SMART Local 265

Fringe Benefit Funds

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SMART Local 265 Health and Welfare Fund

Announcing Important Plan Changes

To: All Eligible Members Participating in the SMART Local 265 Health and Welfare Fund

From: The Board of Trustees

As the Board of Trustees of the SMART Local 265 Health and Welfare Fund (Plan), we are advising you of the following changes to the Plan's benefits. Please keep this document with the Summary Plan Description (SPD) that was recently mailed to you and review the flyers included with this mailing that explain other benefits you have available to you. **Look for additional communications about Benefit Seminars that the Fund Office will be holding to address these changes and to explain the benefits available to all eligible members.**

Effective January 1, 2023, the Plan is amended as follows:

Appendix A: Summaries of Benefits Updates

- In and Out of Network deductibles and Out of Pocket maximums are no longer combined and are applied separately.
- In and Out of Network deductibles and Out-of-Pocket maximums have increased.
- In and Out of Network coinsurance amounts for the patient have increased.
- There is now a family deductible maximum.
- Pharmacy copayment amounts have increased
- All In and Out of Network inpatient care requires precertification.

Appendix A: Summaries of Benefits for Class A, B, D, E, G, H, and I are updated as follows:

Medical Benefits	**Coverage (All inpatient care requires precertification)**
Deductible	
PPO Network Providers	$500 per person per calendar year; $1000 per family per calendar year
Non-PPO Network Providers	$1000 per person per calendar year; $2000 per family per calendar year (Expenses incurred during the last three months of a calendar year will also count toward the next year's Deductible)
Out-of-Pocket Maximum[1]	
PPO Network Providers	$3,000 per person per calendar year; $6,000 per family per calendar year (includes Deductible for PPO charges)
Non-PPO Network Providers	$6,000 per person per calendar year; $12,000 per family per calendar year
[1] Certain expenses do not apply toward your out-of-pocket maximum; refer to page 17 of your Summary Plan Description for a listing of these expenses.	

Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges 60% of Reasonable and Customary Charges; except 80% of PPO Allowable Charges for No Surprises Act claims
[2] Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).	
Home Health Care/Durable Medical Equipment	Plan pays: 80% if precertified (60% of Reasonable and Customary Charges if not precertified)
Skilled Nursing Facilities PPO Network Providers Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges Not covered
Inpatient Hospice Care Services PPO Network Providers Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges Not covered
Emergency Services PPO Network Providers and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges
Disease Awareness/Education Services	$250 per person per calendar year (limit does not apply to diabetes education)
Diabetes Education	80% of PPO Allowable Charges (in-network) or 60% of Reasonable and Customary Charges (out-of-network)
Chiropractic	Chiropractic limits apply only to participants age 6 and older
Treatment	$75 per visit up to $2,000 per person per calendar year
X-rays/Lab Services	80% of PPO Allowable Charges (in-network) or 60% of Reasonable and Customary Charges (out-of-network)
Mental Health and Substance Abuse Benefits	
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges 60% of Reasonable and Customary Charges
Preventive Services Benefit	
Routine Physical Examination[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 60% of Reasonable and Customary Charges, after Deductible
[3] Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.	
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 60% of Reasonable and Customary Charges, after Deductible

Prescription Drug Benefits	
Out-of-Pocket Maximum	$6,000 per person per calendar year; $12,000 per family per calendar year
Retail Pharmacy Program Copayment[4]	You pay:
Generic Medication	20% with $10 min/$25 max for less than 84 days; 20% with $25 min/$65 max for greater than 84 days
Brand-Name Formulary Medication	30% with $35 min/$65 max for less than 84 days; 30% with $70 min/$165 max for greater than 84 days
Brand-Name Non-Formulary Medication	40% with $70 min/$140 max for less than 84 days; 40% with $80 min/$185 max for greater than 84 days
Specialty Medication	20%, up to $200
[4] If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted price of the prescription, not the retail price of the prescription.	
Mail-Order Copayment	You pay:
Generic Medication	20% with $25 min/$65 max
Brand-Name Formulary Medication	30% with $70 min/$165 max
Brand-Name Non-Formulary Medication	40% with $80 min/$185 max
Specialty Medication	20%, up to $200

Vision Benefits for Class A, B, D, E, G and I – Non-PPO Providers

The Plan will no longer offer vision coverage for out-of-network (non-PPO) services. Previously, the Plan provided up to $200 in coverage for services from non-PPO providers. You may only use a provider with EyeMed or Union Eyes. All other providers are no longer covered under the Plan.

Precertification Required for Physical Therapy, Occupational Therapy, Speech Therapy, and Developmental Disorders

Precertification through Valenz Health is required from the beginning of treatment for physical therapy, occupational therapy, speech therapy associated with all medical and surgical conditions and developmental disorders, except for the initial evaluation. Benefits are only available for approved therapy. Precertification is not required for an initial evaluation or for treatment received at a Union Wellness Center (UWC).

New Hearing Benefit Provider - TruHearing

The Plan will offer the TruHearing discount program, replacing EPIC, to all eligible participants except Class C Medicare-eligible retirees. The following changes will also occur:

- The Plan pays for PPO providers. You will pay 100% of the cost if you utilize a non-PPO network provider.
- An initial audiology exam, fitting, and adjustment visits with a TruHearing provider are covered.
- The Plan will cover 100% of PPO allowable charges for hearing aid devices, repairs, and ear molds
- The frequency period for hearing aid devices, repairs, and ear molds have been increased from 24 to 36 months.

