Summary of Material Modification No. 8

to the

IBEW Local 347 Electrical Workers Health and Welfare Fund
Combination Plan Document and Summary Plan Description

The purpose of this Summary of Material Modification ("SMM") is to provide you a summary of the changes and clarifications that were made to the IBEW Local 347 Electrical Workers Health and Welfare Combination Plan Document and Summary Plan Description ("SPD"). Most of the changes were made in the normal course of business. These changes are addressed in **Part I – Standard Plan Amendments**. Other changes are temporary and were adopted in response to the coronavirus public health emergency ("Public Health Emergency"). These changes are addressed in **Part II – Temporary COVID-19 Amendments**.

We suggest you keep this SMM with your SPD. This SMM is also available at the website www.ibew347benefits.com. If you would like a copy of the full text of the new SPD provisions or have any questions, please contact the Fund Office.

Part I – Standard Plan Amendments

1. Extension of the Special Rule for Retirees who Return to Covered Employment Between January 1, 2015 and September 30, 2021:

Effective January 1, 2015, a special rule was added to the Plan for Retirees who returned to Covered Employment between January 1, 2015 and September 30, 2015. This special rule was subsequently extended. Based on this extension, the rule will apply to Retirees who return to Covered Employment between January 1, 2015 and September 30, 2021 and meet the criteria below.

As explained in greater detail in Section 1.12 of your SPD, if a Retiree returns to Covered Employment for 120 or more hours during a consecutive three-month period, the individual will no longer be considered a Retiree on the first day of the third month after (s)he has worked for 120 or more hours during a consecutive three-month period. Generally, when this occurs, the Retiree will not be permitted to receive coverage from the Plan as a Retiree for 12 consecutive months after the date that his or her Retiree eligibility and coverage were terminated. The individual may be permitted to receive coverage under the Plan as a Covered Employee during these 12 months if his or her eligibility and coverage as a Covered Employee are reinstated in accordance with Section 1.15(b) of your SPD.

The special rule provides that if a Retiree meets all of the following requirements, (s)he will not be subject to the rule in the paragraph above which prohibits a Retiree from receiving coverage from the Plan as a Retiree for 12 consecutive months from the date that his or her Retiree eligibility and coverage were terminated:

- The Retiree must have returned to Covered Employment between January 1, 2015 and September 30, 2021;
- The Retiree's eligibility and coverage from the Plan must have been terminated in accordance with Section 1.13(b) between January 1, 2015 and December 31, 2021; and
- After the occurrence of the events in both of the bullet points above, the Retiree must have completely ceased working in Covered Employment between January 1, 2015 and December 31, 2021.

This means that pursuant to this special rule, a Retiree who meets all of the requirements above may receive coverage from the Plan as a Retiree on the first day of the month after (s)he has fulfilled all of the requirements of Section 1.06 or Section 1.07 of the Plan, as applicable.

2. <u>New Employee Assistance Program Services Provider</u>:

Effective January 1, 2021, the Plan's employee assistance program provider changed from the UnityPoint Health Employee and Student Assistance Program ("UnityPoint") to Empathia, Inc. LifeMatters program ("LifeMatters"). This means that LifeMatters will provide the services that UnityPoint used to provide.

LifeMatters is a free program and assists Covered Persons with a variety of life problems, including: alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship discord; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and educational and career related problems. All contact with LifeMatters is confidential.

The Trustees encourage you to take advantage of the services offered by LifeMatters before you seek inpatient or outpatient treatment for mental health or substance abuse.

To utilize this program, please contact LifeMatters at (800) 634-6433. Information is also available at: www.mylifematters.com.

3. <u>New Rule Regarding Coverage of Surviving Dependent Children Who Are Not Dependents of a a Surviving Spouse</u>:

As explained in Section 1.21 of your SPD, a Dependent child's eligibility and coverage will terminate when the Covered Employee or Retiree's coverage terminates unless the surviving Dependent child's coverage continues in accordance with Section 1.22 or 1.23. Prior to February 1, 2020, Sections 1.22 and 1.23 of your SPD provided that a surviving spouse's Dependents, who were also Dependents of the deceased Covered Employee or Retiree on the date of the Covered Employee or Retiree's death, may remain covered as long as the spouse remained covered, so long as they continued to meet the Plan's definition of Dependent. This meant that if a deceased Covered Employee or Retiree's surviving Dependent child was not also a surviving spouse's Dependent, the surviving Dependent child's eligibility and coverage terminated on the first day of the month following the month in which the Covered Employee or Retiree died.

