Utah Pipe Trades Trust Funds

Pension
Health and Welfare

SUMMARY OF MATERIAL MODIFICATIONS
OCTOBER 2023

This Notice, called a summary of material modifications ("SMM"), advises you of certain material modifications that have been made to the Plan Document/Summary Plan Description ("SPD") for the Utah Pipe Trades Welfare Trust Fund dated January 1, 2020 (the "Plan"), as modified by prior SMMs. Please be sure that you and your covered family members read this notice carefully. It should be kept with your SPD (including the Cigna benefits booklet that is part of the SPD) for future reference.

Prescription Drug Benefit Program Changes

The Trustees are always looking for better ways to provide our participants and their families with the most cost-effective quality health care. Recently we worked closely with Express Scripts (ESI), the Plan's pharmacy benefit manager, to develop programs intended to save you and the Fund money on your outpatient prescription medications. These changes are effective for prescriptions purchased on or after January 1, 2024.

***SaveOnSP Specialty Pharmacy Copay Assistance Program*:** Effective for prescriptions purchased on or after January 1, 2024, the Plan will provide a Specialty Pharmacy Copay Assistance Program through SaveOnSP for certain specialty drugs. This program is intended to help both you and the Fund save money on certain specialty medications by obtaining copay assistance from drug manufacturers when it is available. Specialty drugs are high-cost medications used to treat complex chronic conditions. These drugs are typically prescribed to a small percentage of members in a health plan. If you are taking a qualifying drug, SaveOnSP will contact you to participate in the program. If you enroll in the Specialty Pharmacy Copay Assistance Program, the specialty drug will be provided at no cost to you after the manufacturer's coupon is applied. If you do not enroll in the program, you must pay the full copay (which is greater than the Plan's regular coverage of 50% coinsurance up to a $60 maximum). More information is available at www.saveonsp.com.

SaveOnSP targets 300+ drugs for the following therapy classes and conditions:

- Asthma & Allergy
- Blood Cell Deficiency
- Cancer
- Cardiovascular
- Central Nervous System
- Cystic Fibrosis
- Endocrine
- Enzyme Replacement/Disorder
- Gastrointestinal
- Growth Hormone

Hemophilia	Inflammatory Conditions	Psychotherapeutic
Hepatitis C	Multiple Sclerosis	Pulmonary Hypertension
Hereditary Angioedema	Ophthalmic	Thrombocytopenia
Hormonal Agent	Osteoporosis	

You are not required to participate in the Specialty Pharmacy Copay Assistance Program; however, you must participate in order to receive the higher benefits under the Plan for your qualifying specialty medications. Those who do not participate in the program will be responsible for a higher copay for certain specialty drugs, higher than the Plan's regular coverage of 50% coinsurance up to a $60 maximum. These copays are subject to change. Drugs subject to the SaveOnSP program are classified as non-essential health benefits. Therefore, copays and/or coinsurance for these drugs will not apply toward your out-of-pocket limit whether paid through the program or directly by you (because you choose not to participate in the program). **This could result in a much higher cost share for those who choose not to participate in the program.**

Patient Savings Example

Sue *ENROLLS* in SaveOnSP to save on her specialty medications.

Current copay	$100
New Copay	$1,000
Final Cost	$0

SaveOnSP will monitor Sue's account to make sure *she incurs no cost ($0)*.

Sue *DOES NOT ENROLL* in SaveOnSP to save on her specialty medications.

Current copay	$100
New Copay	$1,000
Final Cost	$1,000

SaveOnSP cannot monitor Sue's account. *She is responsible for the copay amount on the attached list.*

For questions and assistance with the Specialty Pharmacy Copay Assistance Program, contact SaveOnSP at 800-683-1074.

Prior Authorization: Effective for prescriptions purchased on or after January 1, 2024, the Plan requires that certain prescription medications be reviewed and approved before they are covered by the Plan. During the review process, your doctor can provide Express Scripts with more detailed information about your prescription to make sure that its use falls within the Plan's rules. These rules are based on the product information approved by the FDA, as well as published clinical trials and guidelines.

If a medication that you or one of your dependents is currently taking appears on the list of drugs requiring prior authorization, ask your doctor to visit the ESI online portal at www.esrx.com/PA or call ESI at 800-417-1764 to arrange for a review of your medication. **If your doctor doesn't visit the online portal or call the toll-free number to get an approval, then you'll be responsible for the full cost of your medication.**

If you have questions regarding this benefit change, please call Express Scripts at 800-282-2881.

Step Therapy: There are many medications within each drug category. Frequently, the newest drug being marketed is also the most expensive option and not necessarily the most effective. In fact, many times a less costly drug can provide the same medical results. For new prescription drugs filled on or after January 1, 2024, if you are prescribed a medication on the "Step 2 Medication List", you must have tried and failed one of the medications on the "Step 1 Medication List" before the Fund will cover the Step 2 Medication. If your Physician feels that you must have access to the Step 2 without trying the Step 1 drug, you may file an appeal with the Fund or your physician can request an exception by contacting Express Scripts.

- Step 1 drugs are typically generic and lower-cost brand name drugs proven to be safe, effective and affordable. In most cases, they provide the same health benefit as a more expensive drug, at a lower cost.
- Step 2 and Step 3 drugs are typically brand-name drugs that are best suited for only a small number of patients who don't respond to Step 1 drugs. These drugs are the most expensive options.

