AUGUST 2018

ALASKA TEAMSTER-EMPLOYER WELFARE TRUST

SUMMARY OF MATERIAL MODIFICATIONS

If you have questions about this report, please call (907) 751-9700 or (800) 478-4450

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SUMMARY OF PLAN CHANGES EFFECTIVE OCTOBER 1, 2018

Please read this important notice summarizing changes to your health Plan.

SECTION 5.14 – PROFESSIONAL SERVICES AND SUPPLIES – CHIROPRACTIC AND ACUPUNCTURE

Chiropractic and Acupuncture limits are being changed from ten (10) visits in a calendar year to fifteen (15) visits in a calendar year – annual deductibles and out-of-pocket maximums still apply.

SECTION 5.4 – PREFERRED PROVIDER PROGRAM

Emergency services provided by a non-Preferred Provider facility or professional are payable as follows: services at facilities located within 75 miles from a Preferred Provider facility are covered at 80% of the Preferred Provider rate for the same service; and services at facilities located more than 75 miles from a Preferred Provider facility are covered at 80% of the greater of the Preferred Provider rate for the same service or the UCR charge.

For non-emergency outpatient services rendered at a non-Preferred Provider facility, the reimbursement rate will be 60% and will apply to each hospital admission and outpatient procedure.

SECTION 18 – GENERAL PLAN DEFINITIONS

The term "Emergency Services" is defined under the Health Care Reform law, but generally means services at a medical facility for an emergency medical condition, and any further services that are necessary to stabilize the patient.

SECTION 5.8 – SURGICAL SERVICES

The Plan covers expenses for non-emergency orthopedic or podiatric surgery expenses *only* if provided through BridgeHealth or a Preferred Provider. This clarifies that effective October 1, 2018, the Plan treats non-emergency podiatric surgery as not covered and will not be paid unless the service is provided by BridgeHealth or a Preferred Provider.

SECTION 5.11 – TRANSPORTATION AND EXPENSES FOR MEDICALLY NECESSARY TREATMENT

Orthopedic or podiatric surgeries that are not performed by an approved BridgeHealth provider or a Preferred Provider of this Plan are not covered at all by this Plan, unless provided in an emergency. A portion of the lodging and incidental expense benefits provided through the BridgeHealth program may be subject to income tax.

SECTION 7 – EXCLUSIONS AND GENERAL LIMITATIONS

No Plan Benefits are extended for services and associated expenses for non-emergency orthopedic or podiatric surgery, except if provided through BridgeHealth or a Preferred Provider. All other Plan exclusions and limitations remain in effect.

SECTION 18 – GENERAL PLAN DEFINITIONS

"Orthopedic Surgery" means surgical procedures to treat conditions involving the musculoskeletal system, other than spinal surgery.

SECTION 6.9 – CASE MANAGEMENT

Effective October 1, 2018, the Plan's Disease Management Program may authorize coverage of care by a non-Preferred Provider at the reimbursement rate for a Preferred Provider, in cases where the case manager has determined that the care was urgently needed to treat a serious medical condition, and treatment by a Preferred Provider was not reasonably available to the Participant or dependent. Any such reimbursement may not exceed the applicable UCR rate, and all other conditions and limitations on Plan benefits continue to apply.

SUMMARY OF MATERIAL MODIFICATION

SUMMARY OF PLAN CHANGES EFFECTIVE JANUARY 1, 2019

Please read this important notice summarizing changes to your Health Plan.

SECTION 5.19 – HEALTHREACH DISEASE MANAGEMENT PROGRAMS

The Plan has partnered with HealthCare Strategies, Inc. (HCS) to provide their HealthReach program. HCS has developed a unique and comprehensive approach to disease management. HealthReach provides ongoing education, support, and mentoring to employees and their covered dependents that live with challenging medical conditions, like diabetes, heart disease, cancer, and others.

HealthReach Coaching: If you are selected to participate in the coaching program, a registered Nurse Care Manager will contact you by phone and mail to provide assistance with possible gaps in care, managing current health conditions, and support to reach personal goals. Your HealthReach Care Manager will provide you with confidential and personalized information to help you understand your options, work collaboratively with your doctors, and improve the care you receive.

Pharmacy Review: HCS will identify members who have medicines that are potentially duplicative – or might be harmful when taken together with other prescriptions. Your primary care physician will then be notified to help improve coordination of care among all doctors prescribing your medications.