The Plan was amended to provide that if a Covered Employee or Retiree died on or after February 1, 2020, the Covered Employee or Retiree's surviving Dependent child can remain covered by the Plan after the Covered Employee or Retiree's death, regardless of whether or not the child was also the Dependent child of a surviving spouse. The following rules apply when a Covered Employee or Retiree's surviving Dependent child is not also the Dependent child of a surviving spouse:

- The surviving Dependent child must be covered by the Plan on the date that the Covered Employee or Retiree died.
- The surviving Dependent child must continue to meet the Plan's definition of Dependent.
- The surviving Dependent child may not receive HRA benefits from the Plan.
- The surviving Dependent child's coverage will terminate on the earlier of the first day of the 25th month following the Covered Employee or Retiree's death or the first day of the month following the date that the child no longer meets the Plan's definition of Dependent.

4. <u>Elimination of Restriction on Listings with the United Network of Organ Sharing</u>:

Prior to April 24, 2020, the Plan provided that covered Transplant Services included one listing with the United Network of Organ Sharing ("UNOS"). This rule was reflected in Section 2.30(a)(5) of your SPD and meant that the Plan would not cover any additional (i.e., more than one) listing with UNOS.

Effective April 24, 2020, the Plan was amended to remove the limit of one listing with UNOS. This means that Transplant Services covered under Section 2.30 may include more than one listing with UNOS. Based on this change, Section 2.30(a)(5) of your SPD was amended to read as follows:

(5) Listings with the United Network of Organ Sharing (UNOS);

Based on this change, Section 2.30(b)(1) of your SPD was clarified to provide that the Plan does not cover the transplant-related services of "Cryopreservation and storage, transportation and lodging, and transplant consultations".

5. New Definition of Generic Drug:

Prior to January 1, 2020, the Plan defined Generic Drug to be any prescription drug that met all of the following criteria:

- The drug was produced by two or more generic drug manufacturers;
- The drug was not in an initial Food and Drug Administration ("FDA") exclusivity period; and
- The drug was considered a generic drug by Medi-Span.

This rule was reflected in the chart for Prescription Drug Benefits on page 10 of your SPD and the chart at the beginning of Article III of your SPD, as revised by Summary of Material Modifications No. 7.

Effective January 1, 2020, the Plan was amended to define Generic Drug to be any prescription drug that is considered a generic drug by Medi-Span.

6. Changes to the Mail Order Pharmacy that Is Used for Specialty Drugs:

Prior to January 1, 2020, the Plan provided that it would not cover a Specialty Drug unless it was filled at the CastiaRx Specialty Pharmacy or met one of the following criteria: (i) the Specialty Drug was a limited distribution drug and it was not available at the CastiaRx Specialty Pharmacy; or (ii) the Specialty Drug was an immediate need drug.

Effective January 1, 2020, the Plan was amended to provide that the Plan will not cover a Specialty Drug unless it is filled at the Sav-Rx Mail Order Pharmacy or meets one of the following criteria:

- The Specialty Drug is not available at the Sav-Rx Mail Order Pharmacy (e.g., if a doctor prescribes Xolair and Xolair is not available at the Sav-Rx Mail Order Pharmacy, the Plan will cover Xolair even if it is not purchased at the Sav-Rx Mail Order Pharmacy).

- The Specialty Drug is an immediate need drug (e.g., if a Covered Person has surgery and a doctor prescribes Enoxaparin to prevent blood clots after the surgery, the Plan will cover seven doses of Enoxaparin even if it is not purchased at the Sav-Rx Mail Order Pharmacy).

Sav-Rx provides a list of Specialty Drugs on their website. If you have questions regarding Specialty Drugs, you can call Sav-Rx at 866-233-IBEW (4239) or visit www.savrx.com.

7. New Coverage of Topical Dental Products:

Prior to January 1, 2020, Prescription Drug Benefits were not be payable for topical dental products. This rule was reflected in Section 3.05(m) of your SPD, which provided that Prescription Drug Benefits would not be payable for topical dental products. Effective January 1, 2020, the Plan was amended to cover topical dental products. Based on this amendment, the exclusion in Section 3.05(m) was removed from your SPD.

