

# NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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**MAY 2023**

**TO: ACTIVE AND RETIRED PARTICIPANTS**

**RE: SUMMARY OF MATERIAL MODIFICATIONS TO THE NORTHERN CALIFORNIA PIPE TRADES HEALTH AND WELFARE PLAN (“PLAN”) FOR COVID-19 BENEFIT CHANGES –TERMINATION OF THE TEMPORARY PUBLIC HEALTH EMERGENCY**

The Board of Trustees of the Northern California Pipe Trades Health and Welfare Plan (“Plan”) is pleased to provide you with the following summary of change to the Plan, called a Summary of Material Modification (“SMM”). Please review the important change to the Plan’s benefits described below.

The Board of Trustees of the Northern California Pipe Trades Health and Welfare Plan (“Plan”) hereby amends the Plan, pursuant to President Biden and the Department of Health and Human Services declaration of the end of the COVID-19 Public Health Emergency (“PHE”), which is scheduled to end by the end of the day on May 11, 2023. Pursuant to State mandate there will be an extension of coverage for the COVID-19 vaccines, testing and treatment without cost sharing to Plan Participants and their Dependents from **May 12, 2023, through November 11, 2023, unless further extended or noted otherwise**, with the insurers Blue Shield of California and Kaiser Permanente. After November 11, 2023, cost-sharing may be applied based on a member’s out-of-network plan benefits obtained for COVID-19 coverage for fully insured group health plans.

## **R. COVID-19 TESTING, SERVICES, TREATMENT AND VACCINE COVERAGE DURING PUBLIC HEALTH EMERGENCY – Plan Amendment**

- 1. Testing & Diagnostic Services or Items Covered**
  - 2. COVID-19 Qualifying Preventive Services and Vaccination Coverage**
  - 3. COVID-19 Treatment Coverage**
- ACTIVE and RETIRED Participants**  
**Article XXI., Sections R.1.2.3.- Effective May12, 2023**

## **R. COVID-19 Testing, Services, Treatment and Vaccine Coverage During Public Health Emergency**

- 1. Testing & Diagnostic Services or Items Coverage.** Effective for services received on or after March 18, 2020, and only until November 11, 2023 (unless further extended), the Plan will cover through its HMO coverage with Kaiser or Blue Shield and insured PPO coverage with Blue Shield charges (both in-network and out-of-network) for the following tests only to detect the SARS-COV-2 or COVID-19 (also known as the Coronavirus) or the diagnosis of the virus that causes COVID-19 (including serological tests [antibody tests] for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-COV-2, the virus which causes COVID-19) at no cost sharing (meaning no copayment, deductible, or coinsurance):
  - (a) tests approved, cleared or authorized by the FDA;
  - (b) a test that a test developer intends or has requested FDA authorization for emergency use;
  - (c) a state authorized test and the state has notified the Department of Health and Human Services; and
  - (d) other tests that the Secretary of Health and Human Services determines appropriate in guidance developed during the COVID-19 public health emergency period.

This COVID-19 coverage extends to any diagnostic services or items provided during a medical visit including an in-person or telehealth visit to a doctor’s office, urgent care center, or an emergency room that results in an order for an administration of the SARS-COV-2 or COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. Prior authorization or other medical management requirements is not required for diagnostic services related to COVID-19 testing.

### **Coverage of Over-the-Counter (“OTC”) COVID-19 Tests.**

Effective for purchases on or after January 15, 2022, and only until November 11, 2023 (unless further extended), the Plan (through its Insured Carriers, currently Kaiser and Blue Shield) will provide coverage for, including reimbursement of, all OTC tests (also known as at-home tests or self-tests): (a) approved, cleared or authorized by the FDA, (b) test that received FDA authorization for emergency use, (c) state authorized test and state has notified the Dept. of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes Coronavirus Disease 2019) or the diagnosis of COVID-19, purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider or individualized clinical assessment.

Pursuant to federal guidance, the Plan or Insurers are permitted (but not mandated) to make quantity and cost limitations under the following Safe Harbors pursuant to FAQ Part 51. If the Safe Harbor requirements are met the Plan or Insurers are permitted to implement the following limitations:

- (a) **Cost Limits (Through Pharmacy Network or Direct Coverage).** The Plan or Insurer is permitted to limit reimbursement from a non-preferred pharmacy or other retailers to the lesser of: (i) the actual price of the test or (ii) \$12 per test, provided that the:
  - (1) Plan or Insurer provides access to direct coverage, without cost-sharing (meaning the Participant does not pay an upfront cost and instead the plan or its contracted entity pays the preferred pharmacy or retailer directly) of OTC COVID-19 tests through a preferred pharmacy network or other retailers, including direct-to-consumer shipping programs; and
  - (2) Plan or Insurer takes reasonable steps to provide adequate access to OTC COVID-19 tests through an adequate number of retail locations (both in-person and on-line locations).
- (b) **Quantity Test limit.** The Plan or Insurer is permitted to limit OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (e.g., Participant, Dependent Spouse, Dependent Child) per 30-day period or calendar month. In applying the quantity limit of 8, the Plan or Insurer may count each test separately, even if multiple tests are sold in one package. The Plan or Insurer is permitted to set more generous limits although not mandated.

If the above Safe Harbors (a) is not met (for example, if there are delays that are significantly longer than the amount of time it takes to receive other items under, if applicable, the Insurer’s direct-to-consumer shipping program), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set limits relating to reimbursement on the amount of OTC COVID-19 tests.

If the above Safe Harbor (b) is not met (for example, OTC COVID-19 test with doctor’s note), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set quantity limits.

