**PLEASE KEEP THIS WITH YOUR SUMMARY PLAN DESCRIPTION**

**METROPOLITAN D.C. PAVING INDUSTRY EMPLOYEES HEALTH AND WELFARE FUND**
7130 Columbia Gateway Drive, Suite A
Columbia, Maryland 21046
410-872-9541

August 2024

## SUMMARY OF MATERIAL MODIFICATIONS #3

Dear Participant:

The Board of Trustees of the Metropolitan D.C. Paving Industry Employees Health and Welfare Fund ("Fund") has issued this Summary of Material Modifications in accordance with applicable law to keep you apprised of material changes made to the Plan of Benefits and Summary Plan Description ("SPD"). Please review this information carefully and keep it with your SPD so that you may refer to it in the future. If you have any questions, please call the Fund office at 410-872-9541.

Effective October 1, 2024, the Board of Trustees amended the SPD dated October 1, 2022 to increase the benefit amounts for Weekly Accident and Sickness Benefits, for dental benefits, and for vision benefits. The Board of Trustees also amended the SPD to add coverage for home health care and hospice services, coverage of which was previously excluded. Finally, the Board of Trustees also reduced the co-payments for certain prescription medications.

Specifically, the SPD was amended to make the following changes:

1. On pages 3-4 of the SPD, in the section titled "A Summary of Your Benefits for Eligible Employees Only":

a. Under “Weekly Accident and Sickness Benefits,” the weekly benefit amount is changed from $250.00 to $500.00.

b. Under “Dental Benefits,” the maximum per person per Calendar Year for adults and non-essential pediatric benefits is changed from $750 to $1000.

c. Under “Dental Benefits,” a new bullet point, “Adult non-essential orthodontics: per person lifetime maximum”, is added, with the lifetime maximum listed as $1,000.00.

d. Under “Vision Care Benefits,” the maximum per person per Calendar Year is changed from $400.00 to $800.00.

2. In order to add coverage for home health care and hospice services, the Board of Trustees amended the section entitled “Definitions” starting on page 5 of the SPD by the addition of the following new definitions, interspersed alphabetically among the existing definitions:

**Bereavement Counseling**-counseling provided to the eligible employee or the spouse or dependent child of an eligible employee to help them cope with the death of the terminally ill individual.

**Caregiver**-a person who is not a Provider who is the primary caregiver of the terminally ill individual in the home. The Caregiver can be related by blood, marriage, or adoption (see Family Caregiver definition), or a friend of the individual, but cannot be a person who normally charges for providing services, except that, at the discretion of American Health Holding, a Caregiver may be an employee of a hospice care hospital or agency.

**Family Caregiver**- an immediate family member who is the primary Caregiver of the terminally ill individual. Immediate family means the spouse, parents, siblings, grandparents, and children of the terminally ill individual.

**Home Health Care or Home Health Care Services**-means the continued care and treatment in the home by a Qualified Home Health Agency if: (1) the institutionalization of the individual in a Hospital or related institution would otherwise be required if Home Health Care Services are not provided; and (2) the plan of treatment covering the Home Health Care Services is established and approved in writing by the Provider and determined to be Medically Necessary by American Health Holding.

**Home Health Care Visits-**refers to a visit by a Home Health Care Services provider to an individual in the home.

**Hospice Eligibility Period**-begins on the first day hospice care services are rendered and terminates one hundred eighty (180) days later or upon the death of the terminally ill individual, if sooner. If the individual requires an extension of the eligibility period, the individual or his or her representative must notify American Health Holding in advance to request an extension of benefits.

**Qualified Home Health Agency-**a licensed program in the CareFirst BCBS Preferred Provider Organization network that is approved for participation as a home health agency under Medicare or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency.

**Qualified Hospice Care Program**-a coordinated, interdisciplinary program provided by a Hospital, Qualified Home Health Agency, or other health facility that is licensed or certified by the state in which it operates as a hospice program and is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and

other health services through home or inpatient care during the illness and bereavement period.

**Respite Care**-temporary care provided to the terminally ill individual to temporarily relieve the Family Caregiver from the daily care of the individual.

**Skilled Nursing Care**-refers to non-custodial care that requires licensure as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance. Custodial care refers to care provided primarily to meet the personal needs of the patient and does not require the continuous attention of skilled medical or paramedical personnel.

3. On page 32 of the SPD, the subsection titled "What is Covered Under Major Medical" is amended by the addition of coverage for Home Health Care and Hospice Care as more specifically described in new paragraphs D and E as set forth below.