8. Elimination of Special Rules for "New to Market" Drugs:

Prior to January 1, 2020, there were certain drugs that the Plan referred to as new to market drugs. A new to market drug was generally an expensive drug that was approved by the FDA during the prior six-month period (i.e., a drug was generally considered a new to market drug for six-months after the drug was approved by the FDA). The Plan only covered a new to market drug if the new to market drug was purchased through the CastiaRx mail order pharmacy. This rule was reflected in Section 3.05(t) of your SPD. Effective January 1, 2020, the Plan was amended

to no longer recognize the special category of new to market drugs. Based on this amendment, the exclusion in Section 3.05(t) was removed from your SPD.

9. <u>New Program for Specialty Drugs that Have Manufacturer Assistance Available</u>:

Effective January 1, 2020, the Plan started utilizing Sav-Rx's High Impact Advocacy ("HIA") program. The way the HIA program works is that when a Covered Person sends Sav-Rx an order to fill a prescription for a Specialty Drug, Sav-Rx will apply for the manufacturer assistance that is available for that drug and then use that assistance to pay the Covered Person's Copay. The result is that the Covered Person will pay $0.00 for the Specialty Drug (i.e., the Covered Person will not have to pay anything for the Specialty Drug because the amount of the assistance will equal the amount of the Copay). Because the Covered Person will not pay anything for the Specialty Drug, the copayment listed in the chart below will not count towards the Covered Person's Prescription Drug Benefit Annual Out-of-Pocket Maximum.

For example, if you have cancer and you are prescribed a Specialty Drug that is on Sav-Rx's HIA program list, you should order that drug from the Sav-Rx Mail Order Pharmacy. Once Sav-Rx receives the order, Sav-Rx will apply for manufacturer assistance. If the cost of the Specialty Drug is $5,000 and Sav-Rx receives manufacturer assistance in the amount of $1,000, then your Copay for the Specialty Drug is $1,000. Sav-Rx will apply the $1,000 from the drug manufacturer towards your Copay, which means you will pay $0.00 for the Specialty Drug. The $1,000 will not count towards your Prescription Drug Benefit Annual Out-of-Pocket Maximum because you will not have actually paid any portion of this amount.

The following chart lists the Copays that apply to Specialty Drugs that have manufacturer assistance available:

If the Specialty Drug is prescribed to treat…	**Your Copayment will equal…**
Multiple Sclerosis, an inflammatory condition, or cancer	20% of the cost of the drug*
Hepatitis C	25% of the cost of the drug*
Cystic Fibrosis	30% of the cost of the drug*

*If the amount of the manufacturer assistance available for the Specialty Drug is less than the amount of the Copay, then your Copay will equal the amount of the manufacturer assistance that is available for the Specialty Drug. This means that the manufacturer assistance will cover your Copay and you will not pay anything for the Specialty Drug.

10. <u>Expanded Coverage of Lenses as Vision Benefits</u>:

Prior to April 1, 2021, the Plan provided that Vision Benefits were payable for lenses once every other calendar year. Prior to April 1, 2021, the Plan also provided that Vision Benefits were payable for contact lenses once every other calendar year as a substitute for all other lenses and frames. These rules were reflected in Section 5.02 of your SPD.

Effective April 1, 2021, the Plan was amended to provide that Vision Benefits are payable for lenses once every calendar year. Effective April 1, 2021, the Plan was also amended to provide that Vision Benefits are payable for contact lenses as a substitute for all other lenses and frames once every calendar year.

Based on these changes, the chart for Vision Benefits on page 10 of your SPD and the chart at the beginning of Article V have been amended to read as follows:

VISION BENEFITS			
COVERAGE (PLAN PAYS)			
BENEFIT	**FREQUENCY ALLOWED**	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Examination	Once Per Calendar Year	100% after $10 Copay	100% after $10 Copay to a maximum of $50
Single Vision Lenses (pair)	Once Per Calendar Year	100% after $20 Copay	100% after $20 Copay to a maximum of $50
Lined Bifocal Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $75
Lined Trifocal Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $100
Lined Lenticular Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $125
Frames	Once Every Other Calendar Year	100% after $20 Copay to a maximum of $120 plus 20% off any out-of-pocket expense	100% after $20 Copay to a maximum of $70
Elective Contact Lenses/Evaluation/Fitting	Once Per Calendar Year as a substitute for all other lens and frames benefits	100% to a maximum of $120	100% to a maximum of $105
Medically Necessary Contact Lenses/Evaluation/Fitting	Once Per Calendar Year as a substitute for all other lens and frames benefits	100% after $20 Copay	100% after $20 Copay to a maximum of $210

Note: As indicated in the chart, Vision Benefits will continue to be payable for frames once every other calendar year.