Additional Charges for Not Participating in Disease Management: Plan members and spouses who are identified for HealthReach Coaching and choose not to participate will be subject to a penalty, reducing the amount of Plan benefits payable. Eligible individuals who, as certified by the disease management/chronic condition management vendor, choose not to participate in the Plan's disease management program will have future medical claims (excluding preventive services required to be paid at 100%) penalized at a 10% reduction in the maximum percentage payable by the Plan. (For example, a charge normally paid 80% by the Plan will be paid 70% by the Plan; a charge normally paid 60% by the Plan will be paid at 50%; etc.) Any 10% reduction applied to you or your spouse applicable under this section **will apply** to your and your family's out-of-pocket maximum limits. The 10% penalty will be ceased beginning with the first of the month following the time that the individual begins actively participating in the disease management program, as certified by the disease management vendor, and if the individual has established compliance with the disease management program later in the same Plan Year that penalties were assessed, penalties for that Plan Year will also be refunded.

In no event will the 10% reduction applied in any Plan Year total more for any individual than 30% of the cost of employee-only coverage for that Plan Year.

If an individual provides (or his or her physician provides) a written statement to the Plan or HCS demonstrating that it is medically inadvisable or unreasonably difficult for that person to participate in the HealthReach Coaching program, the Plan will waive the 10% penalty for that Plan Year and prospectively.

Please note all communications between members and HealthReach remain **completely private and confidential**.

the PACIFIC HEALTH COALITION

(www.phcoalition.org)

The Alaska Teamster-Employer Welfare Trust is a member plan with the Pacific Health Coalition (PHC), known as the "Coalition" of union member plans. The PHC has direct contracts with many providers and facilities in Alaska of which the Alaska Teamster-Employer Welfare Trust participates in. Many of our members in Anchorage and Fairbanks are familiar with the Coalition Health Center, but did you know there are other coalition providers?

Coalition Direct Provider Contracts:

- **Ascension Physical Therapy**
- **Chugach Physical Therapy**
- **Alaska Hand Rehab**
- **New Frontier Anesthesia**
- **Alaska Center for Ear, Nose & Throat (ACENT)**
- **Surgery Center of Anchorage**
- **Alaska Regional Hospital**
- **Mat-Su Regional Medical Center**
- **Pathology Associates**
- **Guardian Flight, Inc.**

MARCH 2020

ALASKA TEAMSTER-EMPLOYER WELFARE TRUST

SUMMARY OF MATERIAL MODIFICATION

SUMMARY OF PLAN CHANGES EFFECTIVE MAY 15, 2020

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Please read this important notice summarizing changes to your health Plan. This document, referred to as a "summary of material modifications," is intended to supplement the Summary Plan Description.

SECTION 8 – PRESCRIPTION DRUG BENEFIT PROVIDED BY THE TRUST FOR ELIGIBLE EMPLOYEES, RETIRED PARTICIPANTS AND DEPENDENTS

8.1 DEFINITIONS

A **"Prescription Drug" or "Drug"** means a Medically Necessary take-home medication or article (including insulin, syringes, diabetic testing supplies, glucose monitoring equipment and self-administered injectables) that may be lawfully dispensed as provided under the federal Food, Drug, and Cosmetic Act (FDA), upon the written prescription of a Physician licensed by law to administer it, and dispensed by a licensed pharmacy.

A Brand-Name Prescription Drug is sold under a trademark name or created by the manufacturer who may hold a patent on the Drug. There is not always a generic version for every brand-name drug. In order to achieve maximum savings to both you and the Plan, the Pharmacy Program includes a special list of brand-name drugs called "Preferred" drugs. These drugs are selected by the Pharmacy Program Manager to be on the list primarily based on drug effectiveness and then cost. The prescription drug benefit requires different copayment amounts for a "Preferred Brand-Name Drug" and a "Non-Preferred Brand-Name Drug." You may still have your prescription filled with a Non-Preferred Brand-Name Drug; however, your copayment will be significantly higher.

A generic Prescription Drug is chemically the same (has the same active ingredients) as the brand-name Drug, and are usually referred to by their common chemical names. Generic Drugs can be produced and sold after the patent has expired on a brand-name Drug. Generic Drugs must meet the same FDA standards as their brand-name counterparts.

A "**Specialty Drug**" means a Prescription Drug; prescribed for a person with a complex or chronic medical condition, defined as a physical, behavioral, or developmental condition; prescribed for rare or orphan disease indications; requiring additional patient education, adherence, and support beyond traditional dispensing activities; has a high monthly cost; requires specific storage or shipment requirements, and may be distributed under a limited distribution.

8.4 MAIL ORDER PHARMACY PROGRAM

If you need to take maintenance medications on an ongoing basis, you may obtain up to a 90-day supply through the Preferred Participating Mail Order Pharmacy program for direct delivery to your home. Maintenance medications are Drugs prescribed for more than 34 days or taken on a regular or long-term basis. Pre-addressed prescription order forms and envelopes are available from the Trust Customer Service Office, the Administrative Office or the pharmacy benefit manager's website; please refer to the Quick Reference Table in the front of this booklet.

