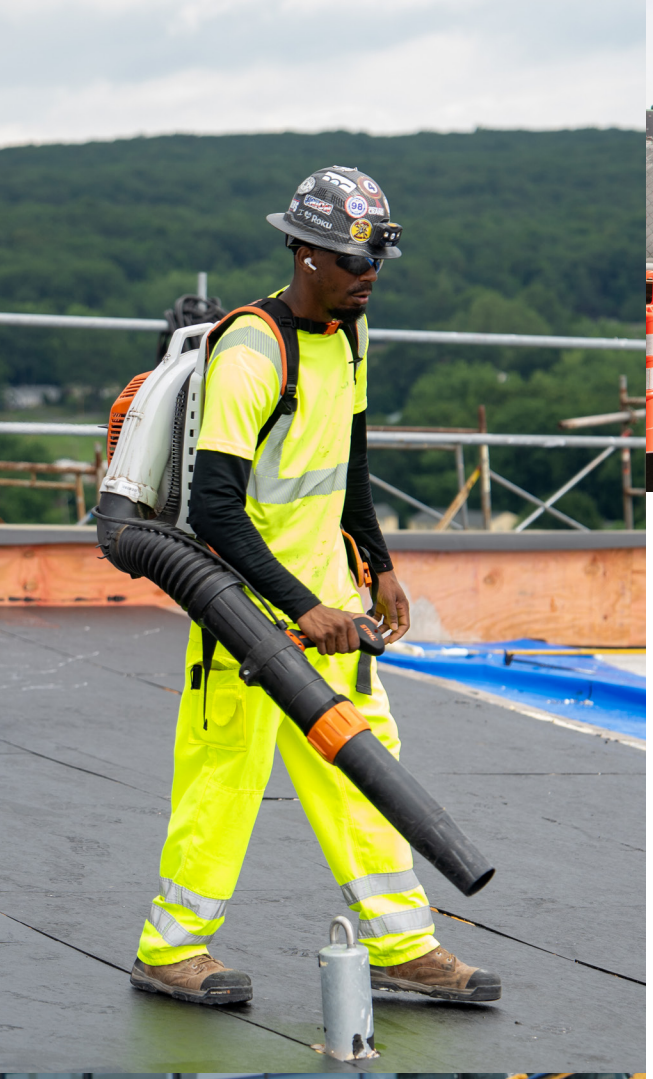
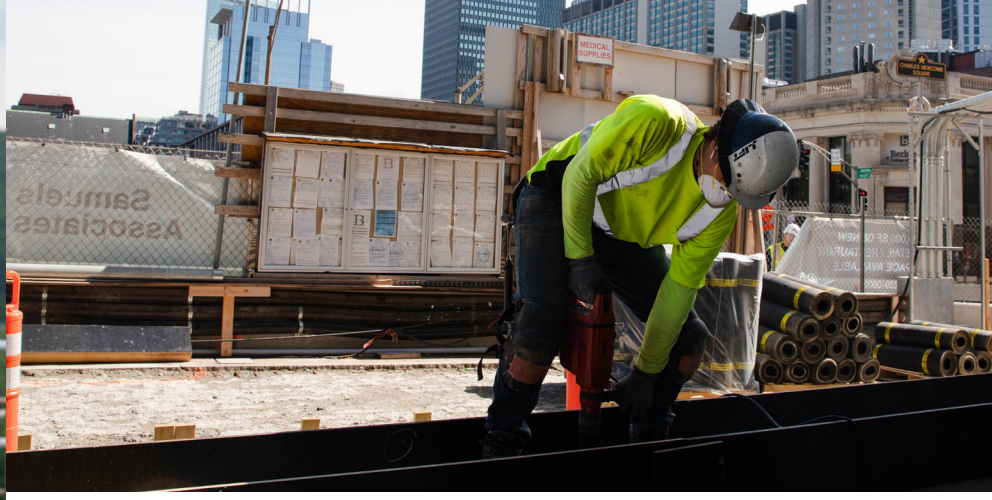




