I.B.E.W. LOCAL NO. 683 HEALTH AND WELFARE PLAN

P.O. Box 8010
Columbus, Ohio 43201
Telephone (614) 421-0600
Toll Free (800) 345-5905

To: **All Participants**
From: **Board of Trustees of I.B.E.W. Local No. 683 Health and Welfare Plan**
Date: **April 10, 2018**
Re: **Notice of Change in Grandfathered Health Plan Status under Patient Protection and Affordable Care Act**

Pursuant to this Notice, you are hereby informed that effective June 1, 2018, the I.B.E.W. Local No. 683 Health and Welfare Plan ("Plan") will no longer be considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("Affordable Care Act"). Based on a recommendation of the Plan's health care consultant, the Board of Trustees decided to implement this change to make the Plan financially stronger and keep it solvent for many years to come. Because of this change in status under the Affordable Care Act, the Plan will be required to provide certain consumer protections that are mandated by the Affordable Care Act. These protections are aimed at improving health care benefits for participants and their eligible dependents without cost barriers.

The following is a summary of changes you can expect because of the Plan's loss of grandfathered status under the Affordable Care Act and other plan design changes that have been approved by the Board of Trustees. In June 2018, or as soon thereafter as administratively feasible, you will receive an updated summary plan description ("SPD") in which the changes in the Plan's provisions stemming from these plan design changes will be more fully described.

I. Loss of Grandfathered Status.

The Plan is currently considered to be "grandfathered." Grandfathered health plans under the Affordable Care Act are those existing without major changes to their provisions since March 23, 2010, the date of the Affordable Care Act's enactment. In order to maintain its grandfathered status, a plan must look at its benefits and contribution levels as of March 23, 2010 and not eliminate or substantially eliminate benefits for a particular condition, increase co-pays by more than $5 or a percentage equal to medical inflation, raise fixed amount cost-sharing other than co-pays by more than medical inflation, lower the employer contribution rate by more than 5% for any group of covered persons, or add or reduce a benefit limit.

Effective June 1, 2018, this Plan will lose its grandfathered status due to changes made to the Plan's benefits, including maximum out-of-pocket limits and Plan subsidies. Since the Plan is now considered to be "non-grandfathered," it must comply with all of the requirements that apply to non-grandfathered plans as of June 1, 2018. These requirements include 100% coverage with no annual maximums for in-network preventive care services and the provision of "essential health benefits" (a term defined by federal regulations) that are subject to maximum deductibles and out-of-pocket limits that are dictated by law.

Specifically, as a non-grandfathered health plan, the Plan must include certain legally required consumer protections, including—

- offering an essential health benefits package to all participants;
- eliminating cost-sharing for certain preventive health services;
- reporting on quality improvement activities;
- guaranteeing access to emergency, pediatric and women's services;
- coverage for qualified participation in approved clinical trials; and
- adopting new external appeals procedures.

II. Changes to Benefits under Non-Grandfathered Health Plan.

As a non-grandfathered health plan, the Plan is legally required to cover certain basic preventive health services without charging you a copayment. This rule applies even if you have not met your annual deductible. These basic preventive health services are free only when provided by a physician or other provider in the Plan's network. **Links to resources regarding the services covered by the Plan as basic preventive health services are provided in Exhibit A, attached to this Notice. It is important to note that limits may apply to some of these services.**

III. Annual Deductible.

Generally, you must pay all the costs from providers up to the deductible amount before the Plan begins to pay for covered services that you use. If you have other family members who are covered by the Plan, each family member must meet his or her own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The Plan's overall annual deductible as of June 1, 2018 remains unchanged at $300 for single coverage and $900 for family coverage along with a $50 deductible per person for prescription drug coverage ($350 for single coverage and $1,050 for family coverage for Teledata along with a $60 deductible per person for prescription drug coverage). This deductible applies for both in-network and out-of-network providers. The Board of Trustees has the discretion to change annual deductibles.