HOW TO USE THE MAIL ORDER PHARMACY PROGRAM

Ask your doctor to prescribe maintenance medications for up to a 90-day supply, plus refills. Complete the prescription order form and mail it with your prescription to the mail order program using the special pre-addressed envelope. For the protection of each Participant, a "patient health profile" questionnaire must be completed and mailed with the first order. The Mail Order Pharmacy Program will use this health history when reviewing your prescriptions for safety and appropriateness. The Mail Order Pharmacy Program will process your order and send your medications to your home via the U.S. postal service. A new order form and envelope will be returned to you with each prescription delivery.

If you need a prescription immediately, *ask your Physician for 2 prescriptions.* The first prescription should be for up to a 34-day supply and should be taken to a retail participating pharmacy to be filled. The second prescription should be sent to the Mail Order Pharmacy Program in the envelope provided for that purpose.

When your prescription is filled you will receive a notice showing the number of times it may be refilled. It will also show your prescription number. In addition, there will be a pre-addressed reply envelope enclosed. Simply fill out the information on the reverse side of the reply envelope, enclose the refill notice, seal, stamp and mail. Your prescription will be refilled and mailed back *to you.*

PRESCRIPTION DRUG COPAYMENTS

	Participating Retail Pharmacy* *(34-Day Supply)*	**Preferred Participating Mail Order Pharmacy**	**Non-Participating Pharmacy****
Generic Drugs	Participant copayment is 20% of the total cost of the Drug.	Participant copayment is the lesser of 20% of the cost of the drug or $20 for each prescription.	No Reimbursement
Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant copayment is 35% of the total cost of the Drug.	Participant copayment is the lesser of 35% of the cost of the drug or $50 for each prescription.	No Reimbursement
Non-Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant copayment is 50% of the total cost of the Drug.	Participant copayment is the lesser of 50% of the cost of the drug or $100 for each prescription.	No Reimbursement
Specialty Drugs(*) Must be filled by participating Specialty Drug mail order facility	Not applicable.	Participant copayment is $100 for each Specialty prescription. 30 day supply.	No Reimbursement

If filled through a participating retail pharmacy, the Plan also covers medications and supplements that are designated as "preventive care" under Health Care Reform and which the Plan is required by law to provide. For a list of the covered medications and supplements, see **www.hhs.gov/healthcare/prevention**. These items are covered at 100% in-network, but you must have a prescription from your doctor (even for the over-the-counter items). Also, not all items are covered for everybody – for example, there are age restrictions, and some items are limited to generic only. Contact the Pharmaceutical Provider for more information.

**REIMBURSEMENT LIMITATIONS:*

If you or your Physician request that your prescription be filled with a brand-name Drug when a generic equivalent is available, you will be responsible for paying the full difference in price between the generic and brand-name Drug *in addition to* your brand-name Prescription Drug copayment. The generic price is established by the Plan's Pharmaceutical Provider.

***OUT OF NETWORK PRESCRIPTIONS:*

If no network pharmacy is located in the area, the co-payment is 50% of the Drug cost per each prescription filled out-of-network.

Specialty medications are generally used in treating unique disease conditions and are typically injectable or that otherwise require special handling considerations. Members that require these specialty medications may receive express delivery to their home or office from the Pharmacy Program Manager's Mail Order facility and also receive clinical support by pharmacists and other educational material to help maximize treatment success. A list of examples of specialty medications can be obtained by visiting the web site. Specialty medications have a minimum copay of $100 for each 30-day prescription, and a 90-day prescription (with a copay of up to $300) may only be obtained if the participant or beneficiary has been prescribed that specialty medication continuously for at least six months.

SPECIALTY VARIABLE COPAY PROGRAM

a. Under the Plan's Specialty Variable Copay Program, the Plan's Specialty Pharmacy is available to assist Participants with enrollment in pharmaceutical manufacturer-sponsored copay card and coupon programs that can reduce, or eliminate, the Participant's out of pocket costs for certain specialty drugs purchased through the Plan's Specialty Pharmacy. Under this Program, both the Participant and the Plan will benefit from a cost reduction from the copay card or coupon programs.

b. If the value of a Participant's manufacturer-sponsored copay card or coupon for a specialty drug exceeds the amount of the Plan's general specialty Drug Copayment, the Copayment required under the Plan increases to match the amount of the copay card or coupon. The copay card or coupon is applied to the Participant's Copayment, and the Participant's out of pocket cost for the specialty drug fill is reduced to $0. The portion of the Copayment covered by the copay card or coupon does not apply to the out-of-pocket maximums.

c. Information about the Specialty Variable Copay Program, including information as to the specialty drugs covered under the Specialty Variable Copay Program, can be obtained by calling the Specialty Pharmacy. Your physician should normally advise you whether a prescribed drug is considered a specialty drug.