11. <u>New Coverage for Impact Resistant (Polycarbonate) Lenses</u>:

Prior to April 1, 2021, Vision Benefits were not payable for extra charges for glasses with impact resistant (polycarbonate) lenses. This rule was reflected in Section 5.04(b) of your SPD, which provided that Vision Benefits were not be payable for extra charges for glasses with special lenses unless they are prescribed by an optometrist or ophthalmologist as Medically Necessary. Effective April 1, 2021, the Plan was amended to cover impact resistant (polycarbonate) lenses. Based on this amendment, the Plan was amended at Section 5.04 by deleting the Section in its entirety and replacing it with the following language:

Section 5.04 – Vision Benefit Exclusions and Limitations
Vision Benefits will not be payable for:

(a) Special/unusual procedures, including but not limited to orthoptics or vision training and any associated supplemental testing, plano lenses (less than a ± .50 diopter power), or two pairs of glasses in lieu of bifocals;

(b) Extra charges for glasses with special lenses, including but not limited to tinted lenses, coated lenses, UV protected lenses, and Cosmetic lenses, unless they are prescribed by an optometrist or

ophthalmologist as Medically Necessary. This exclusion does not apply to the extent the extra charges for glasses with special lenses are for impact resistant (polycarbonate) lenses;

(c) Replacement of lenses and frames which are lost or broken except at the normal intervals as described in the chart at the beginning of this Article;

(d) Medical or surgical treatment of the eyes;

(e) Charges in excess of the benefit maximums listed in the chart at the beginning of this Article; and

(f) Services and treatment excluded under Article VIII – Benefit Exclusions and Limitations.

12. <u>Expansion of Expenses that Are Reimbursable From the Plan's HRA</u>:

Prior to July 1, 2020, the Plan provided that if an expense is incurred for medicine or drugs (other than insulin), the medicine or drug must be prescribed even if the medicine or drug is an over-the-counter drug for the expense to be an Allowable HRA Expense. Prior to July 1, 2020, the Plan also did not specifically provide that expenses incurred for menstrual care products were Allowable HRA Expenses. These rules were reflected in Section 17.05 of your SPD.

Effective July 1, 2020, the Plan was amended to provide that expenses incurred for medicine or drugs, including expenses incurred for over-the-counter drugs, are Allowable HRA Expenses regardless of whether or not the drugs are prescribed. The Plan was also clarified to provide that expenses incurred for menstrual care products are Allowable HRA Expenses.

13. <u>New HRA Prepaid Benefit Card</u>:

Effective November 1, 2020, your HRA balance was loaded onto a prepaid benefits card.. Your card will continue to be loaded with additional amounts as they are credited to your HRA. Your card can be used for Allowable HRA Expenses as long as you remain eligible for benefits. Your card can also be used by you and your Dependents for Allowable HRA Expenses. Replacement cards or lost cards can be reissued for a $10 fee that will be deducted from your HRA balance.

Your card can be used at Hospitals, Doctors' offices, dental offices, and vision care providers. It can also be used at certain pharmacies, department stores, and supermarkets for prescriptions and eligible over-the-counter items. You can also fill in your card number on bills you receive from providers to pay amounts that are owed.

If your medical provider does not accept credit card payments, you may file a claim for reimbursement. Prior to November 1, 2020, the Plan provided that the minimum required claim amount was $25. Prior to November 1, 2020, the Plan also provided that if the balance in a Covered Person's HRA Account is less than $25, the Plan will only reimburse a claim if it is for the entire remaining balance. This rule was reflected in Section 17.07(a) of your SPD. Effective November 1, 2020, the Plan was amended to remove the minimum HRA claim amount. This means that you can submit HRA claims for amounts less than $25, even if the claim is not for your entire remaining balance.

You should save all itemized receipts when you use your card. Most of the time, eligibility of the expense will be automatically verified. However, you may sometimes receive a letter/notification asking you to furnish an itemized statement to verify the expense. When you receive such a request, you must submit the requested documentation as soon as possible to avoid having your card suspended.

