Summary of Material Modifications
to the Eighth District Electrical Benefit Fund Regular and Basic Plans

This Summary of Material Modifications (SMM) will advise you of certain material modifications that have been made to the Regular and Basic Plans sponsored by the Eighth District Electrical Benefit Fund. This information is important to you and your dependents. Please take the time to read this document carefully. You can use this SMM along with the Eighth District Electrical Benefit Fund Summary Plan Description (SPD)/Plan Rules and Regulations ("the Plan") and its amendments thereto to get a more complete understanding of the plan of benefits offered by the Trustees and any changes to the Plan over time.

The current Plans, its amendments, and SMMs can be found on the Fund's website at www.8thDistrictBenefits.org. Hard copies are available by contacting the Administrative Office.

SUMMARY OF MODIFICATIONS TO THE REGULAR & BASIC PLANS

New ID Cards

Due to a change in Cigna's Utilization Management services, you will be receiving a new ID card. Your benefits will continue to be provided by Eighth District Electrical Benefit Fund. The other providers on your ID card are services that Eighth District utilizes to provide the best service to employees and dependents.

Extended Expanded Telehealth Benefit

Effective for services incurred from January 1, 2021 – March 31, 2021, the Plan will continue to cover all virtual visits that are provided by a Physician's office via telephone call or video chat in lieu of a face to face visit in the office. Virtual visits can be for any diagnosis, it does not have to be COVID-19 related. If the virtual visit is provided by an In-Network provider, it will be at **no cost to you**. If the virtual visit is provided by an Out-of-Network provider, it will be paid according to the Plan's standard Out-of-Network rates, up to the Allowed Charge, including the deductible and applicable coinsurance. This means that if you choose an Out-of-Network provider, you could be balanced billed in addition to the deductible and applicable coinsurance.

Prior to this change, the expanded Telehealth Benefit applied to services incurred from March 24, 2020 – December 31, 2020.

Annual Coinsurance Maximum Removed

Effective March 1, 2021, there will no longer be an annual coinsurance maximum for the Regular Plan. As a reminder, the In-Network medical maximum out-of-pocket limit of $2,500 per person or $5,000 per family remains unchanged. There is no out-of-pocket maximum for Out-of-Network providers.

Prior to this change, there was a limit to the amount of coinsurance a person would pay each year.

Chiropractic Care – Regular Plan Only

Effective October 1, 2020, benefits for chiropractic care for the Regular Plan are modified to clarify that a covered person is not required to have a written prescription from their physician to receive benefits. As a reminder, covered services must be medically necessary and are limited to 20 visits per calendar year.

Important Notice regarding your 2020 IRS Form 1095-B:

Per IRS guidance, for Tax Year 2020, the Fund will not automatically be mailing IRS Form 1095-B to participants. **However, participants may receive a copy of their 2020 IRS Form 1095-B from the Fund upon request to the Fund Office.** If you would like a copy of your 2020 Form 1095-B, you may request a copy by email at Eligibility@8thdistrictbf.org, by phone at 844-989-2321, or by mailing your request to: P.O. Box 30751, Salt Lake City, UT 84130.

As a reminder, the 2020 IRS Form 1095-B indicates the months in 2020 in which participants had qualifying health coverage from the Fund. In the past, the IRS has used this information for two purposes: (1) to enforce the individual mandate penalty in the Affordable Care Act, and (2) to determine eligibility for a premium tax credit for individuals receiving coverage through the Health Insurance Marketplace. However, in 2019, Congress reduced the individual mandate penalty to $0. Participants no longer need the information on Form 1095-B to complete their federal income tax return. As such, the IRS is no longer

requiring the Fund mail the form to Participants, and the Fund has elected not to do so. However, the Fund is still required to submit this information to the IRS. Accordingly, if you would you like a copy of your 2020 IRS Form 1095-B, you have a right to receive a copy by contacting the Fund Office.

Vision Benefit Limit Changes- Regular Plan Only

All eligible Active Participants and their eligible Dependents under the Regular Plan:

Effective January 1, 2020, the Plan will cover up to $100 maximum per eligible Active Participant and their eligible Dependent(s) under the Plan for one annual eye examination. Additionally, vision benefits will be considered excepted benefits under the Regular Plan. Upon written request to the Fund Office, eligible Participants and their eligible Dependent(s) may opt out of (and, if applicable, opt back in to) Vision Care Benefits from this Plan. Because contribution rates to the Plan are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant or Dependent who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after the written request is received by the Fund Office.