AUGUST 2020

ALASKA TEAMSTER-EMPLOYER WELFARE TRUST

SUMMARY OF MATERIAL MODIFICATIONS
SUMMARY OF PRESCRIPTION DRUG CHANGES EFFECTIVE OCTOBER 1, 2020, AND EXTENSIONS OF COBRA, ENROLLMENT, AND CLAIM DEADLINES DURING CORONAVIRUS OUTBREAK PERIOD

Please read this important notice summarizing changes to your health Plan. This document, referred to as a "Summary of Material Modifications," supplements and updates your Summary Plan Description.

Effective October 1, 2020, the following changes to the Plan's prescription drug coverage will go into effect. Details are provided below.

- The Plan's Prescription Drug Program provider is being changed from OptumRx to AmWINS. Contact information for AmWINS is at the end of this notice.
- The Plan's mail-order pharmacy program will require that after an initial retail prescription, all available maintenance medications be obtained through mail order, or coverage for the prescription will not be provided.
- To reduce costs, the Plan is adopting payment assistance programs through AmWINS and Paydhealth. If your medication is covered under one of these programs and you do not enroll or provide required information, benefits for those medications will not be provided.

In addition, the Plan has extended certain deadlines during the coronavirus "Outbreak Period." Details are provided below. The extended deadlines may apply to:

- "Special Enrollment" of family members
- The time allowed to elect and pay for COBRA continuation coverage; and
- Deadlines to submit initial benefit claims and appeals of denied claims.

PRESCRIPTION DRUG BENEFIT CHANGES

The Plan is changing the mail order pharmacy program and adding payment assistance programs to reduce costs for you and for the Plan overall. Participation in these programs is required and benefits will not be provided for your medications if you do not participate and provide all required information, as described below.

With these changes, Plan Section 8.4 will now state as follows:

8.4 Mail Order Pharmacy Program and Payment Assistance Program Requirements

If you need to take maintenance medications on an ongoing basis, the first time you fill a

prescription for this drug, it may be filled at retail. For any subsequent prescription for a maintenance drug, you **must** obtain a minimum 84-day or a maximum 90-day supply through the AmWINS Mail Order Pharmacy program for direct delivery to your home. Maintenance medications are Drugs prescribed for more than 34 days or taken on a regular or long-term basis. Pre-addressed prescription order forms and envelopes are available from the Trust Customer Service Office, the Administration Office, or the pharmacy benefit manager's website.

How to Use the Mail Order Pharmacy Program

Failure to participate in the Mail Order Pharmacy Program for maintenance medications will result in the participant or family member being responsible for the entire cost of the prescription – not just the co-pay.

Ask your doctor to prescribe maintenance medications for a minimum 84-day supply or a maximum 90-day supply, plus refills. Complete the prescription order form and mail it with your prescription to the mail order program using the special pre-addressed envelopes. For the protection of each Participant, a "patient health profile" questionnaire must be completed and mailed with the first order. The Mail Order Pharmacy Program will use this health history when reviewing your prescriptions for safety and appropriateness. The Mail Order Pharmacy Program will process your order and send your medications to your home via the U.S. postal service. A new order form and envelope will be returned to you with each prescription delivery.

If you need a prescription immediately, you must *ask your Physician for 2 prescriptions*. The first prescription should be for up to a 30-day supply and should be taken to a retail participating pharmacy to be filled. The second prescription should be sent to the Mail Order Pharmacy Program in the envelope provided for that purpose. Your prescriber may choose to send the prescriptions to the pharmacy electronically.

When your prescription is filled you will receive a notice showing the number of times it may be refilled. It will also show your prescription number. In addition, there will be a pre-addressed reply envelope enclosed. Simply fill out the information on the reverse side of the envelope, enclose the refill notice, seal, stamp and mail. Your prescription will be refilled and mailed directly to you.

PRESCRIPTION DRUG COPAYMENTS

	Participating Retail Pharmacy* *(34-Day Supply)*	**Preferred Participating Mail Order Pharmacy**	**Non-Participating Pharmacy****
Generic Drugs	Participant copayment is 20% of the total cost of the Drug.	Participant co-payment is the lesser of 20% of the cost of the drug or $20 for each prescription.	No Reimbursement
Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant copayment is 35% of the total cost of the Drug.	Participant co-payment is the lesser of 35% of the cost of the drug or $50 for each prescription.	No Reimbursement
Non-Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant copayment is 50% of the total cost of the Drug.	Participant co-payment is the lesser of 50% of the cost of the drug or $100 for each prescription.	No Reimbursement
Specialty Drugs (*) Must be filled by participating Specialty Drug mail order facility	Not applicable.	Participant co-payment is $100 for each Specialty prescription for a 30-day supply. Noncompliance and failure to participate in the Patient Assistance Program, participant out-of-pocket is 100%.	No reimbursement.