All other hearing benefits remain unchanged.

Mental Health and Substance Abuse Services

Effective immediately, the Plan will cover mental health and substance abuse treatment rendered by a licensed mental health and substance abuse provider. Previously, the Plan covered these services only when provided by specific licensed providers as described in the SPD.

The following changes to eligibility are effective on January 1, 2023:

Eligibility Lookback Period

For your coverage to continue to the next quarter, you must continue working for a Contributing Employer, and your Employer must contribute to the Plan on your behalf for at least 700 hours in the corresponding Contribution Quarter and prior Contribution Quarter combined (if you do not meet the 350 hours in the corresponding Contribution Quarter). Your eligibility for coverage continues on a quarter-by-quarter basis. As long as sufficient Employer Contributions are made on your behalf to continue coverage, your coverage will continue.

Continuing Coverage and SASMI Contributions

The requirements for continuing coverage will include coverage provided through SASMI contributions. If you would otherwise lose eligibility due to a lack of sufficient Employer contributions made on your behalf, you and your eligible Dependents may make self-payments to the Plan up to a maximum of 10 successive benefit quarters. The 10-quarter maximum includes payments made by SASMI and the member.

Delta Dental - New Dental PPO Provider

Effective October 1, 2022, Delta Dental will be the Plan's dental PPO provider, replacing Dental Network of America. In addition, the following changes will take effect:

- The $2,000 benefit specifically for Sjogren's Syndrome will be removed and treatment will be covered under the $5,000 limit for surgical dental treatment under Covered Medical Expenses as described in the Summary Plan Description (SPD). Surgical dental treatment is covered at 20% coinsurance and not subject to a deductible.
- A predetermination is required for Dental Benefits. This includes dental claims with facility/anesthesia charges for children and handicapped dependents. Upon approval by the Case Manager, coverage will include:
    - anesthesia charges for Eligible Dependent children who either have a medical condition that requires hospitalization or requires general anesthesia for dental care; or
    - an individual who has a handicap or disability.

All other dental benefits will remain unchanged.

Coverage of Wegovy and Saxenda Weight Loss Medications through Express Scripts SafeGuardRx Weight Management Care Value℠ Program

Effective September 1, 2022, the Plan will cover the weight loss medications Wegovy and Saxenda through Express Scripts (ESI) SafeGuardRx Weight Management Care Value℠ Program. The Plan requires precertification for obesity treatments, including Wegovy and Saxenda. The precertification for these medications is handled by Express Scripts.

The ESI SafeGuardRx Weight Management Care Value[SM] Program provides you with the following benefits in connection with the administration of Wegovy and Saxenda:

- A Digital Obesity Solution where a cellular-connected scale automatically transfers weigh-ins to a coach for review, and you have access to personalized coaching from registered dieticians, an individualized weight loss program, peer support, and more.
- You can fill Wegovy and Saxenda from any in-network pharmacy.

If physical therapy is required in conjunction with the administration of Wegovy and Saxenda, you will need to contact the Union Wellness Center (UWC) at (312) 421-1016 or www.unionwellnesscenters.com.

Other weight loss medications and services for the treatment of obesity, diet, or weight control will continue to be excluded from coverage by the Plan, except that the Plan covers medically necessary surgical procedures provided in connection with an overweight condition or condition of obesity.

Class D Unavailable to Members Not Retired as of January 1, 2023

Class D will be unavailable for those not already retired as of January 1, 2023. Those who retire on or after January 1, 2023, and are eligible for Medicare coverage, whether you have applied or not, will move directly to Class C, including handicapped children over the age of 26. Members who have retired prior to January 1, 2023 and are part of Class D will remain in Class D until they turn age 65 and become eligible for Class C.

Class C Medicare Retirees

The $1,700 Health Reimbursement Arrangement (HRA) benefit is available to Medicare-eligible handicapped dependents age 26 and older of Class C retirees. Previously, the HRA benefit was provided only to Class C retirees and their Medicare-eligible spouses.

The Plan will also offer Union Wellness Center (UWC) access to all Class C Medicare-eligible retirees, spouses, and dependents for a one-year trial period beginning January 1, 2023 through December 31, 2023. Only retirees known to be in IL and IN will be auto-enrolled in 2023. After December 31, 2023, Medicare retirees who elect the UWC access will be eligible for a HRA benefit of $1,500 per employee and $1,200 for spouses and dependents. For 2024, there will be a one-time open enrollment in the fall of 2023 for current Medicare retirees to choose between the current HRA ($2,000/Employee and $1,700/spouses and dependents) or the HRA with UWC access ($1,500/employee and $1,200/spouses and dependents). Future Medicare-eligible retirees will be able to make their election decision when they are eligible to move to Class C.

If you have questions about your Plan coverage in general, feel free to call the Fund Office at 630-668-7260.

This is a Summary of Material Modification for the SMART Local 265 Health and Welfare Fund. Benefits under the Plan are not vested or guaranteed. Full details of the Plan are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify or discontinue all or part of the Plan at any time.

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Date of Notice: November 1, 2022