LOCAL 812 HEALTH FUND
AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS,
CHAUFFEURS -- WAREHOUSEMEN & HELPERS OF AMERICA
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This notice contains important information regarding your Local 812 Health Fund benefits.

We are providing you and your family with this notice to inform you of benefit changes adopted by the Board of Trustees of the Local 812 Health Fund (the "Fund"). ***These changes will become effective May 1, 2024.*** You should keep this notice (known as a "Summary of Material Modification") together with your Summary Plan Description at all times. The two documents should be read together for an accurate depiction of your current health plan benefits. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. If you have any questions, contact the Fund. ***Please note that, as a result of these changes, the Fund will no longer have "grandfathered" status. The effects of the loss of this status, and additional benefits provided as a result, are discussed below.***

1. Benefits will be subject to a deductible - an amount that you and your eligible dependent must pay on an annual basis before covered claims become eligible for payment. The deductible is generally $750 per person (maximum $1,500 per family) for in-network claims and $1,500 per person (maximum $3,000 per family) for out-of-network claims for each calendar year. However, because the deductible is going into effect on May 1, the deductible for 2024 will be limited to $500 per person (maximum $1,000 per family) for in-network claims.
2. After you have met your deductible, the required copayment for primary care physician, specialist and urgent care visits has been increased from $25 per visit to $40 per visit.
3. Benefits for Emergency Room visits, whether in-network or out-of-network, are subject to a copayment of $100 once the deductible has been met.
4. The Fund has adopted a prescription drug formulary. A formulary is a list of prescribed medications or other pharmacy care products, services or supplies chosen for their safety, cost, and effectiveness. Medications are listed by categories or classes and includes both brand and generic prescription medications. You and your doctor can use the formulary to help you choose the most cost-effective prescription medications. Not all medications are on the Fund's formulary. A medication may be excluded from coverage under the Fund's pharmacy benefit when it works the same as, or is similar to, another prescription which is on the formulary or an over-the-counter ("OTC") medication. If your medication is not on the formulary, you, your authorized representative or your doctor can request coverage by calling the number on your member ID card.
5. As before, you will be able to obtain up to a 90-day supply of any covered prescription drug or medication other than a specialty drug at a participating pharmacy by presenting your prescription card and paying your required co-payment. You will also be able to obtain up to a 90-day supply of a prescribed drug or medication (other than a specialty drug) through OptumRx's Mail Order Program. In either case, you will now be charged a 30% copayment for your prescription. (It was previously 20%.) However, you will not be charged a copayment for a prescription for a generic drug. (Previously, the absence of a required copayment was limited to 90-days supplies.) Prescription drugs and medications continue to not be subject to a Deductible.

6. When you obtain a specialty drug through OptumRx's specialty pharmacy, BriovaRx, you will be charged a 30%, rather than 20%, copayment for a 30-day supply of your generic or brand prescription. After you have filled five consecutive prescriptions for a 30-day supply of a brand or generic specialty drug, your prescription may be designated as a "maintenance drug." You may obtain a 90-day supply of a specialty maintenance drug and will be charged a 30%, rather than 20%, copayment for your specialty maintenance prescription unless the prescription is for a generic specialty drug. No copayment will be charged for a 90-day supply of a generic specialty maintenance drug.

EFFECTS OF LOSS OF GRANDFATHERED STATUS

As discussed above, until now, the Fund has been a "grandfathered" plan for purposes of the Patient Protection and Affordable Care Act ("ACA") and was exempted from certain ACA requirements. Effective May 1, 2024, the Fund will lose its grandfathered status. As a result of the loss of grandfathered status, the Fund will comply with additional ACA requirements as summarized below.

Preventive Services
The ACA requires non-grandfathered funds to cover certain in-network preventive services, including preventive prescription drugs, at no cost to you. The Fund will now pay 100% of the costs incurred for covered preventive services and preventive prescription drugs when those services and drugs are provided by an in-network provider.

The required services include services that are highly recommended by the U.S. Preventive Services Task Force (that is, said services have an "A" or "B" rating), and recommendations of the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), and the federal Centers for Disease Control and Prevention Advisory Committee on Immunization Practice (ACIP).