REIMBURSEMENT LIMITATIONS:
If you or your Physician request that your prescription be filled with a brand-name Drug when a generic equivalent is available, you will be responsible for paying the full difference in price between the generic and brand-name Drug *in addition to* your brand-name Prescription Drug copayment. The generic price is established by the Plan's Pharmaceutical Provider.

OUT OF NETWORK PRESCRIPTIONS:
If no network pharmacy is located in the area, the co-payment is 50% of the Drug cost per each prescription filled out-of-network.

If filled through a participating retail pharmacy, the Plan also covers medications and

supplements that are designated as "preventive care" under Health Care Reform and which the Plan is required by law to provide. For a list of the covered medications and supplements, see www.hhs.gov/. These items are covered at 100% in network, but you must have a prescription from your doctor (even for the over-the-counter items). Please note that not all items are covered for everyone - for example, there are age restrictions, and some items are limited to generic only. Contact the Pharmaceutical Provider for more information.

Payment Assistance Programs

As described further below, the Plan is providing payment assistance programs through AmWINS and Paydhealth to help offset the costs of certain expensive specialty and non-specialty drugs. Not all medications will be eligible for these programs. However, if a medication you are taking is eligible, then you must participate in the program. Failure to participate in these programs will result in you being responsible for the entire cost of the prescription, not just the copay.

AmWINS Patient Assistance Program (Program)

The Plan has engaged AmWINS to assist with certain high cost non-specialty medications that are eligible under this Program and provide certain medications at zero out of pocket cost.

Any person taking a non-specialty medication covered by the AmWINS Patient Assistance Program must enroll in the Program. Failure to enroll or to provide all required information will result in you being responsible for the entire cost of the drug – not just the copay. AmWINS will contact you to enroll you in the Program if you are taking or are prescribed a covered medication. To be enrolled, you may be required to provide information such as your driver's license, SSN, W-2 or other income verification, and a HIPAA authorization form. The enrollment process will take some time to complete – until enrollment is completed, normal Plan benefits will apply. Once you are enrolled, medications covered by the Program will have $0 out of pocket cost to you. For additional information, you can contact the AmWINS Rx Customer Service Center at 855-693-3920.

If a medication is not covered by the Program, normal Plan benefits apply.

Paydhealth Select Drugs and Products Program

The Plan has engaged Paydhealth to assist with certain high cost specialty medications that have been identified by Paydhealth to allow alternative sources of funding. Paydhealth maintains a list of these medications on its Select Drugs and Products^{SM} List. If you are prescribed a medication on the Select Drugs and Products List, you are required to enroll in this program. For additional information, you can contact the Paydhealth's Specialty Contact Center at 877-869-7772.

Some Paydhealth identified alternate funding programs require verification of income. In such cases, you must provide this information directly to the alternate funding program, and such information will not be provided to the Plan and is not considered in determining coverage by the

Plan.

Failure to enroll or to provide all required information will result in you being responsible for the entire cost of the medication – not just the copay.

If an attempt by Paydhealth to obtain funding for a medication on the Select Drugs and Products List is unsuccessful, the Plan's Prescription Drug Program provider shall process a benefit reconsideration, and may determine that the drug is medically necessary and in such a case the cost of the drug is considered a prescription claims expense under the terms of this Plan.

Together with these changes, Plan Section 8.1 is being modified to include an updated definition of "Specialty Drugs," as follows:

8.1 Definitions

- "Specialty Drugs" are medications that are more complex than other drugs and often require special handling, distribution, storage, administration, and/or monitoring. Specialty drugs may also be high cost medications, though cost alone is not sufficient to consider a drug a specialty medication. Specialty medications are commonly required to treat patients with complex, serious or life-threatening conditions including cancer, rheumatoid arthritis, multiple sclerosis, cystic fibrosis, hepatitis, and bleeding disorders. In many cases, a clinical review for prior authorization is required. Specialty medications often cannot be dispensed at a typical retail pharmacy because the therapy usually requires special handling as well as significant patient support and education regarding appropriate utilization. Additionally, ongoing clinical monitoring is provided to manage side effects and ensure compliance with the treatment regimen.

