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PLUMBERS 98 MCA Detroit
Mechanical Contractors Association of Detroit

PLUMBERS LOCAL 98
FRINGE BENEFIT FUNDS
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To: Plumbers Local 98 Insurance Fund Participants

From: Board of Trustees of the Plumbers Local 98 Insurance Fund

Re: Summary of Material Modification –
KEEP WITH SUMMARY PLAN DESCRIPTION

Date: August 2023

Please read this Notice carefully as it contains important information about changes to the Plumbers Local 98 Insurance Fund Plan (Plan) effective September 1, 2023 (unless otherwise set forth below). This document should be read carefully and attached to your Plumbers Local 98 Insurance Fund Summary Plan Document (SPD). Please contact the Fund Office if you have any questions about the changes described in this Notice.

PLAN CHANGES

Additional Weekly Disability Benefits

The Plan currently provides a weekly disability benefit of $300.00 per week, less FICA tax, for up to 26 consecutive weeks. The Plan has been amended to provide that an Active Employee who remains disabled after 26 weeks, if approved by the Trustees, can receive an additional 26 weeks of benefits if approved for a Social Security Extension of eligibility, discussed below.

Eligibility While Disabled

If, while eligible, an Active Employee suffers a Disability, his/her eligibility Bank will be frozen, to be restored when he/she is no longer disabled, as set forth below. While covered under this section, an Active Employee may elect to switch Options under the same circumstances as other Participants.

A Disabled Active Employee will be eligible for benefits for up to 26 weeks from the first day of such continuous Disability. Once an Active Employee has had coverage under this provision for

26 weeks, he may continue coverage by way of his/her remaining eligibility Bank for so long as the Active Employee remains Disabled. **After an Active Employee has had coverage under this provision for 26 weeks, he/she will not be eligible for any further coverage under this section for the same Illness or Injury until credited with 80 or more hours of work as a plumber for a contributing Employer.**

Social Security Extension: If an Active Employee remains Disabled after a 26-week period of continuous Disability, provided he/she has applied for Social Security Disability benefits, has 10 years of service under the Plumbers Local 98 Defined Benefit Fund, and has applied for a disability pension with the Plumbers Local 98 Defined Benefit Fund, he/she may apply, in writing, to the Trustees to continue eligibility for an additional 26-week period. After an Active Employee receives this extension, if he/she subsequently returns to work, no extended coverage for Disability of any kind will be provided for one year following the last day eligibility was maintained under these provisions.

Coverage under these provisions is not available to Irrigation Plumbers. Once an Irrigation Plumber's eligibility terminates, he/she will be offered COBRA coverage.

Termination of Eligibility

The termination of eligibility provisions were amended to add paragraph (c), below:

Notwithstanding any other provision in the Plan, eligibility shall immediately terminate

(a) For an individual who:

(i) works for a noncontributing employer in the plumbing and pipefitting industry, or

(ii) works for a noncontributing employer performing work of the type for which Contributions would be required to be paid to the Fund if performed for a contributing Employer under the Collective Bargaining Agreement.

(b) If (a), above, does not apply, eligibility shall immediately terminate for an individual who works for an employer who is not in the plumbing and pipefitting industry if such individual is not available for work for a contributing employer.

(c) If (a) or (b), above, do not apply, eligibility shall immediately terminate if a participant is maintaining coverage by using the Bank or self-payments and is not working for a contributing Employer or is not on the Union's out of work list. An individual will be treated as not on the Union's out of work list where they have turned down two jobs, for which they are qualified, for a contributing Employer within six months. (This provision shall not apply to a participant who is Disabled and using their Bank to maintain eligibility after exhaustion of coverage.)

If eligibility is terminated under any of the above provisions, the participant's Bank will be immediately extinguished (as well as his/her HRA), COBRA continuation coverage will be offered, and to be eligible for coverage in the future he/she must re-establish initial eligibility.

