ST. PAUL ELECTRICAL WORKERS HEALTH PLAN
SUMMARY OF MATERIAL MODIFICATIONS

To: All Participants and Beneficiaries

From: Board of Trustees

Date: February 1, 2022

Re: Coverage of at-home Covid-19 tests, the Plan's definition of Medical Necessity and adoption of policy regarding outpatient drug testing claims, Pharmacy Benefit Manager transition, Sharecare wellness incentive program.

The Board of Trustees announces the following two changes to the Plan, effective January 1, 2022. The first change relates to the Plan's definition of Medical Necessity or Medically Necessary Treatment. The second change is an adoption by the Plan of the Plan's third-party administrator, Wilson-McShane Corporation's internal policies regarding the Identification, Documentation, and Routing of Outpatient Drug Testing Claims Related to a Diagnosis of Substance Use Disorder for Medical Necessity Review. In addition to the noted changes, this notice also updates you on some transition matters related to the Plan's moves to UMR and CVS Caremark.

1. **Coverage of At-Home Covid-19 Test Kits**

Pursuant to recent U.S. Department of Labor guidance, the Plan will provide coverage for at-home Covid-19 tests subject to the following provisions.

- **When was coverage of at-home Covid-19 tests effective?** Covid-19 tests are covered if purchased on and after January 15, 2022, and through the end of the declared public health emergency related to Covid-19.

- **How many tests are covered?** Coverage is provided for up to eight (8) tests per covered individual in a 30-day period.

    - For example, a family of four covered under the Plan, may receive at no cost up to 32 tests (8 per covered person) in a 30-day period if purchased at an in-network provider.

- **What kind of tests are covered?** Only FDA-approved tests will be covered under this program. Go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test before purchasing.

- **Do I have to pay anything for the tests if I buy them in-network?** No. The Plan will cover the cost of at-home Covid-19 tests without cost-sharing (no deductible or coinsurance) for tests purchased directly or online at a CVS/Caremark in-network store.

    - If, for any reason, your in-network store is unable to process your claim when you purchase your covered tests, keep your receipts. You can submit for full reimbursement of the expense at www.caremark.com or through the CVS Caremark mobile app.

- **Can I purchase tests digitally?** Yes. Here is how it works:

    - Go to CVS.com or the CVS Pharmacy mobile application and click on "COVID-19 OTC tests"
    - Enter your zip code, and you will be directed to the closest CVS store locations that have test inventory. The mobile application will include inventory across 7,100 CVS Pharmacy locations (Target and Schnucks are not included)

- Select OTC tests and enter the required information.
- You will be sent a confirmation and within an hour of order confirmation, you can pick up your OTC tests at the CVS store. If you do not pick up your order within 72 hours, it will be cancelled.
- Soon you will also have the option of selecting a "delivery" option during checkout to ship to your home. Shipping fees may apply.

- **What if I purchased the tests out-of-network?** If you purchase tests from an out-of-network pharmacy, your reimbursement will generally be the actual amount you paid per test or $12 per test, *whichever is less*. If you purchased at-home Covid-19 tests at an out-of-network pharmacy, you must submit for reimbursement of your expenses at www.caremark.com or through the CVS Caremark mobile app.

- **What if I already bought and paid for tests before receiving this notice?** If you purchased tests previously and have your receipts for the purchase, you can submit for reimbursement online through www.caremark.com or the CVS Caremark mobile app.

- **Free at-home Covid-19 Tests:** Every home in the U.S. is eligible to order 4 free at-home Covid-19 tests. Go to www.COVIDtests.gov to order your free at-home Covid-19 tests.

- **Important note:** Covered at-home Covid-19 tests include only those for at-home medical use by you or your covered household family members. Tests for employment purposes, resale, or travel requirements will not be covered or reimbursed under this program.

2. **Prescription Drug Benefit Manager Conversion from Prime Therapeutics to CVS/Caremark**

As the Board of Trustees previously announced, the Plan changed its Pharmacy Benefit Manager provider from Prime Therapeutics to CVS Caremark, effective January 1, 2022. The Board of Trustees made this transition in the best interests of the Plan and its participants to continue to provide a comprehensive prescription drug benefit at a prudent cost.

As a result of this transition, there are no changes to the Plan's Prescription Drug Schedule of Benefits. There are no changes to the Plan's copay structure whether at retail or mail order, whether your drugs are brand, generic or specialty. There are no changes to the Plan's annual out-of-pocket limits for prescription drugs. The Schedule of Benefits remains the same.

However, invariably any time a transition of this nature takes place, individual members may be impacted by the change of pharmacy benefit managers. For example, certain prescription drugs in the Prime Therapeutics formulary may be replaced by a different prescription drug in the CVS Caremark formulary. Additionally, certain internal programs that Prime Therapeutics may have offered to assist Plan participants may not be offered by CVS Caremark or may be replaced by a different program or programs they offer. As an example, the Prime Therapeutics copay maximization program is not currently in place with CVS Caremark. However, the Trustees may elect to implement a similar type of program in the future. Participants will be notified of any other copay assistance type programs as they become available.

If you are a participant who has questions regarding this transition, please contact the Fund Office for assistance.