EXTENSIONS OF CERTAIN PLAN DEADLINES DURING CORONAVIRUS "OUTBREAK PERIOD"

On May 4, 2020, the federal government adopted an emergency Extension Rule that extends certain Plan deadlines during the coronavirus "Outbreak Period," including: deadlines for "Special Enrollment"; deadlines to elect and pay for COBRA continuation coverage; and deadlines to submit initial benefit claims and appeals of denied claims. The Outbreak Period began on March 1, 2020, and unless changed by a further notice from the federal government, it will end 60 days following the announced end of the National Emergency Concerning the Novel Coronavirus or on February 28, 2021 – whichever comes first. This notice should be read in conjunction with the Plan's Summary Plan Description (SPD), which describes the deadlines impacted by the Extension Rule in further detail.

The Extension Rule requires that **during the Outbreak Period**, any portion of each of the following deadlines that passes **does not count** against the ordinary Plan deadline involved:

- The 60-day "Special Enrollment" periods for enrollment in Plan coverage outside the Plan's normal initial and annual enrollment periods (these Special Enrollment periods

apply in certain situations where other healthcare coverage is lost, or when a new spouse and/or other eligible dependent(s) are acquired through marriage, birth, adoption or placement for adoption;
- The 60-day election period for COBRA continuation coverage;
- The 45-day period for the initial COBRA premium payment and the 30-day grace period for payment of each monthly COBRA premium payment;
- The 60-day period for notifying the Plan of a COBRA Qualifying Event caused by divorce, separation, loss of dependent status, or a disability that can extend COBRA coverage;
- The one-year period for submitting a claim for benefits to the Plan;
- The period for submitting an appeal of a denial of a claim for benefits under the Plan; and
- The four-month period to request independent external review of a denied appeal, and the period allowed for providing any information needed to complete such a request.

Applying the Extension Rule to these deadlines means: (1) If the deadline would have normally fallen during the Outbreak Period, the deadline is extended to the end of the Outbreak Period <u>plus</u> the number of days of the deadline that passed during the Outbreak Period; and (2) if the deadline falls <u>after</u> the end of the Outbreak Period, but a portion of the ordinary deadline passes during the Outbreak Period, the portion of the ordinary deadline that passes during the Outbreak Period is added at the end of the Outbreak Period, which has the effect of extending the normal deadline by that amount of time. Examples for each category of these extensions that may apply during the Outbreak Period are provided below.

Special Enrollment Extensions

Examples:

1) Robert was an eligible participant under the Plan when he had a new child, Lucy, born on May 1, 2020. His ordinary special enrollment deadline to enroll Lucy and have her covered under the Plan retroactive to her birth date is June 30, 2020 (60 days after May 1, 2020). But because all 60 days of the ordinary "special enrollment" period for Lucy fall within the Outbreak Period, those days are not counted and Robert's 60-day special enrollment deadline for Lucy will instead be 60 days after the end of the Outbreak Period. If Robert enrolls Lucy at any time before the end of the extended deadline for special enrollment, she will be covered retroactive to May 1, 2020.

2) Jim was an eligible participant under the Plan when he married Sally on February 1, 2020. Jim's ordinary special enrollment deadline to enroll Sally and have her covered under the Plan retroactive to the date of marriage would have been April 1, 2020 (60 days after February 1, 2020). Jim did not enroll Sally by that deadline. However, because of the Extension Rule, Jim's expired special enrollment period for Sally is reinstated, and will now end 32 days after the end of the Outbreak Period to enroll Sally, since there were 32 days left in the special enrollment period when the Outbreak Period began on March 1, 2020.

COBRA Election and Payment Extensions

Examples:

1) Terry lost coverage on December 31, 2019 and received a COBRA election notice on January 20, 2020. Terry did not elect COBRA coverage by March 20, 2020 (the 60-day deadline under the normal COBRA election rules). The 20-day portion of Terry's COBRA election window that falls within the Outbreak Period (March 1-March 20) is not counted. Terry's expired COBRA election period is reinstated and will now end 20 days after the end of the Outbreak Period.

2) John lost coverage due to a reduction of hours and received a COBRA election notice on April 1, 2020. John's COBRA election period would normally end on May 31, 2020, but will now end 60 days after the end of the Outbreak Period.

3) Susan was receiving COBRA coverage through March 2020 and is eligible to continue receiving COBRA coverage through December 2020 (the end of her maximum COBRA period). COBRA premium payments for each month are due on the first of the month, plus a 30-day grace period. Susan made a timely March 2020 COBRA premium payment but has not made any payments since then. As of August 1, 2020, Susan has made no premium payments for April, May, June or July. For purposes of this example, assume that the Outbreak Period ends on July 31, 2020. With the 30-day grace period for COBRA payments added after the end of the Outbreak Period, Susan's premium payments for those four months (April through July) are all due by August 30, 2020.

    a) The health plan will not pay for any benefits and services retroactively for April through July unless Susan pays the COBRA premium by August 30, 2020.

    b) If payment is not made for all months of COBRA eligibility by the end of the extension period, COBRA coverage will only be provided for the <u>earliest</u> months for which premiums have been paid. For example, if Susan only submits payment equivalent to two months' COBRA premiums by August 30, 2020, benefits and services provided in April and May 2020 would be covered but COBRA eligibility will end and she will have no coverage for benefits or services provided after May 2020.

    c) In this example, any COBRA premium payments due August 1, 2020 and later are not extended because they fall outside the Outbreak Period, but Susan will have the ordinary grace period of 30 days from the due date to make any such payments.