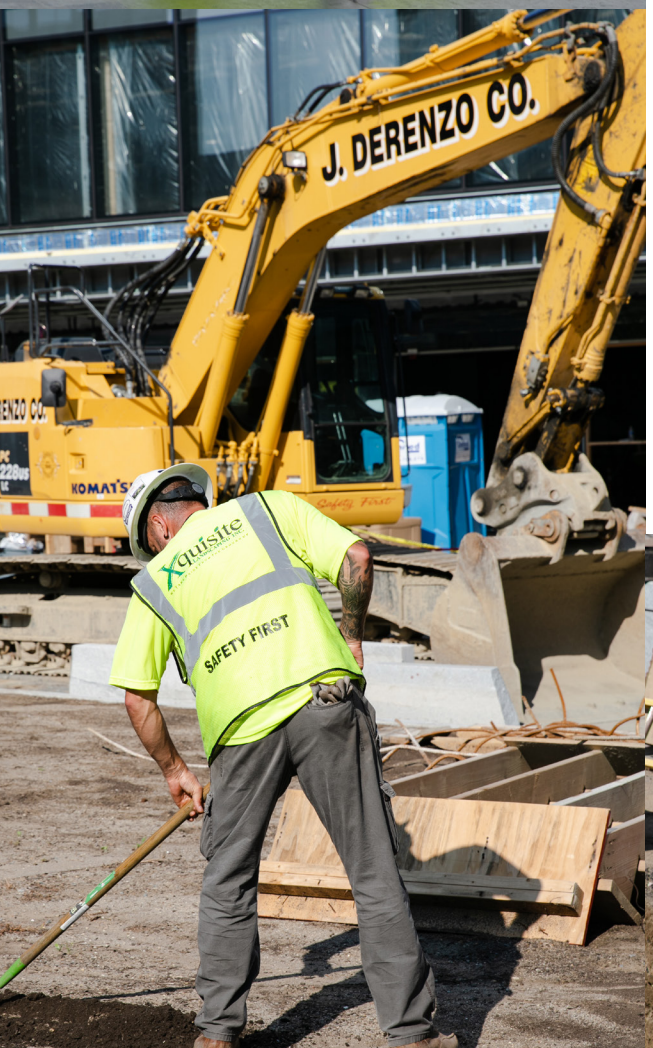
HEALTHCARE • PENSION • ANNUITY • LEGAL SERVICES
BENEFITS FOR LABORERS

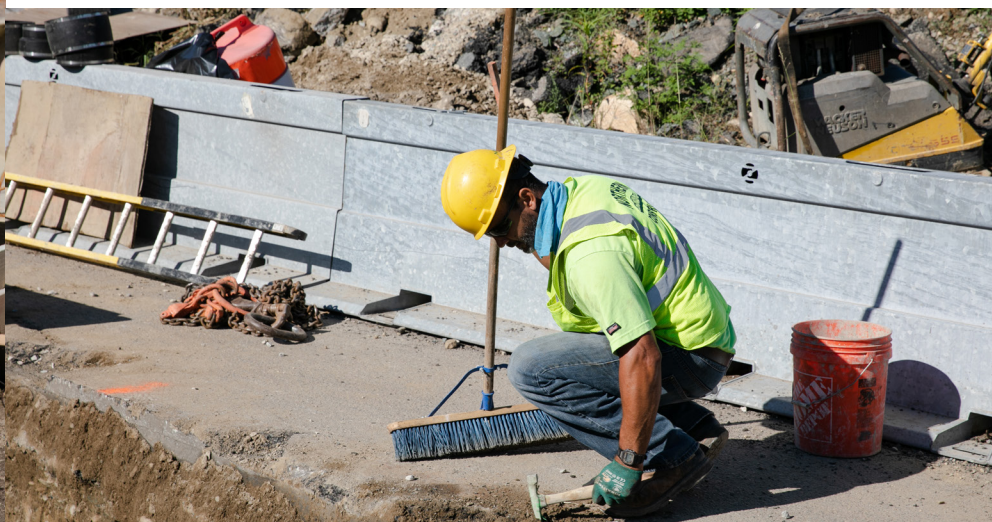
MASSACHUSETTS
LABORERS' BENEFIT FUNDS

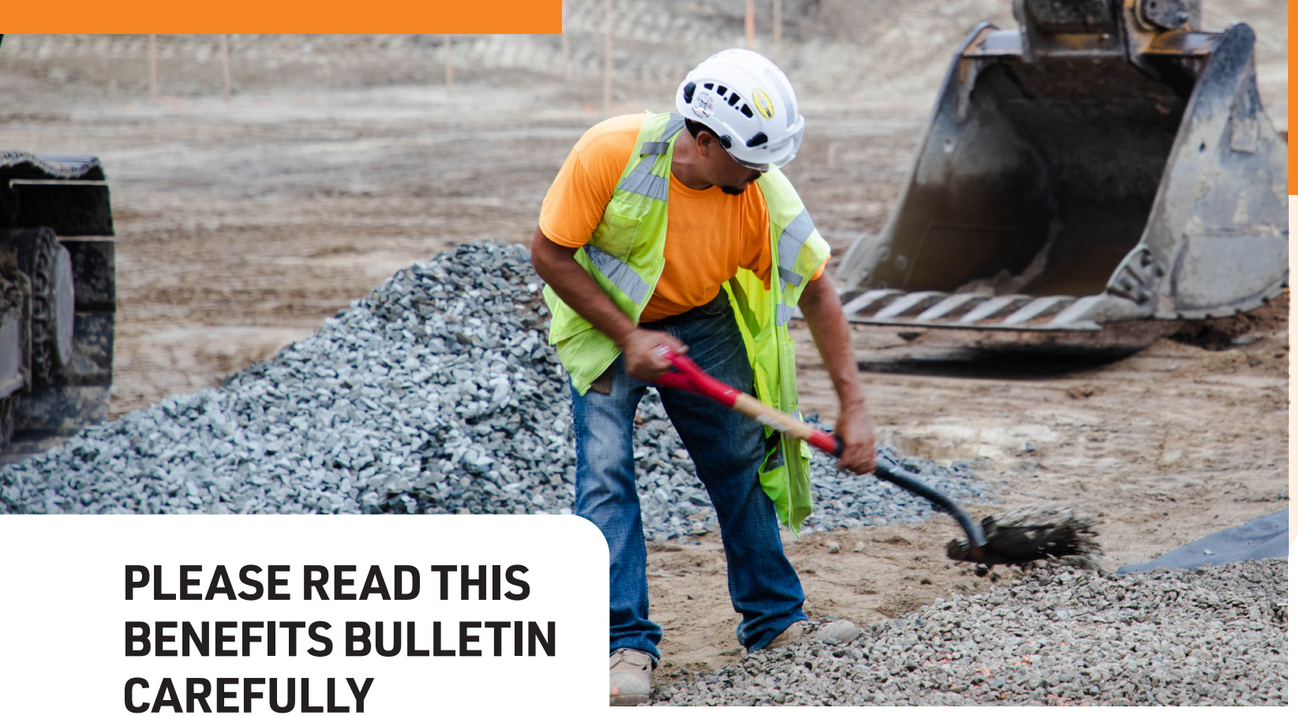
HEALTH AND WELFARE BENEFITS BULLETIN

WHAT'S NEW IN 2026 WITH YOUR HEALTH PLAN

Effective January 1, 2026







PLEASE READ THIS BENEFITS BULLETIN CAREFULLY

This bulletin includes important information about your Health and Welfare coverage. **The Massachusetts Laborers' Health and Welfare Fund** and our **Board of Trustees** are committed to helping our members get the most from our coverage at the best cost. We want to help you understand your coverage, so please do not hesitate to contact the Fund office if you have questions about your eligibility or benefits.