Part II – Temporary COVID-19 Amendments

14. Coverage of COVID-19 Testing During the Public Health Emergency:

Special rules were added to the Plan for Covered Persons who receive COVID-19 tests during the Public Health Emergency. During the period beginning on March 18, 2020 and ending on the date that the Public Health Emergency ends, as determined by the Secretary of the U.S. Department of Health and Human Services or other appropriate federal authority, the Plan will pay the following percentages for COVID-19 tests and certain related tests received by Covered Persons:

- For COVID-19 tests provided by a PPO Provider, the Plan will pay 100% of Covered Charges, regardless of whether the test is administered, ordered, or prescribed during a Physician's Office Visit or at a Hospital or Facility.

- For any other tests (i.e., tests for conditions other than COVID-19) provided by a PPO Provider, the Plan will pay 100% of Covered Charges, regardless of whether the test is administered, ordered, or prescribed during a Physician's Office Visit or at a Hospital or Facility, if the test causes the provider to administer, order, or prescribe a COVID-19 test and the test is administered during the same visit in which the COVID-19 test is administered, ordered, or prescribed.

- For COVID-19 tests provided by a non-PPO Provider, the Plan will pay 100% of Covered Charges, regardless of whether the test is administered, ordered, or prescribed during a Physician's Office Visit or at a Hospital or Facility, up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated by UnitedHealthcare ("UHC").

- For any other tests (i.e., tests for conditions other than COVID-19) provided by a non-PPO Provider, the Plan will pay 100% of Covered Charges, regardless of whether the test is administered, ordered, or prescribed during a Physician's Office Visit or at a Hospital or Facility, up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated by UHC if the test causes the provider to administer, order, or prescribe a COVID-19 test and the test is administered during the same visit in which the COVID-19 test is administered, ordered, or prescribed.

15. Coverage of Telehealth Benefits During the Public Health Emergency:

Special rules were added to the Plan for Covered Persons who incur charges for telehealth benefits during the Public Health Emergency. The Plan typically does not provide coverage for telehealth benefits unless the benefits are provided by Doctor on Demand. During the period beginning on March 18, 2020 and ending on the date that the Public Health Emergency ends, the Plan will pay the following percentages for telehealth benefits received by Covered Persons from providers other than Doctor on Demand:

- For telehealth benefits provided by a PPO Provider wherein the Provider orders or prescribes a COVID-19 test, the Plan will pay 100% of the Covered Charges.

- For telehealth benefits provided by a PPO Provider wherein the Provider does not order or prescribe a COVID-19 test, the Plan will pay 100% of the Covered Charges after the Covered Person has paid a $20 Copay (Deductibles do not apply).

- For telehealth benefits provided by a non-PPO Provider wherein the Provider orders or prescribes a COVID-19 test, the Plan will pay 100% of the Covered Charges up to the lesser of the cash price listed by the provider on a public internet website or the rate negotiated by UHC.

- For telehealth benefits provided by a non-PPO Provider wherein the Provider does not order or prescribe a COVID-19 test, the Plan will pay the following percentages: (i) if the Covered Person has not met his or her annual out-of-pocket maximum, the Plan will pay 60% of the Covered Charges after the Covered

Person has met his or her Deductible; and (ii) if the Covered Person has met his or her annual out-of-pocket maximum, the Plan will pay 80% of the Covered Charges.

16. <u>Suspension of Certain Deadlines During the Public Health Emergency</u>:

Special rules were added to the Plan which suspend certain deadlines during the period beginning on March 1, 2020 and ending on the date 60 days after date that the Public Health Emergency ends ("Outbreak Period"). This means that days during the Outbreak Period will not count towards determining whether or not these deadlines are met. The following deadlines are suspended during the Outbreak Period:

- Dependent enrollment deadlines
  - Suspension of the 90-day deadline for a Covered Employee to submit an enrollment form for a newly acquired Dependent: The Plan provides that if a person becomes a Dependent of a Covered Employee through marriage, birth, adoption, placement for adoption, or a court order (including a Qualified Medical Child Support Order ("QMSO")), that Dependent will be covered effective 12:01 a.m. on the date of the marriage, birth, adoption, placement for adoption, or court order if the Dependent's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of the marriage, birth, adoption, placement for adoption, or court order. This deadline is suspended during the Outbreak Period.
  - Suspension of the 90-day deadline for a covered Retiree to submit an enrollment form for a newly acquired Dependent: The Plan provides that if a person becomes a Dependent of a covered Retiree through marriage, birth, adoption, placement for adoption, or a court order (including a QMSO), that Dependent will be covered effective 12:01 a.m. on the date of the marriage, birth, adoption, placement for adoption, or court order if the Dependent's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of the marriage, birth, adoption, placement for adoption, or court order. This deadline is suspended during the Outbreak Period.