Extension for Submitting Benefit Claims

Examples: For both of these examples, assume that the Outbreak Period ends on November 15, 2020.

1) Joe is covered by the Plan and incurred expenses for a medical treatment covered by the Plan on April 30, 2019. Ordinarily, the claim for that treatment would have needed to be submitted by April 30, 2020 – one year after Joe received the service. However, because April 30, 2020 falls during the Outbreak Period that began on March 1, 2020, the days from March 1 to April 30 (61 days) are not counted, and in this example the extended claims submission deadline is January 15, 2021 – 61 days after the end of the Outbreak Period.

2) Pat is covered by the Plan and incurs expenses for a medical treatment covered by the Plan on June 20, 2020. Pat's ordinary deadline to submit this claim would be June 20, 2021, one year after the date of service. In this example, although Pat's ordinary deadline to submit the claim is after the Outbreak Period ends on November 15, 2020, part of the one-year period passes during the Outbreak period and is therefore not counted. In this situation, the one-year claim deadline doesn't begin to run until after the end of the Outbreak Period, and Pat is allowed until November 15, 2021 to submit this claim.

Extension of Deadlines for Benefit Claim Appeals and External Review

Example: Vic's claim for benefits was denied by Plan on April 15, 2020, and Vic was advised that a written appeal could be submitted within 180 days in accordance with the Plan's Claims Review Procedures. The ordinary appeal deadline – 180 days after April 15, 2020 – is October 12, 2020. Assume for this example that the Outbreak Period ends on November 15, 2020. Under the Extension Rule, Vic's extended deadline for the appeal is May 14, 2021 (180 days after the end of the Outbreak Period, since all 180 days of Vic's ordinary appeal deadline passed during the Outbreak Period).

Please contact Alaska Teamster-Employer Welfare Trust at 907-751-9700 if you have any questions about this Summary of Material Modifications, or any other questions about the Plan.

ALASKA TEAMSTER-EMPLOYER WELFARE TRUST
Please Read Carefully – This Notice Modifies the Plan's Summary Plan Description

Important Notice of Plan Changes
To Participants and Covered Family Members of the Alaska Teamster-Employer Welfare Trust (the "Plan")

Effective for services provided on and after July 1, 2022 covered by the Plan, federal law and the Plan provide new protections against unexpected medical bills.

Your Rights and Protections Against Surprise Medical Bills

On and after July 1, 2022, when you get emergency care, are treated by a Non-Preferred Provider at a Preferred Provider hospital or ambulatory surgical center, or receive air ambulance services, you will be protected from "surprise billing" or "balance billing."

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't a Preferred Provider.

An **"Out-of-network"** or **"Non-Preferred Provider"** is a provider or facility that hasn't entered into a contract setting its charges under the Plan. Usually, Non-Preferred Providers are allowed to bill you for the difference between what the Plan pays and the full amount they charge. This is called "**balance billing**." This amount is often more than a Preferred Provider charges for the same service, and might not count toward your deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at a Preferred Provider facility, but are unexpectedly treated there by a Non-Preferred Provider.

Effective July 1, 2022, you are protected from balance billing for:

Emergency Services
If you have an emergency medical condition and get emergency services covered by the Plan from a Non-Preferred Provider or facility, the most that provider or facility may bill you is the Plan's Preferred-Provider cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get for that emergency condition after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at a Preferred Provider hospital or ambulatory surgical center
When you get services covered by the Plan from a Preferred Provider hospital or ambulatory surgical center, certain providers there may be Non-Preferred Providers. In these cases, the most those Non-Preferred Providers providers may bill you is the Plan's Preferred-Provider cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other covered services at a Preferred Provider facility, Non-Preferred Providers **can't** balance bill you, unless you give written consent and give up your protections.

Air Ambulance Services
If you receive air ambulance services covered by the Plan, the most that provider or facility may bill you is the Plan's Preferred-Provider cost-sharing amount. You **can't** be balance billed for these services.

You're never required to give up your protections from balance billing. You also aren't required to get care from Non-Preferred Providers. You can choose a Preferred Provider or facility in the Plan's network.