LANGUAGE ASSISTANCE IS AVAILABLE.

We have Spanish and Portuguese-speaking staff at the Fund office who may assist you in your preferred language whenever possible.

- **Español:** Contamos con personal que habla español en la oficina del Fondo y que puede ayudarle en su idioma de preferencia siempre que sea posible.
- **Português:** Temos funcionários que falam português no escritório do Fundo e que podem ajudá-lo em seu idioma de preferência sempre que possível.

*This document is not intended to serve as a Summary of Material Modifications (SMMs). For the complete SMM outlining the 2026 plan changes, please visit **MLBF.org**.*

BIGGEST CHANGE FOR 2026:

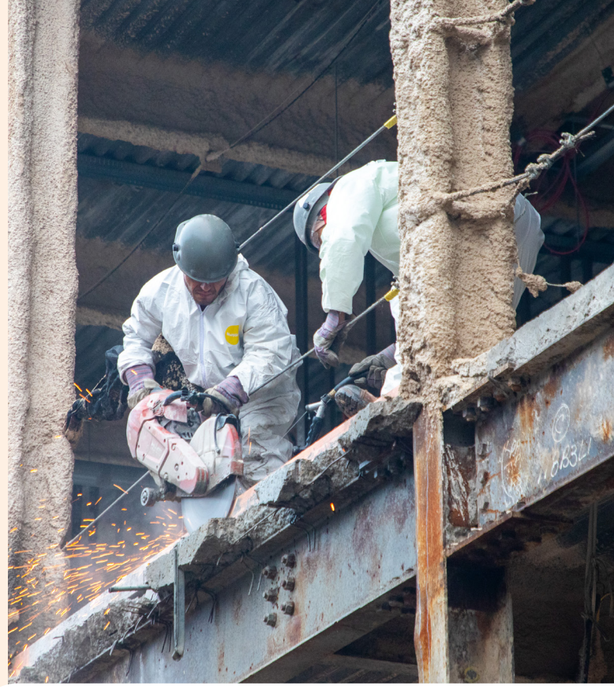
PRESCRIPTION DRUG COVERAGE

Your plan now uses a prescription drug coinsurance model. This means instead of paying a flat copay, you will pay a percentage of the prescription's cost.

WHAT IS COINSURANCE VS. COPAY?

COINSURANCE is a cost-sharing model in which a member pays a percentage of the total cost, and the Fund pays the rest. There is a cap that limits how much you can be charged for each prescription.

COPAY is a fixed, flat fee you pay for a specific service or prescription at the time of service.



WHAT IS OUT-OF-POCKET MAXIMUM?

Out-of-pocket maximum is the **most** you will pay for covered prescriptions in a plan year. Once you reach this limit, the plan pays 100% of covered costs for the rest of the year.

Both plans A and B include an annual out-of-pocket maximum of:

- **$2,000 per individual**
- **$4,000 per family**

***Note:** The Fund has separate out-of-pocket maximums for medical benefits and pharmacy benefits.*

UNDERSTANDING PRESCRIPTION DRUG COVERAGE

What you pay for your prescription depends on the full cost of the medication and whether it is generic or brand-name. Medications are grouped into three tiers based on drug type and cost.

OUT-OF-POCKET COST BREAKDOWN

	MEMBER'S RESPONSIBILITY	30-DAY SUPPLY	90-DAY SUPPLY
GENERIC	Coinsurance = 20% of the cost of the medication	$10 minimum $30 maximum	$20 minimum $60 maximum
PREFERRED BRAND NAME	Coinsurance = 20% of the cost of the medication	$30 minimum $90 maximum	$60 minimum $180 maximum
NON-PREFERRED BRAND NAME	Coinsurance = 20% of the cost of the medication	$50 minimum $150 maximum	$100 minimum $300 maximum

90-DAY SUPPLY RETAIL PENALTY

If you take a medication on an ongoing or maintenance basis, it **must** be filled as a 90-day supply through one of the following options:

- Express Scripts mail order
- 90-day prescription with CVS

After three 30-day retail fills, **you will be responsible for the full cost** unless you switch to a 90-day supply.

PRESCRIPTION DRUG COVERAGE EXAMPLES

GENERIC

Joe has been prescribed an albuterol inhaler for asthma. He has two refill options:

30-DAY SUPPLY	90-DAY SUPPLY
Out-of-pocket cost: min $10, max $30	Out-of-pocket cost: min $20, max $60
Medication cost: $19.84 Joe's total cost for 30 days (coinsurance): $10	Medication cost: $59.50 Joe's total cost for 90 days (coinsurance): $20

Joe saves $10 with the 90-day supply option

PREFERRED BRAND NAME

Mike takes Mounjaro as a maintenance medication* for his type 2 diabetes.

90-DAY SUPPLY
Out-of-pocket cost: min $60, max $180

Medication cost: $3,200
Mike's total cost for 90 days (coinsurance): $180

***Reminder:** Long-term medications must be filled as a 90-day supply. After three 30-day fills at retail, you'll pay the full cost unless you switch.*

NON-PREFERRED BRAND NAME

Mary has been prescribed and approved for a fluticasone inhaler*.