Coronavirus/COVID-19 Coverage

During the pandemic, the Plan covered certain COVID-19 Testing/facility charges and Treatment at 100% for both in and out-of-network. Such charges will now be covered the same as other Illnesses covered by the Plan. The Plan will no longer cover over-the-counter (OTC) COVID-19 tests for personal use.

Preventive Services Coverage

The Plan was amended to clarify the preventative services (relating to both medical and prescription drugs) federal law requires to be covered on an in-network basis with no cost-sharing (i.e., copayment, co-insurance, or deductible) from those preventive services the Plan has elected to cover in-network without cost-sharing. Appendix A reproduces the portion of the Plan relating to these preventive services.

Hines & Associates/Pre-Certification and Pre-Authorization

Any reference in the Plan to Health Plan Advocate is replaced with Hines & Associates.

Therefore, among other things, Hines & Associates are now providing Pre-Certification and Pre-Authorization services. The following is a list of services to be Pre-Certified by Hines (this list may change from time to time, so please contact Hines at 888-826-5769 if you have any questions as to whether a service requires Pre-Certification):

- Acute Inpatient Admissions (medical, surgical, behavioral health)
- Skilled Nursing Facility
- Behavioral Health Residential Stays
- Select outpatient Surgeries:
    - Nasal Surgeries
    - Blepharoplasty
    - Ventral hernia repair
    - Varicose vein surgery
    - Bioengineered skin and soft tissue replacement
    - Partial or Full Joint Replacements
    - Osteochondral Autografts
    - Sclerotherapy
    - Panniculectomy
    - Abdominoplasty

- Breast Reduction
- Hysterectomies
- UP3/UPPP – uvulopalatopharyngoplasty
- Excess skin removal of arms, chests, and legs
- AV Fistula or graft access for dialysis
- Bariatric (weight loss) Surgery
- Shock wave lithotripsy for plantar fasciitis
- AICD and Biventricular device insertions
- Oncology related surgeries including Port Insertions
- Spinal surgeries (Including spinal injections for pain management)
- Maxillo-facial surgery
- Biopsies as primary procedures
- Back or neck procedures including:
  - IDET (intradiscal Electrothermal Annuloplasty)
  - Percutaneous Radiofrequency Neurotomy
  - Artificial Intervertebral Disk Implantation
  - Automated Percutaneous Lumbar Diskectomy (APLD)

- Select Outpatient Diagnostic Testing Review:
  - CT Angiogram
  - CT Calcium screening
  - MRI of the heart
  - Capsule Camera Endoscopy
  - Virtual Colonoscopy
  - Oncology related PET, CT, or MRI
- Select Outpatient infusion and injection therapies. A Covered Person should call Hines to confirm whether an infusion or injection requires precertification. **See the limitation on outpatient infusion therapy in the section on Plan Exclusions, below.**

Any Pre-Certified service is subject to all other Plan terms, conditions, and exclusions.

Plan Exclusions

The following Plan Exclusions have been modified or added. Neither medical nor prescription drug coverage will be provided for:

- Charges for care, items, services or treatment for gender dysphoria (e.g., sex transformations, gender reassignment surgery and related treatment). This exclusion includes all medication, implants, surgery, medical or psychiatric treatment, both pre- and post-operative care, and related hormone treatments.

- Charges for acupressure, acupuncture, therapeutic massage, biofeedback, and homeopathy therapy.

- Charges for ground ambulance transportation in excess of charges that would have been approved if the person were taken to a local facility equipped to provide treatment, taking into consideration Medical Necessity.

- Charges for air ambulance transportation:

    (a) where there is a facility equipped to provide treatment that could have been timely reached by ground ambulance, taking into consideration Medical Necessity (in which case the Plan will cover charges that would have been approved if the person were taken by ground ambulance to such facility); or

    (b) in excess of charges that would have been approved if the person were taken to a local facility equipped to provide treatment, taking into consideration Medical Necessity.