When balance billing isn't allowed, you also have the following protections (effective July 1, 2022):

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was a Preferred Provider). For covered services, the Plan will pay Non-Preferred Providers and facilities directly.

- The Plan will:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by Non-Preferred Providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay a Preferred Provider or facility, and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or Non-Preferred Provider services toward your and your family's deductible and annual out-of-pocket limits.

Independent External Review

The Plan has rules that allow you to request review of certain medical claims by an independent review organization, and requiring that the decision by that independent organization be followed. Effective July 1, 2022, this right to voluntary independent review also applies to all of the following claims under the Plan:

- Whether pre-authorization was improperly required for emergency services
- Whether emergency services by a Non-Preferred Provider should have been covered at the Plan's Preferred Provider rates
- Whether treatment at a Preferred Provider facility by a Non-Preferred Provider should have been covered by the Plan at its Preferred Provider rates
- Whether Non-Preferred Provider air ambulance services should have been covered at the Preferred Provider rates for those services

If you believe that you've been wrongly billed, you can contact the Alaska Teamster-Employer Welfare Trust at (907) 751-9700 for further information and assistance.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

ALASKA TEAMSTER-EMPLOYER WELFARE PLAN AND TRUST

SUMMARY OF MATERIAL MODIFICATIONS REGARDING PRESCRIPTION DRUG AND TELEMEDICINE PROGRAMS

Please read this important notice summarizing changes to your health coverage under the Alaska Teamster-Employer Welfare Plan (the "Plan"). This document supplements and updates your Summary Plan Description and previous updates to the Plan.

Effective October 1, 2023, the following changes to the Plan's prescription drug providers will go into effect:

- The Plan's Prescription Drug Program provider is being changed from AmWINS Rx to Costco Health Solutions.
- The Plan's mail-order pharmacy program is being changed from Elixir to Costco Mail Order Pharmacy.
- The Plan's mail-order pharmacy program will require that after an initial retail prescription, all available maintenance medications be obtained through mail order, or further coverage for that prescription will not be provided. An initial retail prescription will also be allowed for maintenance medication prescriptions already in effect as of October 1, 2023, and after that refills of that prescription can only be obtained by mail order.

Telemedicine appointments with Physicians who are covered by the Plan will continue to be covered on the same basis as in-person appointments. This is in addition to the Plan's Teladoc benefit, which also continues to be provided.

Important Information:

- The Plan's coverage and limitations for prescription benefits – for example, deductibles, co-payments, and brand-name and specialty drug provisions – will remain unchanged.

- Any amounts paid toward prescription deductibles and out of pocket amounts as of September 30, 2023 will continue to be recognized in 2023 and will be transferred to Costco Health Solutions.

- New identification cards will be mailed by approximately September 14, 2023. New identification cards will replace the current cards effective October 1, 2023.

- Mail order prescriptions will be on hold until you create a profile with Costco Mail Order Pharmacy at www.pharmacy.costco.com. Each family member must register under a separate email address and complete the patient profile.

- This Summary of Material Modifications updates and supplements the Summary Plan Description for the Plan. This specifically includes adding telemedicine consultations as a covered physician benefit under Plan section 5.14, subpart 1, removing the exclusion in section 7, subpart 16 for cyber medicine providers, and changes throughout the Summary Plan Description to address the updated prescription drug program. Additional information will be provided within the next month.

Alaska Teamster-Employer Welfare Plan

Summary of Material Modifications

Summary of Plan Changes Effective January 1, 2025

Please read this important notice summarizing changes to your health coverage under the
Alaska Teamster-Employer Welfare Plan (the "Plan").
This document supplements and updates your Summary Plan Description and previous updates to the Plan.

- Effective January 1, 2025, the individual and family deductibles are reduced to:

  Individual Deductible $750.00
  Family Deductible: $2,250.00

SECTION 5.1 CALENDAR YEAR DEDUCTIBLE
The deductible amount for each eligible Employee is the first $750 of Covered Expenses incurred in a calendar year. To meet the family annual deductible of $2,250, three or more Participants in the same family must have paid a total of $2250 for Covered Expenses incurred in one calendar year.

- Effective January 1, 2025, Hinge Health is a new benefit that will be offered to you and your eligible family members at no additional cost to you. This benefit will offer virtual physical therapy programs that combine gentle exercise with one-on-one support to improve your condition, reduce pain, and help you move confidently. *The Hinge Health program is separate from and does not apply to the Physical Therapy limits under Section 5.14 Professional Services and Supplies*.

The Board of Trustees is pleased to be able to make these benefit changes and enhancements to the health plan. If you have questions regarding these changes, please contact the Trust office at 907-751-9700.