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

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

(410) 872-9544
(410) 872-1275 Fax

August 2023

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND
Summary of Material Modification # 11

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund announces the following benefit changes. Please keep this SMM with your Summary Plan Description.

I. DEDICATED PHONE LINE

The Fund Office now offers a dedicated phone line for participants in the Asbestos Workers Local 24 Medical and Pension Funds. **The dedicated phone number is 410-872-9544.** Please use this dedicated line for any Funds-related questions, including medical eligibility, self-pay, benefits, and claims. Questions about your pension or annuity benefits can also be directed through this phone number.

II. ADDITION OF COVERAGE FOR CDC RECOMMENDED VACCINES FOR ADULTS

Effective July 1, 2023, the Fund will cover CDC recommended vaccines for adults. Vaccinations will be covered at 100% and *are not subject to application of your benefit schedule's deductible.*

III. COBRA CONTINUATION COVERAGE RATES

Effective September 1, 2023 the rates for individuals who elect and pay for COBRA continuation coverage will change. If you and your Dependents are presently eligible for benefits based on your hours worked, self-pay or through retiree coverage, COBRA continuation coverage likely does not affect you.

COBRA is an alternative self-payment for participants or Dependents who lose eligibility based on *qualifying events* such as:

- Death of the participant
- Divorce
- Child's loss of status as a "Dependent" under the Plan

More information on COBRA coverage can be found on pages 23-26 of the Summary Plan Description.

Effective September 1, 2023, the COBRA rates will be as follows:

COBRA Rates – Regular, Core Medical:	
Single	$658.92/month
Family	$1,724.41/month
COBRA Rates – Regular, Medical/Dental/Vision:	
Single	$697.06/month
Family	$1,824.24/month

COBRA Rates – Disability, Core Medical:	
Single	$969.00/month
Family	$2,535.92/month
COBRA Rates – Disability, Medical/Dental/Vision:	
Single	$1,025.10/month
Family	$2,682.71/month

IV. PRE-CERTIFICATION/UTILIZATION REVIEW

Page 42 of the Summary Plan Description has been revised to clarify the Fund's pre-certification rules, as follows:

The Board has retained American Health Holdings (AHH) to provide **mandatory** pre-certification/ utilization review and case management services. These programs are designed to help ensure that you get the most appropriate and cost-effective medical treatment. The ultimate goal of these programs is to help to ensure the best medical outcomes while at the same time saving you and the Plan from inappropriate or unnecessary expenditures.

You or your medical provider (hospital, doctor, etc.) must obtain pre-certification through American Health Holdings for claims related to medical services when:

- A non-emergency hospital admission is necessary.
- Inpatient or outpatient elective surgery is to be performed.
- A pregnancy has been physician-confirmed.

Claims for services requiring pre-certification that fail to obtain such pre-certification through AHH will be denied by the Fund. In addition to the above services requiring pre-certification, you must notify AHH within 48 hours after an emergency hospital admission.

AHH will then assign your own dedicated nurse case manager, who can:

- Coordinate your medical care with your doctor and other medical care providers to make sure that you get the best and most appropriate treatment.
- Help you navigate the health care system.
- Provide you with information about your specific condition and prescribed course of treatment.
- Track your recovery progress.
- Assist with follow-up care arrangements like physical therapy or home health services, as needed.

The toll-free number for AHH is 1.800.641.5566

Case Management

You do not need to do anything to initiate this program. If you are treated for any number of different conditions, such as diabetes, certain types of cancer, chemical dependency, you may be selected by AHH for Case Management services. If your case meets their criteria, a nurse manager will be assigned to you and to your family to help to make sure that you get the services that you need.

Outpatient Services Pre-Authorization

Pre-Authorization for outpatient services ("Outpatient Pre-Authorization"), when covered by the Fund, is required for the certain services/procedures detailed below.

Participation in this Program is designed to help Participants and Beneficiaries access the right care, at the right time, in the right setting. With pre-authorization, you will find out in advance whether the service is covered, which can help you lower costs and avoid unnecessary procedures.

Who is responsible for getting Outpatient Pre-Authorization?

Your referring physician should request the Pre-Authorization. However, your claim will be denied if your physician fails to obtain Outpatient Pre-Authorization.

- If your referring physician is in-network, they should handle this for you.
- If your physician is out-of-network, you must ask the physician to call AHH and request the Pre-Authorization. You can also call AHH yourself to ensure the process is started. Remember that you will be assessed higher cost-sharing rates for using an out-of-network provider.

