January 18, 2024

Dear I.A.T.S.E. National Health and Welfare Fund Participants and Covered Family Members:

This notice memorializes recent changes to the prescription drug and medical benefits provided by the I.A.T.S.E. National Health and Welfare Fund (the "Plan" or "Fund"). These changes apply to all Plan C options - Plans C-1, C-2, C-3, C-4.

Changes to Prescription Drug Benefits

Effective March 1, 2023, the Fund's prescription drug benefits have been administered by CarelonRx. CarelonRx is part of Empire BlueCross BlueShield, the Fund's medical benefits network provider and claims administrator. Therefore, all references to "CVS Health" in the Summary Plan Description are replaced with references to "CarelonRx."

This means that, effective March 1, 2023, prescription drug benefits are no longer offered to Fund participants and their covered family members through CVS Health. However, s if you incurred any eligible claims before March 1, 2023 you may still submit them to CVS Health for consideration as long as you file within the appropriate time frame.

The Fund's prescription drug benefits did not change with the move to CarelonRx. This means that participant cost-sharing is the same as it was when CVS Health was the Fund's prescription drug benefits administrator. However, drugs are now grouped in tiers, and cost-sharing depends on which tier your drug is on. Please see below for more information on CarelonRx and cost-sharing:

CarelonRx National Direct Plus Formulary

The Fund only covers drugs listed on the CarelonRx "National Direct Plus Formulary." A "formulary" is a list of drugs that are preferred to treat specific conditions because of the effectiveness of the drug and/or the cost of the therapy. CarelonRx decides which drugs are listed on the formulary and which are excluded. If your doctor prescribes a drug that is not on the CarelonRx "National Direct Plus Formulary," an alternative drug may be covered. There is a medical appeal process if your doctor indicates that there are medical reasons why you need an excluded formulary drug. If you meet those medical conditions, you will be able to receive the excluded drug.

Participant cost-sharing for prescription drugs are:

In-Network Retail Pharmacy: You can receive a 30-day supply or refill of a medication through a CarelonRx network pharmacy

Type of Drug	Plan C-1	Plan C-2	Plan C-3	Plan C-4
Tier 1 Drugs	$5	$5	$5	Subject to deductible and 50% coinsurance
Tier 2 Drugs	20% coinsurance ($25 minimum and $40 maximum)	20% coinsurance ($40 minimum and $60 maximum)	20% coinsurance ($40 minimum and $60 maximum)	
Tier 3 Drugs	40% coinsurance ($35 minimum and $50 maximum)	40% coinsurance ($50 minimum and $70 maximum)	40% coinsurance ($50 minimum and $70 maximum)	
Tier 1 Specialty Drugs	$5	$5	$5	Subject to deductible and 50% coinsurance ($200 maximum)
Tier 2 Specialty Drugs	20% coinsurance ($25 minimum and $150 maximum)	20% coinsurance ($40 minimum and $150 maximum)	20% coinsurance ($40 minimum and $150 maximum)	
Tier 3 Specialty Drugs	40% coinsurance ($35 minimum and $150 maximum)	40% coinsurance ($50 minimum and $150 maximum)	40% coinsurance ($50 minimum and $150 maximum)	

Mail Order Pharmacy: You can receive a 90-day supply via mail order or at a CarelonRx network pharmacy

Type of Drug	Plan C-1	Plan C-2	Plan C-3	Plan C-4
Tier 1 Drugs	$10	$10	$10	Subject to deductible and 50% coinsurance
Tier 2 Drugs	20% coinsurance ($60 minimum and $100 maximum)	20% coinsurance ($90 minimum and $140 maximum)	20% coinsurance ($90 minimum and $140 maximum)	
Tier 3 Drugs	40% coinsurance ($100 minimum and $130 maximum)	40% coinsurance ($115 minimum and $175 maximum)	40% coinsurance ($115 minimum and $175 maximum)	
Tier 1 Specialty Drugs	$10	$10	$10	Subject to deductible and 50% coinsurance ($200 maximum)

Tier 2 Specialty Drugs	20% coinsurance ($60 minimum and $300 maximum)	20% coinsurance ($90 minimum and $300 maximum)	20% coinsurance ($90 minimum and $300 maximum)
Tier 3 Specialty Drugs	40% coinsurance ($100 minimum and $300 maximum)	40% coinsurance ($115 minimum and $300 maximum)	40% coinsurance ($115 minimum and $300 maximum)

At an Out-of-Network Pharmacy:

You must pay the full charge of a drug you receive from an out-of-network pharmacy, and then file a claim for reimbursement with CarelonRx. For eligible covered drugs, you will be reimbursed for the difference between the pharmacy's charge and the applicable co-pay.

Certain limitations and exclusions may apply to some medications. If you have any questions about a specific medication, please call CarelonRx at 1-833-396-0317

You will not have to pay anything for any prescription considered preventive care under the Affordable Care Act. For more information as to whether a particular drug is preventive, please contact CarelonRx at (833) 396-0317.

In order to maximize your prescription drug benefits, please register at empireblue.com with your member ID and set up your account. At empireblue.com you can:

- Find a pharmacy
- Check the Plan's formulary (drug list)
- Compare medication costs
- Set up home delivery and refill prescriptions
- Review your claims
- Check your copay, deductible and coinsurance amounts

You can also use Empire's Sydney Health app to manage your benefits.

Participants should have received an ID card from CarelonRx in the mail. Please contact CarelonRx at (833) 396-0317 for a new member ID card if you have not received one.

Address for Appeals of Prescription Drug Claims: Appeals of prescription drug claims incurred on or after March 1, 2023 should be sent to:

Anthem BlueCross BlueShield
1407 Church Street Station
New York, NY 10008-1407
Attention: Appeal Department

Coverage of Licensed Clinical Social Workers: Changes to Medical Benefits Definitions

As of January 1, 2023, the Plan C Summary Plan Description is amended to eliminate the requirement for Licensed Clinical Social workers to have three years of post-licensure experience in order to cover claims for services provided by Licensed Clinical Social Workers.

Specifically, the definition of "provider" on pages 62 and 150 of the SPD is revised to read as follows:

> **Provider** means a hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Empire will pay benefits only for covered services within the scope of the practitioner's license. For behavioral healthcare purposes, "provider" includes care from licensed psychiatrists or psychologists; licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof. For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Additionally, the description of "Covered Mental Health Care" on page 88 of the SPD is revised to replace the second bullet point with the following language:

- direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

If you have any questions about these changes, or about any aspect of the Plan, please contact the Fund Office by calling (212) 580-9092 or (800) 456-FUND (3863) or emailing the Participant Services Center at PSC@iatsenbf.org.

You should take the time to read this notice carefully and share it with your family. It is very important that you retain this notice; it is intended to serve as a Summary of Material Modifications ("SMM") to the Plan rules. Your Summary Plan Description ("SPD") booklet has a pocket on the back cover for keeping such notices handy. While every effort has been made to make this SMM as complete and as accurate as possible, it does not restate the existing terms and provisions of the Plan other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPD (other than with respect to the specific terms and provisions this summary is modifying), or if any point is not discussed in this summary or is only partially discussed, the terms of the SPD will govern in all cases.

The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or qualification for such benefits), in whole or in part, at any time and for any reason.