Asbestos Workers Local 24 Medical Fund
Asbestos Workers Local 24 Pension Fund

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July 2022

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND
Summary of Material Modification # 7

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund announces the following benefit change. Please keep this SMM with your Summary Plan Description. Please keep this document with your SPD. These changes are effective July 1, 2022.

1. **Schedule of Benefits**

On pages 9 (Active Employees), 11 (Hazmat Employees) and 26 (NOG and Newly Indentured Apprentices) of the SPD, the first sentence following the schedule for benefits is revised to read:

> The Plan only pays 50% of the stated amount if a non-PPO provider is used, except that, effective July 1, 2022, services for Medical Emergencies rendered by either a PPO or non-PPO provider will be covered up to 100% of the stated amount in accordance with the terms and conditions described on page 38.

2. **Coverage of Emergency Services rendered by non-PPO Providers**

On page 38 of the SPD, the last three paragraphs are revised to read:

> If you do not use a Participating PPO Provider, your benefits will be paid at 50% of the amount the Fund would have paid if you used a PPO provider, unless one of the following applies:
>
> 1. You are receiving services for a Medical Emergency, as described on page 39;
> 2. You are receiving services from a non-PPO provider at a facility that is part of the CareFirst network, as described on page 39.
> 3. If you reside more than 25 miles from the CareFirst PPO Regional Preferred Network Service Area or National BlueCross BlueShield PPO; or
> 4. When you or your Dependent require medical service while traveling outside the CareFirst Service Area.
> 5. When an eligible employee receives benefits under the Annual Physical benefit.
>
> In the event exception No. 4 above applies to you, you are responsible for notifying the Fund Office within two business days or the penalty will be applied. The Fund Office will identify those living outside the CareFirst PPO Service area by zip code.

3. **PPO and non-PPO Coverage of Medical Emergencies**

The heading at the top of page 39 is revised to read "Additional PPO Rules and Definitions"

The third item, Medical Emergency, is deleted and replaced with the following:

3. Medical Emergency - A serious health-threatening or disabling condition manifested by severe symptoms occurring suddenly and unexpectedly, which could reasonably be expected to result in serious physical impairment or loss of life or limb if not treated immediately. A Medical Emergency includes any medical condition a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care.

   Effective July 1, 2022, services for a Medical Emergency are not subject to the 50% penalty that would otherwise apply to services rendered by a non-PPO provider. This also includes air ambulance services by non-PPO providers.

4. Services Provided at an In-network facility – Effective July 1, 2022, if a non-PPO provider fails to obtain your informed consent about surprise billing when providing non-emergency services at a facility that is part of the CareFirst network and that are otherwise covered by the Plan, coverage of such services is not subject to the 50% penalty that would otherwise apply to services rendered by a non-PPO provider.

4. **Continuing Care**

The following section is inserted on page 39 of the SPD, prior to the section entitled "Voluntary Pre-certification/Utilization Review":

CONTINUING CARE PATIENTS

If a participating provider leaves the CareFirst PPO network, a Continuing Care Patient who is receiving care with that provider may continue to receive such care at the same in-network co-payment for up to 90 days after the provider leaves the network.

A **Continuing Care Patient** is an individual who is: (1) receiving a course of treatment for a "serious and complex condition," defined as an acute illness requiring specialized treatment to avoid the reasonable possibility of serious harm, and which requires treatment over a prolonged period of time; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; or (4) determined to be terminally ill and receiving treatment for the illness.

5. **Maximum Allowable Charge**

The following section is added on page 44, prior to the section entitled "Deductible":

Qualifying Payment Amount

Notwithstanding the foregoing, for services for Medical Emergencies, air ambulance services, services provided by non-PPO provider at a participating facility (see page 39), and other services for which surprise billing is prohibited under the No Surprises Act

("NSA"), benefits (and coinsurance) shall be based on the "Qualifying Payment Amount" ("QPA"), as defined under the NSA.

6. **Notice regarding your Rights under the No Surprises Act**

Federal law requires that you receive the following notice of your rights under the No Surprises Act:

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Employee Benefits Security Administration.

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

REMINDERS!!!

Dependent Coverage

Remember that children of Employees continue to be covered by the Fund until they reach age twenty-six (26). Natural, adopted, step and foster children no longer have to remain unmarried or show they are dependent upon the Employee for support. "Children" also include other children who depend upon the Employee for support and who live with the Employee in a regular parent-child relationship. Except as otherwise provided in the Summary Plan Description, coverage for your Eligible Dependent child will end on the last day of the month in which the child turns age 26.

Each Covered Child or other dependent must be listed on a "Dependent Eligibility Form" signed by the Employee and filed with the Fund Office, along with evidence or proof of status satisfactory to the Trustees. Each change in Dependent enrollment after the initial enrollment must be submitted with evidence or proof of Child or other Dependent status satisfactory to the Trustees.

Change in Marital Status

If you become divorced, your former spouse is no longer covered as of the effective date of your divorce. You are required to notify the Fund immediately if you become divorced. If you fail to notify the Fund, your former spouse's continued use of Fund coverage after the date of the divorce will be considered an act of fraud, and you and your spouse will be responsible for repaying the Fund for any benefits so provided. Furthermore, as provided on page 21 of the Summary Plan Description, you and your former spouse have sixty (60) days from the date your divorce becomes effective to notify the Fund Office in order to self-pay for continued coverage under the Fund's COBRA self-payment rules.

Medicare Reminder

Please remember, ***if you are a Retiree or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible***. Medicare is generally available to all individuals who are either disabled or age 65 and has three parts – Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Benefits (Part D). Part A covers inpatient Hospital care and generally is available at no cost. Part B covers doctors' services, outpatient hospital services and other medical supplies and requires a monthly premium. Part D covers prescription drugs and also requires a monthly premium. *If you are a Medicare-eligible Retiree or Dependent, you are required to sign up for Medicare Parts A and B, even though you will have to pay a premium for Part B.* **You are *not* required to sign up for Part D (Prescription Drug Coverage).** For a full explanation, *see* the Summary Plan Description, p. 70 and the Annual Medicare Prescription Drug notice, or contact the Fund Office.

Grandfathered Plan

This plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the telephone numbers listed below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Credit Cards Accepted by Medical Fund

The **Asbestos Workers Local 24 Medical Fund** accepts credit card payments for self-pays, those electing COBRA and direct pay of retiree premiums. All major credit cards **except** American Express are accepted.

Retirees who elect to make a direct quarterly payment of retiree premiums may request the form from the Fund Office if they wish to charge their premiums to a credit card. A separate form will be required for each payment being authorized to the credit card and will not be automatically recharged each quarter.

Please note that if you elect to make your self-pay by credit card and any adjustments are made later (due to credit for late hours received, reciprocity, sick hours, etc.,) the same credit card will be refunded for the calculated adjustment.

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The Board of Trustees of the Asbestos Workers Local 24 Medical Fund is:

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