Summary of Material Modifications

May 2018

As the Trustees of the Local Union No. 9, I.B.E.W. and Outside Contractors Health & Welfare Plan (the Plan), our priority is to provide you and your families with comprehensive benefits that are affordable for you, our contractors and the Plan. In order to continue meeting our objective, we have elected to make some Plan changes. The changes and their effective dates are explained in this notice.

Please review this Summary of Material Modifications (SMM) carefully and share it with your family. You should keep it with your Summary Plan Description ("SPD") and other SMMs.

1. *The first change is to the disability claims and appeals requirements. The change is effective for claims incurred on and after April 1, 2018. The changes are highlighted in yellow below.*

IF A CLAIM IS DENIED

If your claim for benefits is denied, in whole or in part, you will be provided with oral and/or written (or electronic, if possible) notice in the form of an EOB not later than the period permitted to make the determination (as previously described).

When the Plan notifies you of its initial denial on a claim, the written notice will include:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and periods to appeal your claim, including:
  - A description of the expedited review process for urgent healthcare claims, if applicable; and
  - A statement that you may bring a lawsuit under ERISA following the appeal and review of your claim; and
- If your healthcare claim is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
  - Medical Necessity, Investigative or Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.
- Effective for any disability benefit claim filed on and after April 1, 2018, or retroactive termination of a disability benefit occurring on or after April 1, 2018, the written statement will also include:
  - An explanation for disagreeing with or not following:
    - The views you presented to the Plan of the health care professionals treating you and vocational professionals who evaluated you
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in conjunction with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A determination regarding your disability that you presented to the Plan made by the Social Security Administration;
  - If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  - Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
  - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- In the case of an adverse benefit determination with respect to a claim for a disability benefit filed on and after April 1, 2018, the notification will be provided in a culturally and linguistically appropriate manner

pursuant to Department of Labor Regulation Section 2560.503-l(o);

- For disability benefit claims filed on and after April 1, 2018, the following will also apply:
  - If the Plan fails to establish or follow claims procedures consistent with the requirements of the Plan, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA §502(a);
  - If the Plan fails to strictly adhere to all the requirements of the Plan's claims and appeal procedures with respect to disability benefit claims, you are deemed to have exhausted the administrative remedies available under the Plan (unless the violations are "de minimis" in accordance with DOL Reg. §2560.503-1(1)(2)(ii)). Accordingly, you are entitled to pursue any available remedies under ERISA §502(a). If you choose to pursue remedies under ERISA §502, in these circumstances the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary;
  - To ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

When filing or appealing a claim, you may authorize a representative to act on your behalf (see page 49).

INFORMATION REQUIREMENTS

If your appeal is denied, in whole or in part, you will be provided with oral and/or written notice no later than the period permitted to make the determination (as previously described).

When the Plan notifies you of a denial on an appeal, the written notice will include:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A statement that you may bring a lawsuit under ERISA following the appeal and review of your claim;
- A statement of any voluntary Plan appeal procedures; and

Allowable Expenses

Any necessary, Reasonable, and Customary Charge, at least part of which is covered under one of the plans covering you or your Spouse or Dependents for which benefit payment is made. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid.

Allowable expenses under medical benefits are not considered allowable expenses under dental benefits and vice versa.

- If your appeal is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the information is available to you at no cost upon request; or
  - Medical Necessity, Investigative or Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.
  - Effective for claims for a disability benefit filed on and after April 1, 2018 or for retroactive terminations of disability benefits occurring on and after April 1, 2018, the following will also apply:
  - Prior to the date that the Plan issues an adverse benefit determination on an appeal of a disability benefit claim, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the Plan insurer or such other person) in connection with your claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided in order to give you a reasonable opportunity to respond prior to that date; and
  - Prior to the date the Plan can issue an adverse benefit determination on an appeal of a disability benefit claim based on a new additional rationale, the Plan will provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on a review is required to be provided in order to give you a reasonable opportunity to respond prior to that date.

- In the case of an adverse benefit determination on an appeal with respect to a claim for a disability benefit filed on and after April 1, 2018, the determination will include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views you presented to the Plan of the health care professionals treating you and vocational professionals who evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in conjunction with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A determination regarding your disability that you presented to the Plan made by the Social Security Administration;
  - If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- Effective April 1, 2018, in the case of an adverse benefit determination on an appeal with respect to a claim for a disability benefit, the notification will be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor Regulation Section 2560.503-1 (o).

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) to obtain benefits.