For preventive prescriptions to be covered, they must be prescribed by a health care provider. The Fund may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Fund will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. If a covered item or drug is available over-the-counter and is covered under this provision, you must present a prescription at the time of purchase in order for it to be covered under the Fund.

A list of all current preventive services is available at www.healthcare.gov/coverage/preventive-care-benefits/.

Out-of-Pocket Maximum
The ACA requires certain out-of-pocket spending to be capped for in-network medical and prescription drug benefits. The Fund will now cap your out-of-pocket costs for medical benefits and prescription drug benefits each year. Effective 2024, the annual out-of-pocket maximums, (that is, the maximum amounts that you are required to pay each year for the deductible, copayments and/or co-insurance) are $2,000 per person/$4,000 per family for in-network medical benefits and a separate $2,000 per person/$4,000 per family for prescription drug benefits. The Trustees reserve the right to adjust these amounts annually, as permitted by ACA regulations. **There is no out-of-pocket maximum for amounts paid for out-of-network services.** Once you or one of your covered Dependents has paid the annual out-of-pocket maximum for in-network medical services or prescriptions, you/(s)he will not be

required to pay any additional copayments and/or coinsurance for the remainder of the year for that type of benefit. For example, if you have paid $2,000 in coinsurance for your prescription drugs, you are no longer required to pay any coinsurance for your prescriptions for the remainder of the year. You are, however, required to pay any copayment for in-network medical services, unless you've also paid the in-network medical benefit out-of-pocket maximum. Once you and your eligible Dependents have paid the family out-of-pocket maximum, no additional copayments or coinsurance is required, even if the individual out-of-pocket maximum has not been met. For example, if you have paid $2,000 in deductible and copayments for medical claims, your spouse has paid $800 in deductible and copayments for medical claims and one of your covered children has paid $1,200 in copayments for medical claims, you and your family have met the out-of-pocket maximum for medical claims for the year.

Routine Patient Costs in Connection with Approved Clinical Trials

The Fund will now cover certain costs in connection with approved clinical trials, as required by the ACA.

If you are eligible to participate in an approved clinical trial with respect to treatment of cancer or another life-threatening disease or condition, the Fund will not deny your participation in the trial; deny, limit or impose additional conditions on the Fund's coverage of routine patient costs for items, services or drugs otherwise covered by the Fund that are furnished in connection with participation in the trial; and will not discriminate against you because of your participation in the trial.

The Fund covers the routine patient costs for participation in an approved clinical trial and such coverage will not be subject to utilization review if the covered individual is eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; your health care provider is a participating provider; and that provider has concluded that your participation in the trial would be medically appropriate and referred you to participate. You will be required to provide medical and scientific information establishing that your participation would be medically appropriate.

The Fund does not cover the cost of investigational drugs or devices; non-health services required for you to receive the treatment; or managing the research or costs that would not be covered by the Fund for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II, III or IV clinical trial that is a federally funded or approved trial; conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or a drug trial that is exempt from having to make an investigational new drug application.

External Review of Coverage Determinations

The Fund provides an internal appeals procedure that allows you and your family the opportunity to request the review of claims decisions that you think are not correct. Under the ACA, if your internal appeal is denied, you will now have the right to appeal to an independent reviewer (External Review) if the denial involved a medical judgment or a rescission of coverage. (External review is also available for claims subject to the No Surprises Act.) Please note that typically you may only request external review after you have exhausted the Fund's internal appeals procedures. Contact the Fund if you wish to request external review.

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Fund, or any benefits provided under the Fund, in whole or in part, at any time and for any reason, in accordance with the amendment procedures established under the Fund and the trust agreement establishing the Fund. The formal Fund documents and Trust Agreement are available at the Fund Office and may be inspected by you during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Fund documents, make any promises to you about benefits under the Fund, or to change any provision of the Fund. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Fund's plan of benefits and decide all matters arising under the Fund.

Plan Sponsor: Board of Trustees of Local 812 Health Fund
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