    D. Charges made for Home Health Care or Home Health Care Services, with the following restrictions/conditions:

        1. The individual must be confined to home due to a physical or mental health condition. "Home" cannot be an institution, convalescent home, or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled, or injured persons;

        2. The Home Health Care Visits must be a substitute for Hospital care or for Skilled Nursing Care provided in a facility;

        3. The individual must require and continue to require Skilled Nursing Care or rehabilitation services in order to qualify for home health aide services or other types of Home Health Care Services;

4. The need for Home Health Care Services must not be custodial in nature. Custodial care refers to care provided primarily to meet the personal needs of the patient and does not require the continuous attention of skilled medical or paramedical personnel;

5. Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (R.N. or L.P.N.);

6. There is a limit of thirty (30) Home Health Care Visits per calendar year, unless American Health Holding determines that up to an additional thirty (30) Home Health Care Visits, which are included in the plan of treatment covering Home Health Care Services, are Medically Necessary;

7. All services must be arranged and billed by the Qualified Home Health Agency.

E. Charges for the following services if provided by a Qualified Hospice Care Program, where: (a) the individual has a life expectancy of six months or less and is therefore considered terminally ill, (b) the individual's Provider submits a written hospice care services plan of treatment to American Health Holding, (c) American Health Holding certifies the need and appropriateness of such services, and (d) the individual meets the criteria of the Qualified Hospice Care Program:

1. Intermittent nursing care by or under the direction of a Registered Nurse;

2. Medical social services for the terminally ill individual;

3. Inpatient care;

4. Counseling, including dietary counseling, for the terminally ill individual;

5. Non-custodial Home Health Care Visits;

6. Services, visits, medical/surgical equipment, or supplies, including equipment and medication required to maintain the comfort and manage the pain of the terminally ill individual;

7. Laboratory tests and X-ray services;

8. Ground ambulance use, if determined to be Medically Necessary by American Health Holding;

9. Respite Care, up to fourteen (14) days annually;

10. Counseling for the covered employee, spouse, and/or eligible dependent child before the death of the terminally ill individual, when authorized by American Health Holding;

11. Bereavement Counseling for the covered employee, spouse, and/or eligible dependent child for the six (6) month period following the individual's death or fifteen (15) visits, whichever occurs first.

4. On page 33 of the SPD, the section titled "Non-Covered Medical Expense Benefits" is amended as follows:

   a. Paragraph I (as added by the Second Amendment to clarify that hospice services were previously excluded from coverage) is deleted in its entirety consistent with the Board of Trustees' addition of coverage for hospice services. Subsequent paragraphs are relettered.

   b. Paragraph V, having been relettered as Paragraph U, is amended as follows to make clear that the SPD's exclusion of private duty nursing or home

health care still applies unless these services meet the SPD's definition of such services that are now covered:

U. Charges for Skilled Nursing Care, private duty nursing, or home health care unless rendered as part of Home Health Care treatment or a Qualified Hospice Care Program;

5. On page 34 of the SPD, the subsection titled "Dental Benefits" is amended to indicate that non-essential adult orthodontics will be covered up to a per person lifetime maximum of $1,000.00. Essential adult orthodontics will not be subject to a lifetime maximum and will be covered up to the maximum per person per Calendar Year described on page 3 of the SPD.

6. On page 35 of the SPD, the subsection titled "Vision Care Benefits" is amended to indicate that the maximum per person annual benefit for adults 19 or older has changed from $400 to $800.

7. On page 36 of the SPD, the subsection titled "Co-Payments" is amended to provide the following amended co-payment amounts for up to a 30-day supply purchased at a participating pharmacy:

| | |
|---|---|
| **Generic:** | **$5.00** |
| **Brand:** | **$10.00** |
| **Non-Formulary:** | **$20.00** |

8. On page 37 of the SPD, the first paragraph in the subsection titled "Excluded Drugs and Prior Authorizations" is amended to indicate that the co-payment amount for excluded drugs for which a prior authorization is obtained will be $20.00.

**Additional Notification:** Please be advised that as of April 1, 2024, the Fund ceased its affiliation with the Teladoc® program and will no longer offer the Teladoc® program as a service to the Fund and its participants.

Sincerely,

**BOARD OF TRUSTEES**

***NOTICE OF GRANDFATHERED STATUS***

*The Board of Trustees believes that the Fund 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 the 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 BeneSys, Inc. at 1-410-872-9541. You may also contact the Employee Benefits Security Administration of the 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.*