2. *The second change involves a number of benefit and coverage changes. The chart below reflects the new coverage offerings and is in addition to the "Schedule of Benefits for Active Employees and their Spouses and Dependents as of January 1, 2015" that was included with your SPD and any SMMs you have received since then. The changes are effective May 1, 2018 (except as noted in the chart) and are highlighted in yellow below.*

Medical Benefit	PPO Provider	Non-PPO Provider
Health Reimbursement Account	While an Active Employee (not retired), once your HRA Account balance exceeds $20,000, you may use the amount over $20,000 to pay deductibles, copayments, coinsurance, and other Qualified Medical Care Expenses for you and your Eligible Spouse and Dependents. The entire HRA Account balance will remain available for reimbursement of Qualified Medical Care Expenses to you or your Eligible Spouse and Dependents after you retire or die.	
Preventive Screening/Immunizations	Plan pays 100% Calendar Year Limit: No limit	Plan pays 100% Calendar Year Limit: No limit
Urgent Care	Plan pays 95%	Plan pays 90%
Assistant Surgeon	Plan pays 90% after deductible No limit on fees	Plan pays 75% after deductible No limit on fees
Prenatal and Postnatal Care	Plan pays 100%	Plan pays 90%
Breast Pump	Plan pays up to $400 per year	Plan pays up to $400 per year
Weight Loss Programs	The Plan covers up to 13 visits per year for physician-prescribed intensive behavioral counseling and weight management.	
Birth Control	The Plan covers birth control as provided or prescribed by a physician for the member and his or her spouse, and the Plan covers birth control for dependent children under the Prescription Drug Benefit.	

Fertility Services	Plan pays 90% after deductible The Plan covers up to a $25,000 Lifetime Maximum subject to the Plan's deductible.	Plan pays 75% after deductible The Plan covers up to a $25,000 Lifetime Maximum subject to the Plan's deductible.
Transplant Benefits	The Plan covers up to $5,000 per transplant for out-of-pocket expenses for the transplant donor.	
Midwives	Plan pays 90% after deductible	Plan pays 75% after deductible
Pregnancy for Dependent Children Up to the Age of 26 Prenatal and Postnatal Care Note: Does **NOT** include services related to a Dependent Child's child.	Plan pays 100%	Plan pays 90%
Prescription Drug Benefit	**Participating Pharmacy**	
Retail Network Pharmacy	The Plan offers a 90-day retail pharmacy benefit for maintenance medications with the same 20% coinsurance for you (the Plan pays 80%).	
Quantity Limitations—Therapeutic Quantity Limits (QL) Program	The Plan uses the Sav-Rx QL program, which places quantity limits on certain categories of medications.	
Dental Benefit	**Coverage**	
Calendar Year Maximum	The Plan covers up to $2,000 per person (excluding orthodontia). There is no maximum for dependent children under age 19.	
Orthodontic Maximum	The Plan covers up to $3,000 per person per lifetime. There is no maximum for dependent children under age 19, including medically necessary orthodontia.	
Dental Implants	The Plan pays 80% up to the $2,000 Dental Benefit Calendar Year Maximum stated above.	
Vision Benefit	**In-Network**	**Out-of-Network**
Frame Allowance (Retail)	Plan pays up to $200	Plan pays up to $70
Standard Contact Lenses in Lieu of Frames	Plan pays up to $200; no copayment required	Plan pays up to $105
Death Benefits (Active Employee Only)	**Coverage**	
Death Benefit	$50,000	
Accidental Death Benefit	$50,000	
Hour Bank Coverage	**Coverage**	
Coverage for Spouses and Dependent Children in the Event of an Active Fund Member Death	Spouses and dependent children may continue coverage by using the Active Member's remaining Hour Bank hours instead of immediately paying monthly COBRA premiums. Note: This change is effective October 1, 2017.	

A FINAL NOTE

Please keep this Summary of Material Modifications (SMM), which describes changes to information provided in the most recent SPD with your SPD for future reference. Only the provisions described in this letter are changing; no other Plan changes are being made at this time. If you have any questions about this change or your benefits, please contact the Fund Office at 708-449-9004.

This notice is a Summary of Material Modifications (SMM), within the meaning of Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. This SMM describes important changes to the most recent Summary Plan Description/Plan Document for the Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan effective as noted in this notice. Please keep this SMM with your Plan Document/SPD for future reference. An SMM is not the SPD, nor is it the Plan Document itself; rather, it is a supplemental document to your Plan Document/SPD. Please contact the Fund Office to request copies of the Plan Document/SPD or any SMM relating to the Plan.