NATIONAL IAM BENEFIT TRUST FUND

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## SUMMARY OF MATERIAL MODIFICATIONS

## October 2025

The following is a summary of changes to the National IAM Benefit Trust Fund's (the "Plan") Summary Plan Descriptions ("SPD") for **Medical Plans A+ and A**, (effective January 1, 2018).

This Summary of Material Modifications ("SMM") supplements the information in the Medical SPDs.

These changes are effective **January 1, 2026**.

## New Pharmaceutical Prior Authorization Requirement

In partnership with CVS Health and Virta Health, the Plan is enhancing support for your health goals with an important update to your prescription benefits. This change involves new requirements for coverage of certain medications, specifically GLP-1 medications for weight loss (e.g., Wegovy, Saxenda, and Zepbound). Prescriptions for GLP-1 medications will have to meet new clinical requirements and be prescribed by the Plan's weight management partner, Virta Health.

## Schedule of Medical Benefits

| Financial | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** (per calendar year – cross accumulates in- and out-of-network – includes 4th quarter carryover) | | |
| **Individual** | $200 | $200 |
| **Family** | $400 | $400 |
| **Out-of-Pocket Limit** (per calendar year – cross accumulate in- and out-of-network – includes deductible, coinsurance and copayments) | | |
| **Individual** | $2,000 | $3,500 |
| **Family** | $4,000 | $7,000 |

| Type of Service/Benefit | Plan Pays In-Network | Plan Pays Out-of-Network |
|---|---|---|
| **PHYSICIAN SERVICES** | | |
| **Primary Care Physician Office Visit** | 100% after $20 copay/visit | 70% after deductible |
| **Specialist Office Visit** | 100% after $25 copay/visit | 70% after deductible |
| **Emergency Room Physician Visit** | 100% after $200 facility copay | 100% after $200 facility copay (70% after deductible if not true emergency) |
| **HOSPITAL FACILITY** | | |
| **Emergency Room** | 100% after $200 copay/visit | 100% after $200 copay (70% after deductible if not true emergency) |
| **Urgent Care Facility** | 100% after $35 copay/visit | 70% after deductible |

## Schedule of Prescription Drug Benefits

| | 34-day Supply All Participating Pharmacies | 90-day Supply All Participating Pharmacies | Specialty Drugs Specialty pharmacy use and pre-authorization required, quantities vary |
|---|---|---|---|
| **Copayment -** Applies for each covered prescription, unless noted, until out-of-pocket limit is met | | | |
| **Generic** | You pay $15 | You pay $30 | You pay $60 |
| **Preferred** | You pay $25 | You pay $50 | You pay $60 |
| **Non-Preferred** | You pay $40 | You pay $75 | You pay $60 |
| **Deductible -** $0 - the medical deductible does not apply to prescription drugs | | | |
| **Out-of-Pocket Limit -** Applies per calendar year for all copayments – the prescription drug out-of-pocket limit is separate from the medical out-of-pocket | | | |
| **Individual** | $2,000 | | |
| **Family** | $4,000 | | |

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