IV. Annual Out-of-Pocket Limit.

The out-of-pocket limit is the most you could pay during a year for covered services after paying the Plan's annual deductible. Effective June 1, 2018, the Plan's out-of-pocket limits will change. Going forward, the out-of-pocket limits will be an amount equal to the combination of two sub-limits, the first for medical expenses and the second for prescription expenses, that include all deductibles and copays under the Plan. **The Plan's new out-of-pocket maximums for both in-network and out-of-network providers are set forth in Exhibit B, attached to this Notice.**

V. Prescription Drug Benefits.

The Plan covers prescription drugs in four different categories: generic, formulary, non-formulary, and specialty. For further information about the Plan's prescription drug benefits, see the Summary of Benefits and Coverage ("SBC") that was sent to you recently.

VI. Claims and Appeals Procedures.

Pursuant to the Affordable Care Act, the Plan's benefit claims procedures are required to provide participants with the option of external, independent claims review following exhaustion of the Plan's existing internal claims procedures. These new benefit claims procedures will be more fully described in an updated SPD that is expected to be issued in June 2018, or as soon thereafter as administratively feasible.

VII. Change in Rules Governing Eligibility.

Initial Eligibility

Effective June 1, 2018, the Plan's eligibility rules will change from the current eligibility system, which is based on hours of employer contributions that are accumulated during a lookback period of three consecutive months ("Work Month Quarter"), to a new system based on a Dollar Bank. Under the new system, you will become eligible to participate in the Plan on the first day of the second month following the month in which the Fund Office receives employer contributions on your behalf of at least $1,135 during a period of three consecutive months.

Continuing Eligibility

Eligibility for coverage continues on a month-by-month basis. As long as you are working in covered employment and have sufficient contributions made on your behalf to cover the monthly cost of coverage, your benefits will continue.

Continuing eligibility is based on a system of Work Months and Benefit Months, as follows:

Work Month Work Performed During:	**Benefit Month** Determines your Eligibility for:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

For coverage to continue for the next Benefit Month, you must continue to work in covered employment, and your employer must make sufficient contributions on your behalf in the corresponding Work Month to cover the monthly cost of coverage.

Money is deducted from your Dollar Bank when the employer contributions made on your behalf are not enough to cover the monthly cost of coverage. On the other hand, money is added to your Dollar Bank when the employer contributions made on your behalf are more than the monthly cost of coverage.

As of June 1, 2018, the monthly cost of coverage under the Plan is $1,135. This cost is determined by the Trustees based on the actual cost of providing health care benefits to participants and their eligible dependents. The Trustees reserve the right to modify this amount periodically as the cost of providing health care benefits changes. You will be notified in advance of any change in the monthly cost of coverage.

VIII. Hour Bank Conversion.

The conversion from your Hour Bank to your new Dollar Bank will be based on the conversion rate, which in turn is based on the contribution rate in the collective bargaining agreement. For example, the contribution rate for Inside Journeymen as of June 1, 2017 is $8.85 per hour worked. If you are an Inside Journeyman and have 300 hours in your Hour Bank as of May 31, 2018, those hours will be converted to a Dollar Bank balance as of June 1, 2018 of $2,655.00 ($8.85 x 300 = $2,655.00). If your contribution rate is different from $8.85 per hour worked, the conversion will result in a different Dollar Bank amount. The number of hours used in the calculation to convert your Hour Bank to your new Dollar Bank will be limited to a maximum of twelve (12) months. **The current contribution rates for various groups of participants who are covered by the Plan are set forth in Exhibit C, attached to this Notice.**

IX. Self-Payment for Active Participants.

Currently, active participants can make self-payments in order to maintain coverage under the Plan. Effective June 1, 2018, you will continue to be able to make self-payments in order to maintain coverage. The required amount of your monthly self-payment will be equal to the excess of—

- the monthly cost of coverage ($1,135) over
- the sum of your Dollar Bank credit plus the employer contributions made on your behalf and received by the Fund Office.

