MASSACHUSETTS
LABORERS' HEALTH & WELFARE FUND

Important Information Regarding Changes to your Health Plan

This information is VERY IMPORTANT to you and your dependents. Please take the time to read it carefully.

Effective January 1, 2026, the following changes to your health benefits will be implemented:

Facility Fees (professional services may be charged separately):

- Outpatient Surgery Hospital & Ambulatory Surgical
- Inpatient Hospital
- Maternity Delivery and Related Services
- Certified Midwifery and Birthing Center
- Inpatient Mental Health
- Inpatient Substance Use Disorder
- Skilled Nursing Care

Before January 1, 2026	After January 1, 2026
Plan A: Fund covers 100% of the first $20,000 plus 85% of the excess charges, up to an out-of-pocket maximum of $2,000 per admission. **Plan B:** Fund covers 100% of the first $7,500 plus 85% of the excess charges, up to an out-of-pocket maximum of $5,000 per admission.	**Plan A:** $100 copay; then Fund covers 100% of the next $20,000 plus 85% of the excess charges, up to an out-of-pocket maximum of $2,000 per admission. **Plan B:** $250 copay; then Fund covers 85% of the excess charges, up to an out-of-pocket maximum of $5,000 per admission.

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Outpatient Infusions Administered in a Facility Setting:

Before January 1, 2026	After January 1, 2026
Plan A: $20 copay. **Plan B:** $20 copay, then Fund covers 90% coinsurance.	**Plan A:** $100 copay; then Fund covers 85% of the prescription drug cost with an out-of-pocket maximum of $2,000 per treatment. **Plan B:** $100 copay; then Fund covers 85% of the prescription drug cost with an out-of-pocket maximum of $5,000 per treatment. **Applicable to Both Plan A and Plan B:** • Coinsurance waived if the facility allows ESI/Accredo to ship prescription drugs to the facility. • Paid at 100% after deductible if preformed at home.

Imaging (MRIs):

Before January 1, 2026	After January 1, 2026
Plan A: $100 copay. **Plan B:** $100 copay then Fund covers 90% coinsurance.	**Plan A:** $250 copay; unless provided at a free-standing radiology facility/doctor's office, then Fund covers 100%. **Plan B:** $250 copay, then Fund covers 90% coinsurance; unless provided at a free-standing

	radiology facility/doctor's office, then Fund covers 90% <u>after deductible</u>. **Applicable to <u>Both</u> Plan A and Plan B:** • Copay waived if no in-network free-standing facility is available within a 30-mile radius of your home.

(Ground/Air) Ambulance Benefit:

Before January 1, 2026	**After January 1, 2026**
Plan A: IN - Fund covers 100% up to $20,000 of charges plus 85% of the excess charges; **OON -** Fund covers 100% except air ambulance same as IN. **Plan B: IN -** Fund covers 100% up to $7,500 of charges plus 85% of the excess charges; **OON -** Fund covers 100% except air ambulance same as IN.	**Plan A:** Fund covers 90% coinsurance; out-of-pocket maximum $2,000. **Plan B:** Fund covers 80% coinsurance; out-of-pocket maximum $5,000. **Applicable to Both Plan A and Plan B:** • The current 100% coverage for ambulance services related to admission or facility transfer remains unchanged.

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Prescription Drug Benefit:

Before January 1, 2026	**After January 1, 2026**
Plan A and B Out-of-Pocket Maximum: $1,000/Individual; $2,000/Family	**Plan A and B Out-of-Pocket Maximum:** $2,000/Individual; $4,000/Family
Plan A and B Copayments: Generic • 30-day supply: $5 • 90-day supply: $10 Preferred Brand-Name • 30-day supply: $15 • 90-day supply: $30 Non-Preferred Brand-Name • 30-day supply: $25 • 90-day supply: $50	**Plan A and B Copayments:** Generic – 20% coinsurance • 30-day supply: minimum $10/maximum $30 • 90-day supply: minimum $20/maximum $60 Preferred Brand-Name – 20% coinsurance • 30-day supply: minimum $30/maximum $90 • 90-day supply: minimum $60/maximum $180 Non-Preferred Brand-Name – 20% coinsurance • 30-day supply: minimum $50/maximum $150 • 90-day supply: minimum $100/maximum $300

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Mandatory Generic Drug Provision:

Effective January 1, 2026, when a multi-source brand-name drug (i.e., a brand-name drug with a generic equivalent) is dispensed at the request of either the prescribing provider or the member, the member will be responsible for the cost difference between the brand-name and the generic drug, in addition to any applicable copayment or coinsurance.

If the prescribing physician determines that the multi-source brand-name drug is medically necessary, a prior authorization process is available. If the request is approved, the member will not be subject to the cost difference between the brand-name and generic drug.

This provision is designed to encourage the use of cost-effective generic medications while maintaining access to clinically appropriate treatments.

GLP-1 Drug Quantity Management (DQM):

The FDA, medical researchers and drug manufacturers look at individual medications to determine a recommended maximum quantity considered safe. This is especially important for drugs that are challenging to take in the proper dose such as inhalers or nose sprays. These medications are added to a DQM program. The Fund currently has several covered drugs under a DQM program.

Effective January 1, 2026, the Fund has added GLP-1 drugs to the DQM program; GLP-1 drugs are limited to one prescription each 21 days, one fill upon strength change or prior authorization.
If you have questions about drug quantity management, or about anything else in your prescription plan, please contact Express Scripts. You can call the number on your member ID card, log in at express-scripts.com or download the Express Scripts® mobile app.

Step Therapy - High-Cost Generic Solution:

Step therapy is a cost-containment strategy used in prescription drug plans to promote the use of clinically effective, lower-cost medications before approving coverage for more expensive alternatives. Members must first try a preferred generic drug or, if no generic is available, a preferred brand drug (Step 1). If the Step 1 drug is ineffective or causes adverse effects, the provider may request an exception to move to a non-preferred drug (Step 2). Exceptions are reviewed based on clinical criteria, and decisions are typically made within a few business days. The Fund currently has several covered drugs under a Step Therapy program.

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Effective January 1, 2026, the Fund has added several high-cost generic drugs to the Step Therapy program, where a preferred generic drug must be tried first.

Log in to your account at express-scripts.com or call Express Scripts at the number on your member ID card to find out if step therapy applies to the medication your doctor prescribed. If it does, you can see a list of first-line alternatives. You can give that list to your doctor to choose the medication your plan covers that best treats your condition.

If you have any questions regarding these changes, please call the Fund office at 781-272-1000, ext. 202.

Para servicios de traducción, comuníquese con la oficina del Fondo al 781-272-1000, extensión 205.
Para serviços de tradução, entre em contato com o escritório do Fundo pelo telefone 781-272-1000, ramal 205.
Código SMM 2026

Summary of Material Reductions

In accordance with ERISA reporting requirements, this announcement serves as your Summary of Material Reductions (SMR) to the Plan. This Summary of Material Reduction in Covered Benefits is intended to notify you of important changes being made to the benefits provided by the Massachusetts Laborers' Health and Welfare Fund (the "Fund" or "Plan"). You should take the time to read this notice carefully and keep it with the copy of the Summary Plan Description ("SPD") (and prior notices) previously provided to you by the Fund. It is intended to be a brief summary of the plan change. It cannot describe each and every Plan provision that may be relevant to your situation. You should always refer to your plan Rules and Regulations for the full details of your Plan. You should keep all Important Plan Benefit Change announcements with your Summary Plan Description, so it contains up-to-date information. Receipt of this announcement does not validate your eligibility under the Plan. You should always call the Fund Office to verify your eligibility prior to any service.

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