You and your family members may be currently taking medications that will cost you more under this program and may no longer be covered under the Plan unless you agree to undertake a trial of a preferred alternative medication. These alternative medications work just as well for most people, and they typically cost a lot less than the medications you or your family members might be currently taking.

If you or your family members are taking Step 2 or Step 3 drugs on the effective date of the Step Therapy Program and these drugs were covered by the Plan in 2023, you and your family members will NOT be "grandfathered" under the 2023 Outpatient Prescription Drug Benefits. All Plan participants and their dependents will be automatically enrolled in the Step Therapy Program for 2024.

If you have questions regarding this benefit change, please call Express Scripts at 800-282-2881.

Drug Quantity Management: Drug quantity management is a program that makes sure patients are using medications at doses that have been proven effective. It provides the medication you need for good health and the health of your family while making sure you receive them in the amount – or quantity – considered to be safe and effective.

For example, your doctor might write a prescription for two 20mg pills once a day. If the medication is available as a 40mg pill, you would need just one a day. Asking your doctor to prescribe the 40mg strength can save you and your Plan money.

When you submit a prescription for a drug that has quantity limits, your pharmacist should see a note in the system indicating that your medication isn't covered for the amount prescribed. This could mean you may have asked for a refill too soon or that your doctor wrote a prescription for a quantity larger than your Plan covers. If the quantity is too large, you can choose one of these options:

- Have your pharmacist fill your prescription for the amount that your Plan covers. You will pay the appropriate copayment, but you may need to fill this prescription more often — for instance, twice a month instead of once a month — which means you pay a copay more often.
- Ask your pharmacist to call your doctor. They can discuss changing your prescription to a higher strength, if one is available. In most cases, if your doctor approves this change, you will have fewer copayments because you will receive your prescription just once a month.

If you have questions regarding this benefit change, please call Express Scripts at 800-282-2881.

Other Benefit Changes

Dental and Vision Care Reimbursement Benefit for 2024:

The Trustees have extended the Plan's temporary dental and vision care reimbursement benefit described in Section VII of the SPD to once again apply for the 2024 calendar year. The available annual reimbursement amount under this benefit for eligible dental and/or vision claims will remain at $1,500 per covered family for 2024. Please see Section VII of your SPD for the full description of this benefit. Additionally, please note that if you prepay for dental or vision services (for example, under a program with your dentist that provides a discount where you prepay for services that will be received in the future), the amount that you pay for the services will be eligible for reimbursement when the services are received (i.e., when the expenses are "incurred") not at the time you make the prepayment.

Colonoscopy Coverage:

The Plan now covers all colonoscopies from in-network providers at 100% with no cost-sharing regardless of whether the colonoscopy would be considered "Preventive Care" under the federal Affordable Care Act. Previously, only colonoscopies that met the criteria for "Preventive Care" were covered at 100% with no cost sharing. Colonoscopies received out-of-network remain covered at 60% after meeting the Plan deductible. This change is effective July 1, 2023.

External Prosthetic Appliances:

As explained in the Plan's July 2021 SMM, the Plan now provides a benefit for external prosthetic appliances, such as wigs and hairpieces, when medically necessary for alopecia as a result of chemotherapy, radiation therapy, and second- or third-degree burns. This benefit is limited to one per lifetime subject to a $300 limit. This benefit was initially adopted with an effective date of

August 1, 2021, but has now been extended to apply to any claims incurred on or after January 1, 2021.

End of the COVID-19 Federal Emergency Declarations:

As described in prior SMMs, the Plan provided certain federally-mandated benefits during the COVID-19 Public Health Emergency period, and federal law also mandated the extension of certain plan deadlines for up to one year during the period of the COVID-19 "Outbreak Period" (which began on March 1, 2020 and extended through the end of the COVID-19 National Emergency plus 60 days). The federally-declared COVID-19 Public Health Emergency and National Emergency ended on May 11, 2023, impacting the Plan as follows:

COVID-19 Testing: After May 11, 2023, over-the-counter COVID-19 tests are no longer covered, and COVID-19 tests at your provider's office (and the related office visit) are subject to the same Plan coverage and cost-sharing rules that apply to other tests and office visits.

COVID-19 Vaccines: After May 11, 2023, COVID-19 vaccines that qualify as "Preventive Care" under the Affordable Care Act continue to be covered at 100% with no cost-sharing as long as they are received in-network. COVID-19 vaccines received out-of-network are not covered

Deadline Extensions: As described in the Plan's April 2021 Summary of Material Modifications (SMM), certain Plan deadlines were extended during the coronavirus "Outbreak Period" (with a maximum deadline extension of one year). The deadlines that were extended included the periods for notifying the Plan of a COBRA qualifying event and for electing and paying for COBRA continuation coverage, the period for enrolling new dependents in the Plan following a HIPAA special enrollment event, and the periods for filing a claim for benefits or an appeal of a denied claim. The Outbreak Period began on March 1, 2020, and ended on July 10, 2023 (60 days after the end of the National Emergency declaration). Suspended deadlines therefore began to run again after July 10, 2023. For more information about the extension rule, see the April 2021 SMM.

Should you have any questions regarding the other benefit changes described above, please contact the Administrative Office (BeneSys) at 877-416-8181.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Administrative Office.

This document has been uploaded and is available on the participant website at www.utpipetradesbenefits.org