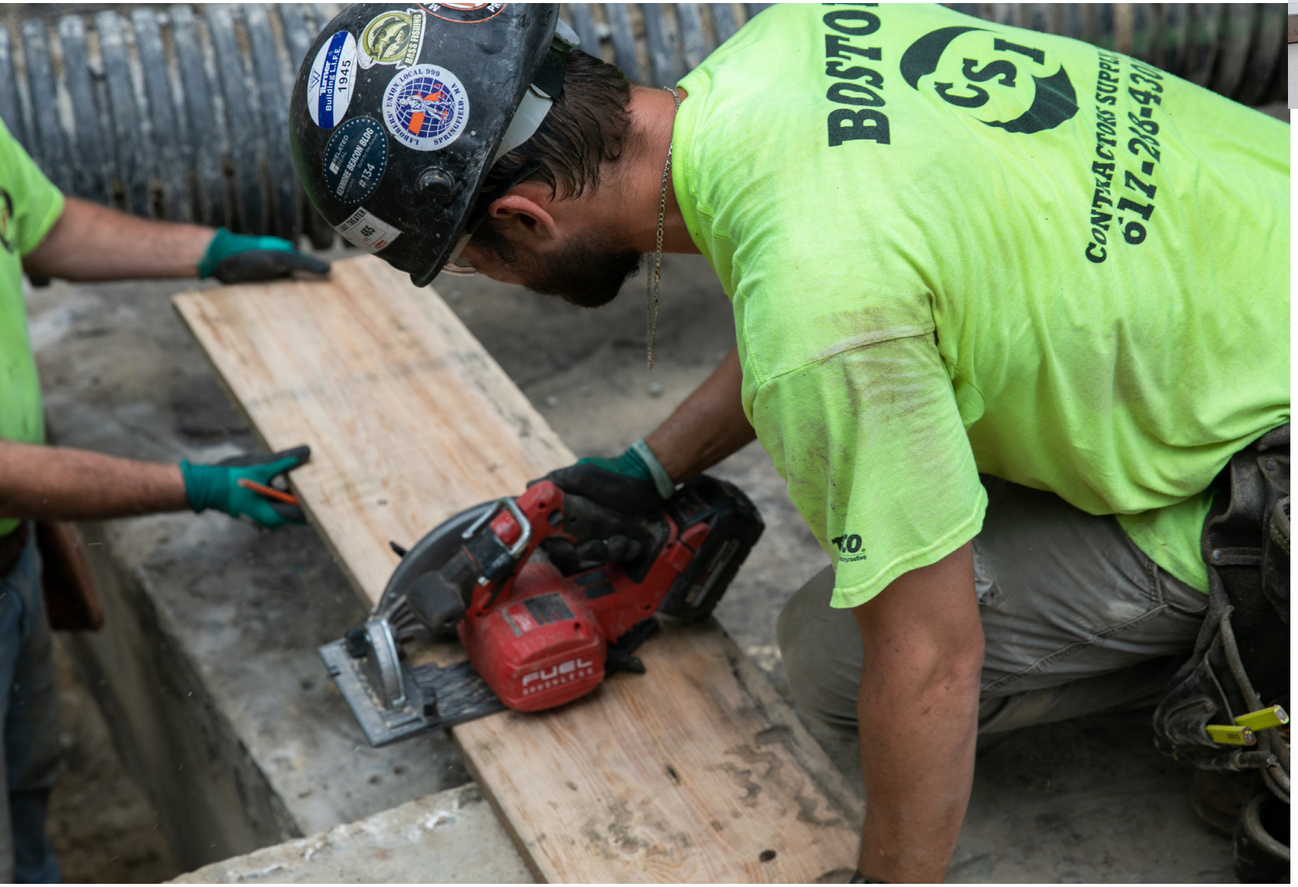
30-DAY SUPPLY	90-DAY SUPPLY
Out-of-pocket cost: min $50, max $150	Out-of-pocket cost: min $100, max $300
Medication cost: $557.85 Mary's total cost for 30 days (coinsurance): $111.57	Medication cost: $1,212.73 Mary's total cost for 90 days (coinsurance): $242.55