- COBRA deadlines
  - Suspension of the 60-day deadline for a qualified beneficiary to elect COBRA continuation coverage: When a qualifying event occurs, the Plan is obligated to send a qualified beneficiary a notice instructing them to elect or waive COBRA continuation coverage. The Plan provides that after a qualified beneficiary receives this notice, (s)he has 60 days to elect COBRA continuation coverage or else (s)he loses his or her right to elect COBRA. This deadline is suspended during the Outbreak Period.
  - Suspension of the 45-day deadline to submit an initial COBRA premium: The Plan provides that a qualified beneficiary has 45 days from the date that (s)he elects COBRA continuation coverage to submit an initial premium payment. This deadline is suspended during the Outbreak Period. The Plan is not obligated to pay the qualified beneficiary's claims until (s)he pays the premium (i.e., although the deadline to pay the premium is suspended, the Plan does not actually have to start paying claims until the qualified beneficiary pays the premium).
  - Suspension of the 30-day deadline to submit subsequent COBRA premiums (i.e., premiums other than the initial premium payment): The Plan provides that for premiums other than the initial premium payment, a qualified beneficiary has 30 days from the date that a COBRA premium is due to submit a premium payment. This deadline is suspended during the Outbreak Period. The Plan is not obligated to pay the qualified beneficiary's claims until (s)he pays the premium(s) (i.e., although the deadline to pay the premium(s) is suspended, the Plan does not actually have to start paying claims until the qualified beneficiary pays the premium(s)).
  - Suspension of the 60-day deadline for a qualified beneficiary to notify the Plan that (s)he has experienced a COBRA qualifying event (this only applies when the event is divorce or a child no longer qualifying as a Dependent): The Plan provides that an employee must give written notice to the Plan Administrator within 60 days after the occurrence of a qualifying event that is a divorce or legal separation or a child ceasing to meet the Plan's definition of Dependent. This deadline is suspended during the Outbreak Period.

- Suspension of the 60-day deadline for a qualified beneficiary to notify the Plan that (s)he experienced a second qualifying event: The Plan provides that if a qualified beneficiary receives a disability determination from the Social Security Administration while (s)he is receiving 18 months of COBRA continuation coverage, the qualified beneficiary must notify the Plan Administrator within the first 60 days after COBRA continuation coverage commences, or, if later, within 60 days from the Social Security Administration's determination of disability in order to receive an additional 11 months of COBRA continuation coverage. Further, the Plan provides that if a qualified beneficiary experiences a second qualifying event while (s)he is receiving 18 months of COBRA continuation coverage (e.g., divorce, death, entitlement to Medicare), the qualified beneficiary must notify the Plan Administrator within 60 days of the second qualifying event in order to receive an additional 18 months of COBRA continuation coverage. These deadlines are suspended during the Outbreak Period.

- Claim and appeal deadlines
  - Suspension of the 12-month deadlines to file a claim for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, and Vision Benefits. The Plan provides that claims for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, and Vision Benefits must be filed within 12 months after the date of treatment. These deadlines are suspended during the Outbreak Period.
  - Suspension of the 12-month deadline to file a claim for HRA Benefits. The Plan provides that claims for HRA Benefits must be filed within 12 months after the date the expense is incurred. This deadline is suspended during the Outbreak Period.
  - Suspension of the 12-month deadline to file a claim for Short-Term Disability Benefits. The Plan provides that claims for Short-Term Disability Benefits must be filed within 12 months after the end of the Period of Disability. This deadline is suspended during the Outbreak Period.
  - Suspension of the 12-month deadline to file a claim for Death Benefits. The Plan provides that claims for Death Benefits must be filed within 12 months from the date of death. This deadline is suspended during the Outbreak Period.
  - Suspension of the 180-day deadlines to file an appeal for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Short-Term Disability Benefits, and HRA Benefits. The Plan provides that a request for review of claims (i.e., an appeal) for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Short-Term Disability Benefits, and HRA Benefits must be made within 180 days of the Claimant receiving the notice of the adverse benefit determination. These deadlines are suspended during the Outbreak Period.
  - Suspension of the 60-day deadline to file an appeal for Death Benefits. The Plan provides that a request for review of claims (i.e., an appeal) for Death Benefits must be made within 60 days of the Claimant receiving the notice of the adverse benefit determination. This deadline is suspended during the Outbreak Period.

Grandfathered Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (844) 347-IBEW (4239). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or: www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.