- Elective Abortions.

- Outpatient infusion and injection therapies must be administered in a home, office, or free-standing infusion center setting to be covered, unless (1) it is Medically Necessary that the treatment be provided in a facility setting; (2) the medication is subject to limited distribution and is available only at certain facilities; or (3) the Covered Person would have to travel more than 50 miles from his or her home to receive services in an office or free-standing infusion center setting. Therapy commenced prior to September 1, 2023, will be subject to a 60-day grace period to allow for any transition to the most appropriate site where services can be safely administered.

Prescription Drugs

Updates have been made to prescription drug coverage as follows:

- Sexual Dysfunction Agents are covered for generic only, at 12 pills per month, with prior authorization; however, such limit may be changed at any time in the discretion of the Pharmacy Benefits Manager.

- The Fund covers preventive health drugs without cost-sharing, as required by federal law. Preventive health drugs must be: (1) prescribed by a healthcare provider (even for over-the-counter products); and (2) obtained from an in-network pharmacy. Preventive health drugs include the following:

- Antiretrovirals (PrEP)
- Aspirin
- Bowel Preparation Products
- Breast Cancer Prevention Drugs
- Female contraceptives, including but not limited to the full range of FDA-approved contraceptives and emergency contraceptives;
- Fluoride
- Folic Acid
- Low to Moderate Dose Statins
- Tobacco Cessation Drugs

Please be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status. Please contact the Fund Office to obtain a list of covered preventive health drugs and the specific coverage criteria applicable to each drug. You may also find a list of a number of such drugs at U.S. Preventive Services Task Force, A & B Recommendations:

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Health Reimbursement Accounts (HRA)

The provisions regarding use of the HRA were amended to clarify:

- Medical expenses for Dependents are eligible for reimbursement if the Dependent is enrolled in the 98 Plan or other group health plan (non-HRA coverage) that satisfies the annual limit and preventive services requirements.
- The HRA may not be used to reimburse premiums for individual market coverage or individual insurance coverage.

Opt Out A – Dental Coverage

The provisions governing Opt Out A Dental Coverage have been clarified as follows:

- A Participant may opt-out of receiving Dental benefits provided under this Opt-Out coverage.
- Type 2 Services – Basic Dental Procedures – include bite splint appliances once every 5 years.
- The Type 1, 2 and 3 combined Annual limit applies to all covered persons, including those under age 19.
- Exclusions include charges for prophylaxis, or oral examinations more often than two times in a calendar year.

Definitions

Medical Necessity: All medical and prescription drug benefits must be Medically Necessary to be covered by the Plan. The definition of Medically Necessary has been amended as follows:

> Medically Necessary (or Medical Necessity) – health care services, supplies or treatment that are required to identify or treat the Illness or Injury which a Physician has diagnosed. To be Medically Necessary the service, supplies or treatment must be:
>
> - Consistent with the diagnosis and treatment of the patient's condition;
> - Consistent with professionally recognized standards of health care;
> - Medically proven to be effective treatment of the condition;
> - Not conducted for research purposes;
> - Not solely for the convenience of the patient, Physician, or supplier; and
> - The most appropriate level of services (including site) that can be safely provided to the patient.

The fact that a Physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

Legal Separation: For clarification, all references to legal separation includes a Judgment or Order of Separate Maintenance under Michigan law or other similar orders or judgment under other applicable state law.

Enrollment of Dependents

New Dependents

Effective 8/4/23, a Participant must request that a new Dependent be enrolled in the Plan within 60 days of the date that such person first qualifies as a Dependent. Coverage for a Spouse shall be effective the first day of the first month beginning after the date a completed request for enrollment is received. Coverage for a Child shall be effective the date such person became a "Child" as defined in the Plan. If a Dependent is not timely enrolled under this section, he/she will not be able to enroll until the next open enrollment period. Notwithstanding, if a Child is not enrolled within this 60-day period, coverage shall be effective the date such person became a Child as defined in Article 1 upon receipt of completed enrollment materials (this exception does not apply an individual who is a Child due to status as a stepchild or legal guardianship). Any request to change coverage elections due to the acquisition of a new Dependent must be made in the same time frames.