To address suspected fraud or abuse the Insurer is permitted to require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of the OTC COVID-19 test or require a self-attestation.

For Kaiser HMO Participants and Kaiser Permanente Senior Advantage (“KPSA”) Retirees, you can submit a claim for reimbursement of FDA-approved rapid antigen home tests by signing onto <https://healthy.kaiserpermanente.org>.

For Active Blue Shield Participants ONLY, you can submit a claim for reimbursement for OTC COVID-19 tests by visiting the following website:  
[https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites\\_content\\_en/coronavirus/how-to-file-claim-covid-test-reimbursement](https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/coronavirus/how-to-file-claim-covid-test-reimbursement). **This reimbursement program is not applicable to Blue Shield Retirees.**

## **2. COVID-19 Qualifying Preventive Service and Vaccination Coverage.**

Effective the earlier of January 1, 2021, or 15 business days after the date on which the United States Preventive Services Task Force (“USPSTF”) or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) makes an applicable recommendation relating to qualifying COVID-19 immunizations, the Plan will cover approved COVID-19 vaccinations, including any qualifying coronavirus preventive service defined as an item,

service or immunization that is intended to prevent or mitigate coronavirus disease 2019 that has received either an “A” or “B” in the recommendation of the USPSTF or the CDC through both the Kaiser Permanente HMO Plan and Blue Shield of California HMO and PPO Plans during the duration of the COVID-19 Public Health Emergency Period.

- **Temporary Extension (through November 11, 2023).** COVID-19 vaccinations are be available to all eligible Participants and Dependents (through Kaiser and Blue Shield) at **no cost (meaning no copayment, coinsurance or deductible) whether received in-network or out-of-network** and **without prior authorization** at doctors’ offices and medical facilities, including applicable participating pharmacies with Kaiser and Blue Shield until November 11, 2023.
- **After November 11, 2023.** Effective November 12, 2023 (unless subject to change by law or subsequent government guidance), as a Non-Grandfathered plan for the Active Plan options, COVID-19 vaccinations will be covered at no-cost only received in-network (through Kaiser and Blue Shield) but COVID-19 vaccinations received out-of-network will either not be covered or will be subject to an applicable cost-sharing pursuant to the medical option policy (ex. Kaiser or Blue Shield) you are enrolled in.

Providers are prohibited from seeking reimbursement from Participants and Dependents for the vaccine itself including the vaccine administration costs whether as a cost sharing or balance billing until November 11, 2023.

### 3. **COVID-19 Treatment Coverage.**

**Blue Shield of California HMO and PPO Plans.** Effective March 1, 2020, and **further extended through November 11, 2023**, if a Blue Shield Plan Participant or Dependent is diagnosed with COVID-19, charges for treatment of the COVID-19 (including anti-viral treatments while supplies last from the government, hospital admission, transportation and pharmacy services) will be covered in accordance with the terms and conditions set forth in the Evidence of Coverage pursuant to the terms and conditions of the Plan. Cost sharing (e.g. copayments, coinsurance deductibles) related to a positive COVID-19 diagnosis and treatment will be waived. After this six-month extension expires, in-network coverage for these services will continue at no member cost-share. Out-of-network coverage for these services will continue to be mandated, but cost-sharing may be applied based on a member’s out-of-network plan benefits.

**Kaiser Permanente HMO Plan.** Effective April 1, 2020, and **further extended through November 11, 2023**, unless superseded by government action or extended by Kaiser, if a Kaiser Plan Participant or Dependent is diagnosed with COVID-19 charges, such as out-of-pocket costs for treatment of COVID-19, will be covered for inpatient medical, inpatient pharmacy, outpatient medical, office visits, telemedicine, hospitalization, emergency room, urgent care, and transportation costs. This means any out-of-pocket costs, co-payments or other cost share related to a positive COVID-19 diagnosis and treatment will be waived by Kaiser. Kaiser should notify its enrollees if anything changes relating to COVID-19 coverage, after the six-month extension expires.

### **Grandfathered Plan Statement (For Retiree Medical Plan Option Only)**

The Board of Trustees believes the Retiree Medical Plan (through Kaiser and Blue Shield) is a “Grandfathered health plan” under the federal law known as the Patient Protection and Affordable Care Act of 2010 (“ACA”). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan’s Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits please visit [www.Healthcare.gov/glossary/essential-health-benefits](http://www.Healthcare.gov/glossary/essential-health-benefits)). **The Active Health & Welfare Plan (also through Kaiser and Blue Shield) is a Non-Grandfathered Plan.**

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 Fund Manager. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (“DOL”) at 866/444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to Grandfathered health plans. Implementation of the ACA’s provisions began with the July 1, 2011, Plan Year.

IN ACCORDANCE WITH THE REQUIREMENTS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED (“ERISA”), THIS DOCUMENT SERVES AS A SUMMARY OF MATERIAL MODIFICATIONS (“SMM”) THAT AND SUPPLEMENTS THE RESTATED SUMMARY PLAN DESCRIPTION (WHICH IS ALSO THE PLAN DOCUMENT) (ALSO KNOWN COLLECTIVELY AS THE PLAN RULES) THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE RESTATED SUMMARY PLAN DESCRIPTION. IF YOU DO NOT HAVE A COPY OF THE PLAN RULES, YOU CAN REQUEST A COPY WITH ITS RECENT AMENDMENTS FROM THE TRUST FUND OFFICE.

If you have any questions, please contact the Trust Fund Office at 925/356-8921 ext. 246.

Respectfully submitted,  
Fund Manager  
On Behalf of the Board of Trustees