30 day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant or dependent cannot be required to pay more than the applicable 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.

The Plan will pay a total Plan payment directly to the Non-Participating 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.

27. Article X, Claims and Appeals Procedures, Section 4 is amended by revising the second paragraph and following subsections in their entirety, with the added text in underline, stating as follows:

You may seek further review through the External Review Process by an **I**ndependent **R**eview **O**rganization (IRO), if your Internal Appeal of a health care Claim, whether Urgent, Concurrent, Pre-Service or Post-Service Claim is denied and it fits within the following guidelines:

(1) The denial involves medical judgment including, but not limited to, those based on the Plan's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is an Experimental or Investigative Procedure. The IRO will determine whether a denial involves a medical judgment; **and/or**

(2) The denial is due to a Rescission of coverage (retroactive elimination of coverage) regardless of whether the Rescission has any effect on any particular benefit at that time; **and/or**

(3) The denial involves consideration of whether the Plan is complying with the surprise billing and Cost-Sharing protections applicable to No Surprises Act Services.

Executed this 29th day of September 2022

DocuSigned by:
Brian Gardner
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Chairman

Co-Chairman