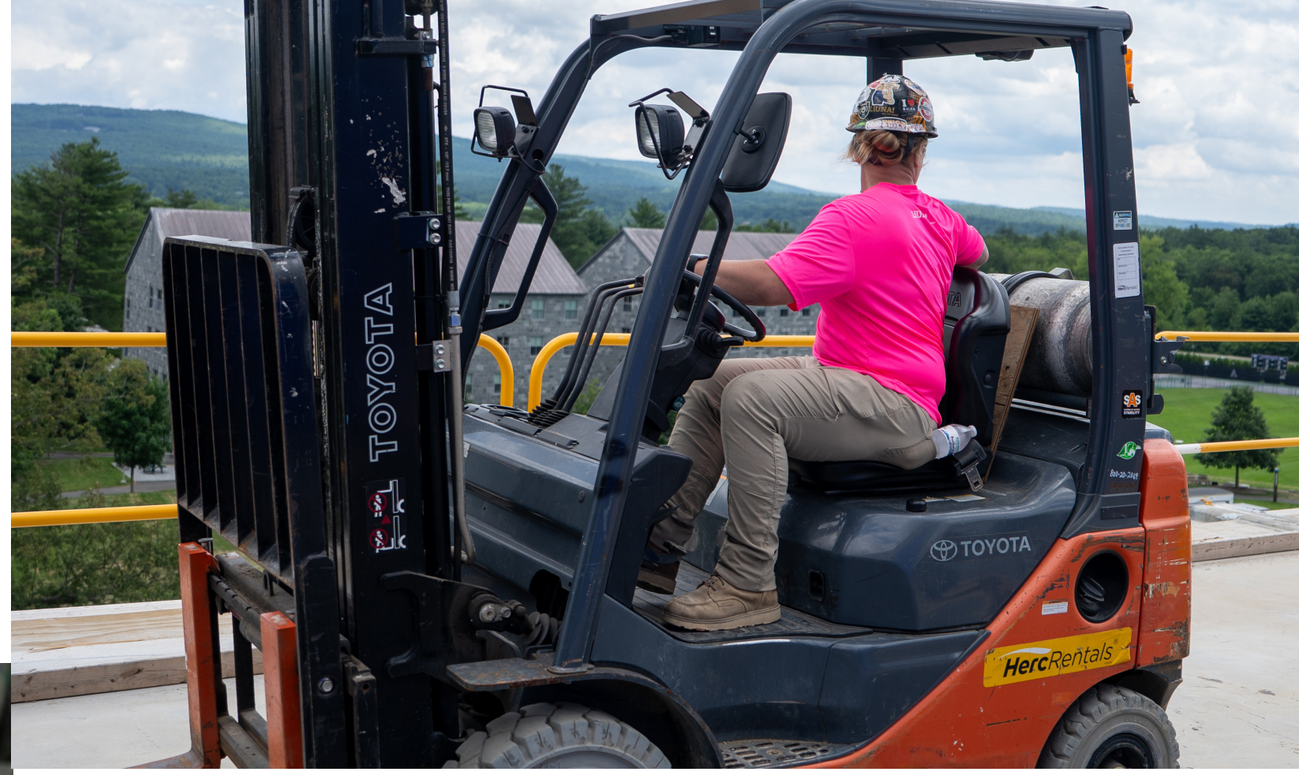
Mary saves $92.16 with the 90-day supply option

***Reminder:** All non-preferred brand medications require authorization.*

WAYS TO SAVE ON PRESCRIPTIONS

- Check with your doctor, pharmacy, or the drug manufacturer to determine whether additional savings programs or copay assistance are available.
- Use the Express Scripts website or app to review medication options and pricing. The coverage check tool helps show the plan's allowable amount so you can compare costs before filling your prescription.
- The Fund partners with **SaveOnSP** for certain specialty medications. If your medication is eligible, SaveOnSP will contact you directly. If you enroll, your out-of-pocket cost will drop to $0.





MANDATORY GENERIC DRUG PROVISION

If a generic medication is available and a brand-name medication is prescribed, you are responsible for the 20% coinsurance of the brand-name medication, plus the price difference. If the generic is prescribed, you are only responsible for the 20% coinsurance of this generic drug. If the prescribing physician determines that the 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.

EXAMPLE: GENERIC VS. BRAND-NAME

If you are being treated for high blood pressure, your doctor may prescribe either a generic or a brand-name medication.

METOPROLOL (GENERIC, 90-DAY SUPPLY):	LOPRESSOR (BRAND-NAME, 90-DAY SUPPLY):
$20	$313

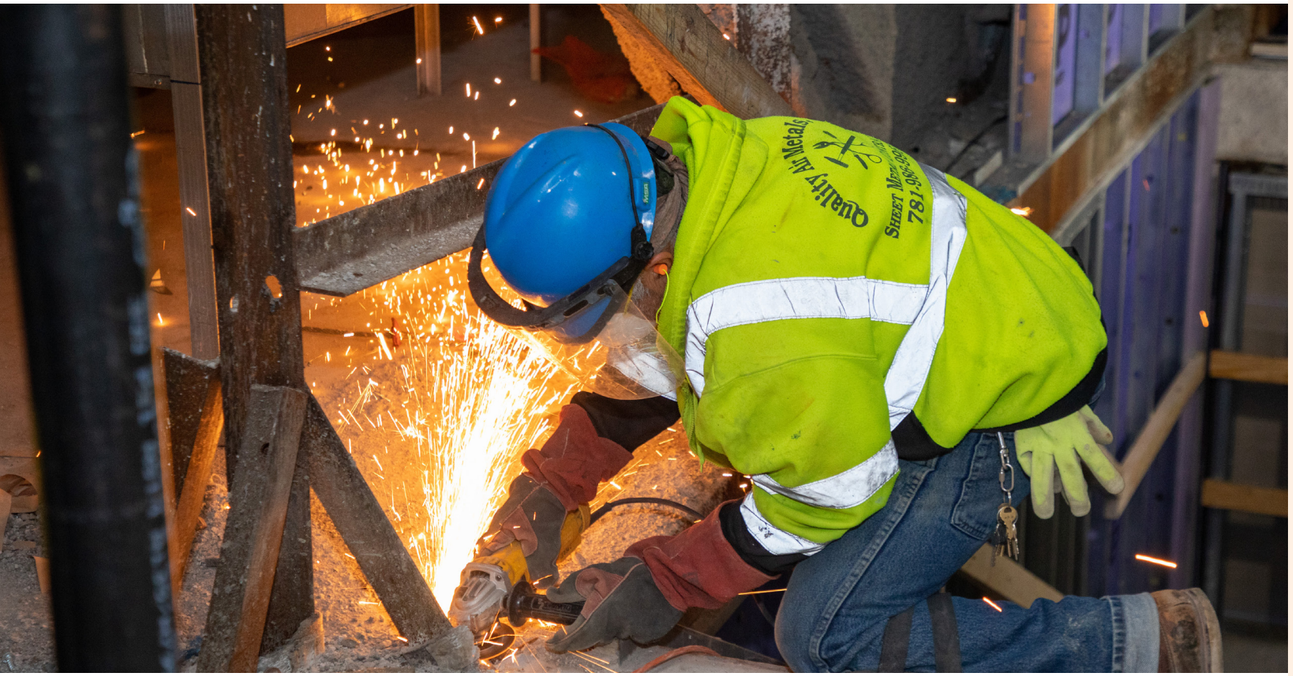
The generic drug has the same active ingredients and works the same way as the brand-name, and saves you $293.