Open Enrollment

Notwithstanding any term of the Plan to the contrary, a Dependent may enroll in the Plan during the Calendar Year if the Dependent loses eligibility for Medicaid or State Children's Health Insurance

Program ("CHIP"), or the Dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP provided this request is made within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Coverage for Children Under Legal Guardianship Between the Ages of 19 and 25

The Plan has been amended to clarify that coverage for Children under Legal Guardianship between the ages of 19 and 25 will terminate as follows:

> Coverage for a Dependent who reaches the age of 19 who does not otherwise qualify for continued coverage under this Plan shall terminate the last day of the calendar month in which such person turned 19. The Participant is obligated to notify the Plan Office of this event.
>
> Coverage will terminate for a Dependent under legal guardianship between the ages of 19 and 25: one (1) year after the first day of a Medically Necessary Leave of Absence, provided the student was covered as a Child under the Plan immediately before the first day of the Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence means a leave of absence (or other change of enrollment) from an Accredited Educational Institution, or any other change in enrollment of such child at such an institution, that:
>
> (i) commences while such child is suffering from a serious illness or injury;
> (ii) is medically necessary, as confirmed in writing by a treating physician of the child which states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary; and
> (iii) causes such child to lose student status for purposes of coverage under the terms of the Plan.

All other terms and conditions for coverage for Children under Legal Guardianship between the ages of 19 and 25 remain unchanged.

Expiration of Extended Plan Deadlines

Due to the National Emergency, beginning March 1, 2020, the deadlines below were extended until the earlier of either (1) one year from the individual's original deadline as stated in the Plan; or (2) 60 days after the announced end of the National Emergency as declared by the President (referred to as the Outbreak Period). This deadline extension applied to these calculations:

- The COBRA election period;
- Timely payment of COBRA premiums;
- Timely notice from covered person of a COBRA qualifying event;
- Timely notice from the plan to a covered person that they may elect COBRA;

- Timely election of HIPAA Special Enrollment rights;
- Timely filing of claims;
- Timely filing of appeals; and
- Timely filing of requests for external review.

The National Emergency ended May 11, 2023, and therefore the above extended deadlines expired on July 10, 2023 (i.e., the end of the Outbreak Period mentioned above). Without these extended deadlines, the deadlines in the Plan reverted to those in place before the National Emergency, i.e. the Plan deadlines set forth in the Plan.

If you have any questions about any deadlines for claims, appeals, or other matters set forth in the Plan, please contact the Fund Office.

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Appendix A – Coverage for Preventive Services

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
Preventive Services Required to be Covered by Law Preventive service benefits are covered without cost-sharing in-network to the extent required under federal law. This means deductibles, co-insurance, and copayments do not apply to these benefits if provided in-network. The following is a representative list of items covered by law as preventive services as of May 1, 2023, but is not a complete list of all such items, and this list changes from time to time. For a list of items and services covered as preventive care under federal law at any given time, please visit the following websites: ● U.S. Preventive Services Task Force, A & B Recommendations: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations ● Health Resources & Services Administration Adopted-Guidelines for Women, Children, and Youth: https://mchb.hrsa.gov/programs-impact/programs/preventive-guidelines-screenings-women-children-youth ● Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html Items and services covered by the Plan for preventive services will be updated and amended automatically as required by law, which may include additions to and subtractions from the representative list of covered items set forth below. Be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status, and impose treatment limitations such as once per lifetime, once per year, etc. Providing all such limitations in this Plan document is not possible. Some of the representative items or services set forth below may indicate coverage once per year, etc., but that does not mean other representative preventive services do not have limitations as to timing, amounts, who is covered, etc. Contact the Fund Office if you have any questions regarding the scope of coverage for any preventive service or item.						
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
For Adults: ● Screenings, most commonly covered annually, including the following: ○ Abdominal Aortic Aneurysm ○ Cholesterol ○ Colorectal Cancer (and follow-up, if required by law) ○ Depression ○ Hepatitis C	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

All benefits are subject to all terms and conditions set forth in the Plan.