The self-pay period will be limited to a maximum of twenty-four (24) months and will be reduced by the amount of Dollar Bank you had accumulated at the time the self-pay period starts.

X. COBRA Rates.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 and related regulations and amendments ("COBRA"), if you or your eligible dependent loses coverage as a result of a COBRA-qualifying event, you or your eligible dependent may elect to continue health coverage under the Plan on a temporary basis from the day on which coverage ends. **Effective June 1, 2018, the premiums charged by the Plan for continuation of coverage under the Plan pursuant to COBRA are set forth in Exhibit D, attached to this Notice.**

If you have any questions regarding this Notice, please contact the Fund Office at the address and telephone number below:

I.B.E.W. Local No. 683 Health and Welfare Plan
P.O. Box 8010
Columbus, Ohio 43201
Telephone (614) 421-0600
Toll Free (800) 345-5905

EXHIBIT A

Preventive Health Services Required to Be Covered without Cost Sharing under the Patient Protection and Affordable Care Act

(Effective as of June 1, 2018)

For a full description of the Plan's preventive health services that are required to be covered for children, adults, women, pregnant women, or women who may become pregnant without cost sharing under the Patient Protection and Affordable Care Act, check the list of preventive services that have an A or B grade from the U.S. Preventive Services Task Force at:

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

or

See a list of the Plan's required preventive health services described by Medical Mutual of Ohio at:

https://www.medmutual.com/For-Individuals-and-Families/Healthy-Living/What-Is-Preventive-Healthcare.aspx.

or

Call Medical Mutual for questions regarding the Plan's preventive health services at (800) 540-2583.

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EXHIBIT B

Out-of-Pocket Maximum
(Effective June 1, 2018)

Inside Journeyman Wireman, Inside Apprentice, Construction Wireman/Construction Electrician, and Office and Salary

Category	Out-of-Pocket Maximum	
	Single Coverage	Family Coverage
Medical	$4,300	$8,900
Prescription	$3,050	$5,800
Combined Medical/Prescription	$7,350	$14,700
	Deductible	
Medical	$300	$900
Prescription (per person)	$50	

Teledata

Category	Out-of-Pocket Maximum	
	Single Coverage	Family Coverage
Medical	$5,150	$10,650
Prescription	$2,200	$ 4,050
Combined Medical/Prescription	$7,350	$14,700
	Deductible	
Medical	$350	$1,050
Prescription (per person)	$60	

EXHIBIT C

Contribution Rates for IBEW Local No. 683 Health and Welfare Fund

The Trustees reserve the right to change the following rates at any time based upon the Plan's financial soundness. The following rates are in effect as of the date indicated.

Employer Contribution Rate for Inside Wiremen and Inside Apprentices	$8.85 per hour worked (effective June 1, 2017)
Employer Contribution Rate for Teledata	$7.32 per hour worked (effective June 1, 2017)
Employer Contribution Rate for Office and Salary Employees	$1,135.00 per month (effective June 1, 2018)

Contribution Rates are based on the current CBA.

EXHIBIT D

COBRA Rates

Actives

Group	Current	Effective June 1, 2018
Journeymen	$900	$1,273 per month
CW/CE	$900	$1,195 per month
Teledata	$850	$1,109 per month

Medicare Retirees

Effective June 1, 2018, Surviving Spouses of Medicare Retirees who elect COBRA coverage will receive the first six months of COBRA coverage at no cost then pay a monthly COBRA premium during the next six months of their COBRA coverage at a Plan-subsidized rate equal to 50% of the full monthly COBRA rate. After the second six months of COBRA coverage, Surviving Spouses who continue to receive such coverage will be required to pay a monthly COBRA premium at 100% of the Full monthly COBRA rate.

Rate Category – Surviving Spouses	Current	Effective June 1, 2018
Subsidized	$172	$242 per month