FACILITY FEES (HOSPITALS AND SKILLED NURSING STAYS)

Facility fees may apply when you are admitted to a hospital or skilled nursing facility for medical care, day surgery, mental health treatment, or substance use care.

MEMBER COST BY PLAN

	COPAY (UPON ADMISSION)	PLAN COVERAGE	YOUR OUT-OF-POCKET MAXIMUM PER STAY
PLAN A	$100	Plan pays 100% of the first $20,000, then 85% of the rest up to your out-of-pocket max	$2,000
PLAN B	$250	Plan pays 85% of covered charges up to your out-of-pocket max	$5,000

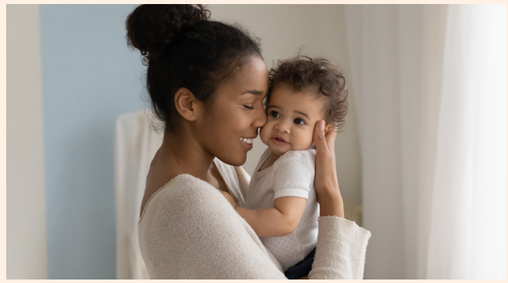


EXAMPLE: DAY SURGERY (ACL-KNEE SURGERY)

PLAN A (JUAN)	PLAN B (DAVIS)
Total covered charges for hospital: $10,000	
Juan pays: $100 copay*	Davis pays: $250 copay + $1,462.50 (coinsurance)* = $1,712.50

**Assuming the deductible has been satisfied.*

EXAMPLE: NEWBORN BIRTH



PLAN A - LUCY

TOTAL COVERED CHARGES FOR LUCY + BABY = $16,700

Lucy's copay..... $100*
Baby's copay..... $100
Baby's deductible..... $250
Plan A pays..... **$16,250**

Total out-of-pocket cost for Lucy and her baby:

$450

PLAN B - MARIA

TOTAL COVERED CHARGES FOR MARIA + BABY = $16,700

Maria's copay..... $250*
Maria's 15% coinsurance..... $1,762.50
Baby's copay..... $250
Baby's deductible..... $500
Baby's coinsurance $592.50
Plan B pays..... **$13,345**

Total out-of-pocket cost for Maria and her baby:

$3,355

**Assuming the deductible has been satisfied.*

OUTPATIENT INFUSIONS

Did you know that you have options to save money on infusions?

LOCATION	COST (AFTER DEDUCTIBLE)
Independent infusion center	$100 copay per visit; medication shipped directly to facility
Home infusion therapy	$0 per visit
Hospital infusion	$100 copay + 15% of medication; max per treatment: $2,000 (plan A) / $5,000 (plan B)

Tip: *Ask your doctor if your infusion can be done at an independent center or at home.*

Please note: *The infusion benefit for chemotherapy and/or immunotherapy for cancer has not changed.*

WHY COSTS CAN VARY BY LOCATION

The same medication can cost much more at a hospital than at a independent infusion center or through home health. When a hospital bills the Fund at a higher price, members share part of the cost.

Find an infusion center near you! Use the BCBSMA website or app and search under Find a Doctor.

AMBULANCE (GROUND/AIR)

If you need an ambulance, you pay 10% of the cost, up to $2,000 (plan A) or $5,000 (plan B). If you are admitted as an inpatient or transferred between facilities, ambulance transport is covered at 100%.

CHOOSE URGENT CARE FOR NON-EMERGENCY NEEDS

For non-emergency health concerns, urgent care centers are often a lower-cost alternative to the emergency room. Choosing urgent care for injuries and illnesses like sprains, stitches, X-rays, burns, and more can help reduce your out-of-pocket costs and wait times.

SAVE ON MRI COSTS

Did you know MRI costs can be much lower if billed by an independent radiology center or doctor's office instead of a hospital? Scheduling your MRI at a lower-cost location can save you money on copays and coinsurance.

MRI LOCATION	PLAN A – COST TO MEMBER*	PLAN B – COST TO MEMBER*
Independent radiology center or doctor's office	$0	10% of MRI Cost
Hospital facility	$250	$250 + 10% of MRI cost

**All member costs assume the deductible has been satisfied. If there is no in-network independent radiology center within 30 miles of your home, your copay will be waived.*

Tip: *Use the BCBSMA Find a Doctor (FAD) tool to search for "Technical Diagnostic Imaging Centers" near you.*

