AUTOMOBILE MECHANICS' LOCAL 701 WELFARE FUND

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IMPORTANT BENEFIT PLAN CHANGES

The Trustees of the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund have made certain changes to the **Premier Plus**, **Premier**, **Classic Bargained** and **Pre-Medicare Retiree** plans as documented in the applicable combination Summary Plan Description and Plan Document ("SPD/Plan") that was previously provided to you. Each change is summarized below and is effective as of September 1, 2019.

1. The Plan's pharmacy benefits manager is changing to EmpiRx Health instead of Express Scripts. This will result in some changes to the mail order service refill requirements, as explained in more detail below.

2. The Plan engaged PaydHealth LLC to be its specialty healthcare advocacy firm for financial case management instead of PillarRx (formerly IPC/Evergreen Rx).

3. The SPD/Plan was amended to add definitions for "Prescription Drug," "Specialty Drug" and "Specialty List" as a result of the switch to EmpiRx Health and the engagement of PaydHealth.

SUMMARY OF MATERIAL MODIFICATIONS

This document, referred to as a "summary of material modifications," is intended to supplement the SPD/Plan. You should retain this summary of material modifications with your copy of the SPD/Plan. If you have any questions, you may contact the Fund Office (708) 482-0110 ~ Toll Free (800) 704-6270.

1. **Change to the Plan's Pharmacy Benefits Manager to EmpiRx Health**

The Plan will be switching to EmpiRx Health as its pharmacy benefits manager. Express Scripts will no longer be managing the Plan's prescription drug program as of September 1, 2019. Accordingly, there will be some changes to the mail order service/Walgreens retail pharmacies refill requirements and specialty pharmacy program, as explained in more detail below. The new contact information for EmpiRx is 1-888-309-1654 or www.empirxhealth.com.

2. **Change to Mail Order Service/Walgreens Retail Pharmacies refill requirements**

As a result of the switch from Express Scripts to EmpiRx Health, a change was made to the refill requirements under the Mail Order Service/Walgreens Retail Pharmacies section of the SPD. As you already know, maintenance medications (i.e., for chronic conditions such as high blood pressure or cholesterol) should be filled through the mail order service program or at Walgreens retail pharmacies. The Plan allows two initial fills of a maintenance medication to be filled at any participating network retail pharmacy (including pharmacies other than Walgreens) without a penalty. As of September 1, 2019, after you have had two initial fills, you will not be able to have your maintenance medication filled at a participating network retail pharmacy other than Walgreens and your prescription refill will be rejected if you choose another pharmacy. **Therefore, after two initial fills, you must either transition your prescriptions for maintenance medications to Walgreens or mail order and the prescription must be for a 90-day supply.**

3. **Implications regarding the Plan's engagement of PaydHealth as its specialty healthcare advocacy firm for financial case management**

The Plan contracted with PaydHealth to be its specialty healthcare advocacy firm for financial case management, replacing PillarRx (formerly IPC/Evergreen Rx) which was the Plan's specialty drug case manager.

The purpose of the advocacy firm is to provide financial case management for Specialty Drugs, products, and services included on the Specialty List (SL), in order to reduce the cost of Specialty Drugs, products and services for you and the Plan.

Specialty Drugs, products, and services included and noted on the Specialty List that have been specifically designated by the Fund are subject to prior authorization, step-therapy, and administrative review prior to the specified Plan coverage limits applying as shown on the Schedule of Benefits tables in the SPD. PaydHealth will work to reduce your and the Plan's costs for these listed items.

The Plan requires you to enroll in the Specialty Healthcare Advocacy Program. Additionally, the Plan requires that you complete the application process, in good faith, for alternate funding programs identified by your Specialty Healthcare Case Coordinator. Completing the enrollment application, meeting medical necessity and step-therapy criteria are prerequisites to receiving any coverage under the Plan for Specialty Drugs, products, or healthcare included on the Plan's SL. If you choose not to enroll in the Specialty Healthcare Advocacy Program, the co-insurance or out-of-pocket cost for Specialty Drugs will be 100% of the pharmacy billed charges and your costs will not apply to your annual maximum amount or deductible.

The Plan is sponsoring this program and you will not be responsible for any payments to the program as a participant in the Plan. However, you may be required to pay a portion of the cost to acquire your Specialty Drug, product or service.

Advocates from the Specialty Drug Advocacy Program will proactively contact you to complete the enrollment process and gather any additional information required to help you maximize your benefit for Specialty Drugs under the Plan. Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, you will be asked to provide this information directly to the advocacy firm or alternate funding program, and such information will not be provided to the Plan.

If you are NOT eligible for an identified alternate funding program, your Specialty Healthcare Case Coordinator will automatically submit your case for benefit reconsideration under the Plan's appeal process. Should your claim meet Plan reconsideration criteria, your out-of-pocket costs will be adjusted to the appropriate co-insurance and other cost-sharing amounts of your applicable Plan option, as shown in the Schedule of Benefits tables in the SPD. Your out-of-pocket costs will never exceed those shown in the Schedule of Benefits tables in the SPD if an appeal is approved.

All Specialty Drug prescriptions paid for by the Plan through benefit reconsideration must be dispensed by EmpiRx Health – who will collect your co-insurance and any other cost-sharing amounts as shown in your applicable Plan option Schedule of Benefits as detailed in the SPD. Any financial assistance you receive will not apply to any deductible or calendar year out-of-pocket maximum amounts.

Questions related to the Specialty Pharmacy Program may be made directly to PaydHealth, by calling 1-877-869-7772.

4. **Addition of new definitions to the Plan/SPD**

As a result of the switch to EmpiRx Health and the engagement of PaydHealth, the following definitions were added to the Plan/SPD:

- **Prescription Drug** means any of the following: a US Food and Drug Administration-approved Drug or medicine which, under federal law, is required to bear the legend: Caution: federal law prohibits dispensing without prescription; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such Drug must be Medically Necessary in the treatment of a Disease, Sickness or Injury.

- **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 a 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 or as part of a US Food and Drug Administration-approved Risk Evaluation and Mitigation Strategies (REMS) program.

- **Specialty List** means a list of Prescription Drugs, products, or services, typically prescribed by a specialist, that may require special handling, storage, transportation services or enhanced clinical monitoring by a specialist or specialty pharmacy provider. The Specialty List is updated periodically by the Plan to address changes in prescription labeling, new market entrants, and safety and efficacy considerations and each listed item requires Plan prior authorization, step-therapy, and administrative review for coverage.