Medical Benefits	Full Plan		Standard Plan		Basic Plan	
	In-Network	Out-Of Network	In-Network	Out-Of Network	In-Network	Out-Of Network
For Adults (continued): ○ HIV ○ Hypertension ○ Latent Tuberculosis ○ Lung Cancer ○ Prediabetes and Type 2 Diabetes ○ Syphilis ○ Unhealthy Alcohol and Drug Use ● Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and population may vary. ● Tobacco Smoking Cessation Interventions ● Unhealthy Alcohol Use Behavioral Counseling ● Weight Loss to Prevent Obesity-Related Morbidity and Mortality Behavioral Interventions						
For Women: ● Screenings, including for the following: ○ Anxiety ○ Breast Cancer (Mammography) ○ Cervical Cancer ○ Diabetes After Gestational Diabetes ○ Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults ○ Osteoporosis ○ Urinary Incontinence ○ STIs (including Chlamydia and Gonorrhea) ● BRCA-Related Cancer Risk Assessment, Genetic Counseling and Genetic Testing ● Obesity Prevention Counseling ● Sexually Transmitted Infections Counseling ● Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

Medical Benefits	Full Plan		Standard Plan		Basic Plan	
	In-Network	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
For Pregnant Women or Women Who May Become Pregnant: ● Screenings, including for the following: ○ Anxiety ○ Bacteriuria ○ Contraception ○ Gestational Diabetes ○ Rh(D) Incompatibility ○ STIs (including Chlamydia, Gonorrhea, Hepatitis B, HIV, and Syphilis) ○ Preeclampsia ○ Urinary Tract or other Infection ● Breastfeeding Services and Supplies (including, but not limited to double electric breast pumps [including pump parts and maintenance] and breast milk storage supplies) ● Contraception Education, Counseling, Provision of Contraceptives and Follow-Up Care (including sterilization surgery) ● Healthy Weight and Weight Gain Behavioral Counseling ● Perinatal Depression Preventive Interventions ● Preeclampsia Prevention ● Substance Use Assessment ● Tobacco Intervention and Counseling ● Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**
For Infants, Children, Adolescents, & Young Adults (Newborn—21 years old): ● Screenings, including for the following: ○ Anemia ○ Autism Spectrum Disorder ○ Behavioral / Social . Emotional ○ Blood Pressure ○ Cervical Dysplasia ○ Depression and Suicide Risk ○ Developmental ○ Dyslipidemia ○ Hearing ○ Lead Level ○ Newborn Blood, Bilirubin, and Critical Congenital Heart Disease	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

Medical Benefits	Full Plan		Standard Plan		Basic Plan	
	In-Network	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
For Infants, Children, Adolescents, & Young Adults (Newborn—21 years old) (continued): ○ Obesity ○ Scoliosis ○ STIs (including but not limited to Chlamydia, Gonorrhea, HIV, and Syphilis) ○ Tobacco, Alcohol, and Drug Use ○ Tuberculosis ○ Vision ● Fluoride Varnish and Oral Fluoride Supplementation ● Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and populations may vary ● Oral Health Risk Assessment and Referral ● Sudden Cardiac Arrest / Death Risk Assessment ● Tobacco, Alcohol, and Drug Use Interventions ● Well-Baby/Child Examinations						
Preventative Services Not Required to be Covered by Law						
Prostate/Immunizations (limited to 1 per calendar year)	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**
Routine Physical	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

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