IMPORTANT REMINDERS

IN-NETWORK COVERAGE ONLY

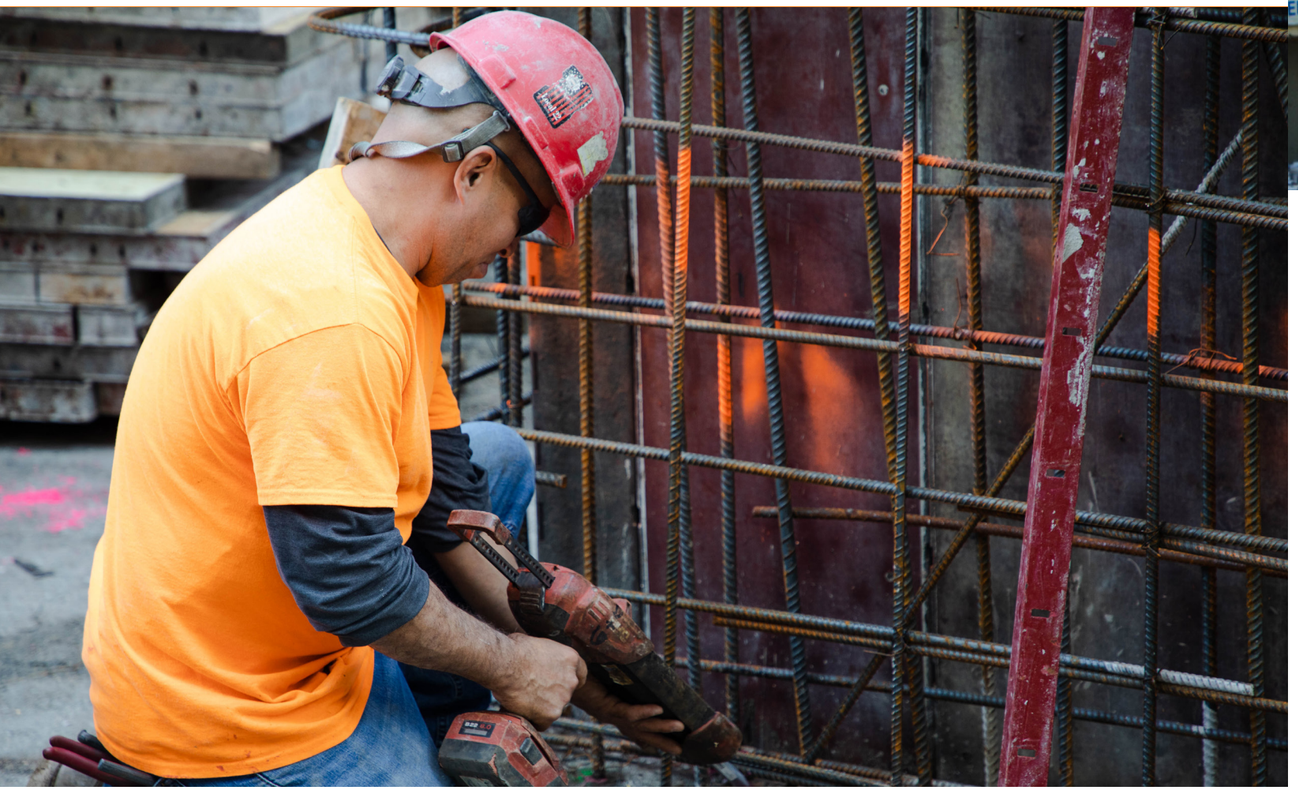
This plan covers services provided by in-network providers only. There is no coverage for out-of-network care. If you choose to see a provider outside the network, you are responsible for the full cost.