3. **Sharecare Wellness Incentive Program**

As the Board of Trustees previously announced, the Plan also changed its medical network provider from Blue Cross Blue Shield of Minnesota (BCBSMN) to UMR, effective January 1, 2022. Similarly to the Pharmacy Benefit Manager change noted above, certain programs offered under BCBSMN are not currently available, or may be different under UMR. As an example, the Sharecare wellness incentive program under BCBSMN is not offered under UMR. However, the Trustees may elect to implement a new wellness program in the future and you will be notified if that should occur.

4. **Plan's definition of Medical Necessity or Medically Necessary**

Effective January 1, 2022, the Board of Trustees has amended the Plan to update its definition of Medical Necessity or Medically Necessary to incorporate language providing that for the medical benefit section of the Plan, the Plan will be relying upon United Healthcare to make Medical Necessity determinations consistent with United Healthcare's internal medical guidelines which are incorporated into the Plan by reference. It is important to note that the Plan has always relied upon its medical network provider to make such determinations. This language clarifies the long-standing approach to operating the Plan and making these determinations.

The Plan's definition of Medical Necessity or Medically Necessary will now provide as follows:

Medical Necessity or Medically Necessary means medical care and treatment that meets all the following conditions:

- A health intervention for the purpose of treating a medical condition;
- The most appropriate Supply or level of service, considering potential benefits and harms to the patient;
- Known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion; and
- Cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" does not necessarily mean lowest price.
- It is specifically allowed by the licensing statutes that apply to the Provider that renders the service.
- With respect to confinement in a Hospital, Medical Necessity further means that the medical condition requires confinement, and that safe and effective treatment cannot be provided as an outpatient.

The Plan has retained UMR as the medical network provider for the Plan's medical benefits. Unless otherwise stated in the Plan, in determining whether a treatment or service is Medically Necessary under the Plan's medical benefits, the Board of Trustees will rely upon UMR to make such determinations consistent with UMR's medical policies which are also herein incorporated into the Plan by reference.

5. **Effective January 1, 2022, the Plan adopts the following Exhibit E, the policy of Wilson-McShane Corporation for the Identification, Documentation, and Routing of Outpatient Drug Testing Claims Related to a Diagnosis of Substance Use Disorder for Medical Necessity Review**

Exhibit E

This Exhibit E outlines Wilson-McShane and the Plan's policy for identifying and routing medical claims for outpatient drug testing related to substance use disorders for medical necessity review by an outside party. The intent of this procedure is to ensure parity of benefits being applied to mental health and substance use claims.

Policy

Any outpatient drug testing claims with a diagnosis, at any level (primary, secondary, tertiary, etc.), of substance use disorder will be processed as follows:

1. The claims examiner will review any information, including clinical edits, suspensions, medical policy, or corresponding medical records, associated with the claim or a specific claim line to determine whether a medical necessity review is required.

    a. If medical necessity review is required, the claims examiner will, following the procedures specific to the system/network on which the claim is handled:
        i. Deny or pend the claim and request any necessary records from the submitting provider.
        ii. The examiner will document the reason for the denial and the request for records.
    b. If medical necessity review is not required, the claims examiner will apply the Plan's participant cost share (including coinsurance, deductible, and co-payments) as well as the appropriate network negotiated rate and/or usual and customary pricing) and approve the claim or claim line.

2. If additional medical records are required, the claims examiner will, following the procedures specific to the system/network on which the claim is handled, document the request for additional records in the system log, and including the following information:

    a. Claim Number
    b. Date of Request
    c. Name of Provider
    d. Clinical edit, suspension, or medical policy reference on which the request for records is based
    e. Claims examiner name.

3. Upon receipt of the requested medical records, the claims examiner will, following the procedures specific to the system/network on which the claim is handled, document the receipt of the requested documents in the system log, and include the following information:

    a. Claim Number
    b. Date of Request
    c. Provider
    d. Clinical edit, suspension, or medical policy reference on which the request for review of medical necessity is based
    e. Claim examiner name
    f. Description of received documents

4. The claims examiner will, following the procedures specific to the system/network on which the claim is handled, send the request for review of medical necessity to the appropriate outside reviewing entity for the Plan. The claims examiner will document the request for additional records in the system log, and including the following information:

    a. Claim Number
    b. Date of Request
    c. Provider
    d. Clinical edit, suspension, or medical policy reference on which the request for review of medical necessity is based
    e. Name of outside medical review entity

5. Upon receipt of the completed review for medical necessity, the claims examiner will, following the procedures specific to the system/network on which the claim is handled, document the reviewer's determination, and process the claim consistent with such determination.

    a. If the claim is determined to be medically necessary, the claims examiner will:
        i. Apply the Plan's participant cost share (including coinsurance, deductible, and co-payments, as well as appropriate network negotiated rate and/or usual and customary pricing) and approve the claim or claim line.
        ii. Document receipt of the medical necessity determination and approval of the claim in the system log.
        iii. Save the medical necessity determination document in the system or record appropriate notes.
    b. If the claim is determined to not be medically necessary, the claims examiner will:
        i. Deny the claim, include the Plan's required medical necessity adverse benefit determination and appeal language.
        ii. Document receipt of the medical necessity determination and denial in the system log.
        iii. Save the medical necessity determination document in the system or record appropriate notes.

Keep this notice, also called a "Summary of Material Modification" or "SMM" with your Summary Plan Description (SPD) for the St. Paul Electrical Workers Health Plan (restated effective January 1, 2017).

If you have any questions, please contact the Plan Administrator, Wilson-McShane Corporation, at 952-851-5949.