Things to note:

1. Outpatient Pre-Authorizations that are requested by someone other than the referring physician may be denied due to lack of clinical information.

2. Make sure your Pre-Authorization was approved prior to having the service performed. (The provider may request that you pay for the service in full if the provider has not obtained an authorization prior to the service.)

3. AHH may contact you if the procedure for which you are seeking authorization can be performed at a lower cost at a facility that will save you out-of-pocket expense.
(For example: If you are scheduled to have an MRI done at a hospital, AHH may request that you have the MRI performed at a non-hospital facility to save you money.)

4. Outpatient Pre-Authorization is not required for Retired Participants who are eligible for Medicare.

What to do if your request is denied:

- If you receive a denial for an Outpatient Pre-Authorization, your doctor should contact AHH to determine why it was denied. In many cases, the denial can be approved once additional information is obtained from your doctor.

- If your Outpatient Pre-Authorization is denied, your doctor can request a peer-to-peer review with an AHH Medical Director. If the denial is upheld once the peer-to-peer review is complete, you have the right to file an appeal with AHH. If the appeal with AHH is denied, you also have the right to request a second-level Appeal with the Fund's Board of Trustees.

Pre-Authorization contact information:

For Inpatient and Pre-certification of Outpatient Procedures, call: 1.800. 641.5566

Procedures that require pre-certification or pre-notification:

- **Acute Inpatient**
- **Skilled Nursing Facility**
- **Residential Treatment for Mental Health/ Substance Abuse**
- **Outpatient Mental Health/ Substance Abuse**
- **Outpatient and Physician – Diagnostic Services**

- ***Prenotification*** **for the following:**
  - CT for non-orthopedic
  - MRI for non-orthopedic
- ***Precertification*** **for the following:**
  - PET
  - Capsule endoscopy
  - Genetic Testing (including BRCA)
  - Sleep Study
- **Outpatient and Physician – Continuing Care Services**
  - **Prenotification for the following:**
    - Dialysis
  - **Precertification for the following:**
    - Chemotherapy (including oral)
    - Radiation Therapy
    - Oncology and transplant related injections, infusions and treatments (e.g. CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g. antiemetic and antihistamine)
    - Hyperbaric Oxygen
    - Home Health Care
    - Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices
- **Outpatient and Physician – Surgery**
  - ***Prenotification*** **for the following:**
    - Biopsies (excluding skin)
    - Vascular Access Devices for the Infusion of Chemotherapy (e.g. PICC and Central Lines)
    - Thyroidectomy, Partial or Complete
    - Open Prostatectomy
    - Creation and Revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for Dialysis
    - Oophorectomy, unilateral and bilateral
  - ***Precertification*** **for the following:**
    - Back Surgeries and hardware related to surgery
    - Osteochondral Allograft, knee
    - Hysterectomy (including prophylactic)
    - Autologous chondrocyte implantation, Carticel
    - Transplant (excluding cornea)
    - Balloon sinuplasty
    - Sleep apnea related surgeries, limited to: Radiofrequency ablation (Coblation, Somnoplasty), Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
    - Potentially Cosmetic Procedures, including but not limited to:
- Abdominoplasty
- Blepharoplasty
- Cervicoplasty (neck lift)
- Facial skin lesions (Photo therapy, laser therapy - excluding MOHS)
- Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
- IDET (thermal intradiscal procedures)
- Liposuction/lipectomy
- Mammoplasty, augmentation and reduction (including removal of implant)
- Mastectomy (including gynecomastia and prophylactic)
- Morbid obesity procedures
- Orthognathic procedures (e.g. Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Otoplasty

- Panniculectomy
- Rhinoplasty
- Rhytidectomy
- Scar revisions
- Septoplasty
- Varicose vein surgery/sclerotherapy

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.

Board of Trustees

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

Union Trustees

Brian S. Cavey, Chairman
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Robert S. McCourt
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Jonathan Potter
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Employer Trustees

Scott Grant, Secretary
Insul-Tech, Inc.
5300 Westview Drive, Suite 101
Frederick, MD 21703

Robert Ciancaglini
Campbell Gibbons
4390 Lottsford Vista Rd.
Lanham, MD 20706

Andrew Tomlinson
G&M Services LLC
7525 Connelley Drive, Suite U
Hanover, MD 21076

Very truly yours,

The Board of Trustees

SPD 05-2019/SMM #11