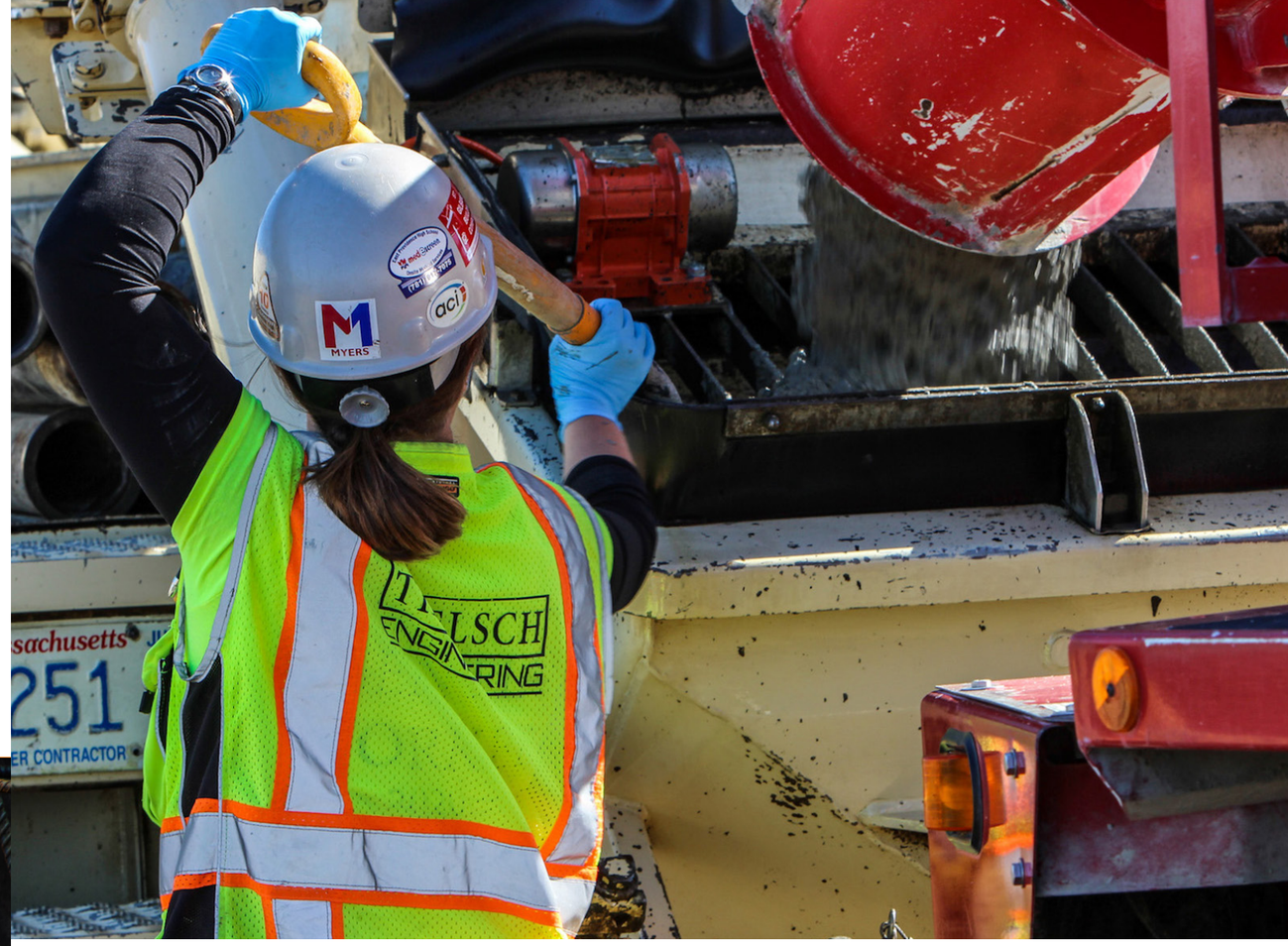
PREVENTIVE CARE IS COVERED AT 100%

Preventive care services are covered at no cost, in accordance with the Affordable Care Act. Staying up to date on preventive care can help avoid more costly medical issues.

Preventive care includes:

- Two dental cleanings per year
- One annual routine physical exam





PRESCRIPTION REMINDER FOR MAINTENANCE MEDICATIONS

If you take a medication daily, filling a 30-day supply more than three times at a retail pharmacy will result in you paying the full cost of the medication.

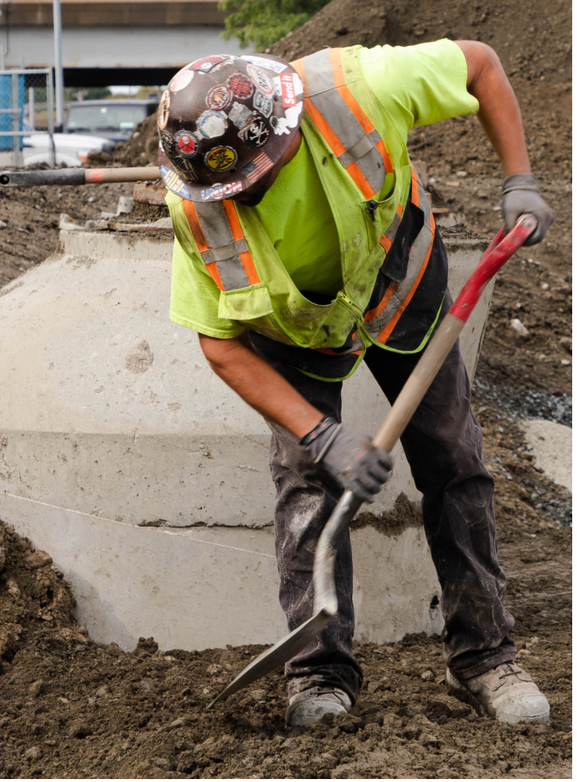
To avoid this:

- Ask your provider to prescribe a 90-day supply
- Fill through Express Scripts mail order or CVS Pharmacy

WHAT IS A DEDUCTIBLE?

A deductible is the amount you pay out of your own pocket for medical care before your health insurance pays most of the costs.

- Plan A: $250 per individual / $500 per family (per calendar year)
- Plan B: $500 per individual / $1,000 per family (per calendar year)



WHAT IS PRIOR AUTHORIZATION?

Prior authorization is approval from your health plan that may be required before certain services, treatments, or prescriptions are covered.

Medical prior authorizations mean your provider must contact Blue Cross Blue Shield of Massachusetts. Prescription prior authorization means your provider must contact Express Scripts.

WHAT IS AN ALLOWABLE AMOUNT?

The allowable amount is the maximum amount the health plan will pay for a covered service. This is often less than what a provider initially bills and is sometimes called the *negotiated rate*.

Allowable amounts are set through contracts between the Fund's vendors, such as Blue Cross Blue Shield of Massachusetts or Davis Vision, and in-network providers.

RESOURCES FROM BLUE CROSS BLUE SHIELD OF MA

BCBSMA offers case management programs to help support your care. If BCBSMA has reached out about a case management program, we encourage you to participate.

A case manager can:

- Help you find the right place for your treatment
- Explain your coverage and costs
- Support you in managing your care efficiently

Tip: *Engaging with a case manager can save you money and make your treatment experience easier.*

ADDITIONAL BENEFITS & WELLNESS RESOURCES

In addition to medical, dental, vision, and prescription coverage, your plan includes access to valuable wellness programs and support services, including:

- LEAN (Laborers Escaping Addiction Now) Recovery Program / Recovery Specialists
- Health coaching
- Hinge Health for musculoskeletal pain
- Maternity case management
- Tobacco and nicotine cessation medications (at no cost)
- Fitness reimbursements for gym memberships or instructor-led classes
- Reimbursement for acupuncture, chiropractic care, and massage therapy
- Laborers' Support Network / Member Assistance Program (MAP)
- Blue365 discount program

CONTACT US!

Scan the QR code to visit our website for more important documents, like your Summary of Benefits and Coverage, Summary Plan Description, and Summary of Material Modifications (SMMs).

Members can sign up for text alerts and follow our social media channels to receive timely updates, reminders, and important information about their benefits.

Address: 1400 District Avenue, Suite 200
Mail to: PO Box 1501, Burlington, Massachusetts 01803

Phone: 781-272-1000 | 800-342-3792 (Toll Free)
Eligibility: x201 | **Claims:** x202 | **Spanish:** x205

Website: MLBF.org
Email: Claims@mlbf.org

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