Active employees and their eligible Dependents whose local union has negotiated a contribution for the following benefits:

Effective March 1, 2021, the maximum allowed amounts for glasses and contacts are modified and will be paid at 100% up to the maximum limits listed below for those Active employees and their eligible Dependent(s) whose local union has negotiated an additional contribution under a collective bargaining agreement for this additional vision benefit coverage:

Service	Maximum Allowed Prior to 3/1/2021*	Maximum Allowed On or After 3/1/2021
Frames for Eyeglasses	$ 50	$ 65
Single Vision (Standard)	$ 30	$ 36
Bifocal	$ 40	$ 51
Trifocals	$ 55	$ 65
Lenticular	$ 55	$ 94
Contact Lenses	$ 80	$165

* Plan pays 10% coinsurance thereafter.

Services That Require Precertification

Effective September 22, 2020, the Plan is modified to clarify the services required to be precertified. The services required to be precertified are maintained by the Administrative Office. The current list is below and is subject to change. Please contact the Administrative Office for more information. As a reminder, if you use a CIGNA provider, your provider will arrange precertification. If you use a provider who is not a CIGNA provider, you are responsible to initiate precertification by calling the Utilization Management Program at (800) 768-4695

1. All Elective Hospital admissions, including an admission for mental health and/or substance abuse. (*Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section*).
2. Partial hospitalization, Residential treatment program admission, skilled nursing facility admission and inpatient rehabilitation admission. (Note that there is no coverage for a non-network residential treatment program, skilled nursing facility or inpatient rehabilitation facility even if precertified).
3. An upcoming transplant as soon as the participant is identified as a potential transplant candidate. Transplantation-related outpatient services and admission to a hospital for a transplant may require precertification.
4. The following procedures: surgical treatment of morbid obesity, such as gastric bypass, lap band, etc.; Cord Blood Harvesting, Pharyngoplasty; Outpatient Vein therapy procedures, spinal procedures; Brachytherapy; Sleep Management; Potential experimental or investigational treatments.
5. Home Health Care services and home infusion services.
6. Outpatient injectable drugs administered in an outpatient facility.
7. Diagnostic radiology type services (such as MRI, CT scan, PET scan, nuclear radiology service, etc.).
8. Speech therapy.
9. Orthotic devices.
10. Prosthetic devices including implantable hearing aids such as cochlear implant.
11. Durable Medical Equipment.
12. For individuals who will participate in a clinical trial, precertification is required in order to notify the Plan that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.

Allowed Charge/Allowed Amount/Allowable Charge for Non-Network Services, including Emergency Services

Effective December 10, 2020 the Plan's definition for Allowed Charge/Allowed Amount/Allowable Charge for non-network services, including emergency services, means the amount this Plan allows as payment for eligible medically necessary services or supplies. The Allowed Charge amount for non-network service is determined by the Plan Administrator or its designee to be:

1. **With respect to a non-network provider for non-Emergency services**, allowed charge amount means the reference-based pricing schedule at the 90th percentile that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. The Plan's allowed charge amount list is based on or is intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR) or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim; or
2. **With respect to a non-network provider for Emergency services**, allowed charge amount means 100% of the billed charges by the non-network provider.
3. **For non-network Assistant Surgeons,** allowed charge amount means 20% of the Allowed Amount for the Primary Surgeon. If the assistant surgeon is a Certified Surgical Assistant, the allowed charge amount will be 10% of the Allowed Amount for the Primary Surgeon.

IMPORTANT REMINDER ABOUT YOUR TELEHEALTH BENEFIT

The use of the telehealth option is at NO COST to you. You can access this Telehealth Benefit at https://patient.doctorondemand.com/register/ or search for "Doctor On Demand" on a smart phone or tablet to download our app for free. More information on the Telehealth Benefit can be found on the Fund's website at www.8thDistrictBenefits.org under the "Doctor on Demand" heading. As a reminder, when signing up for Doctor on Demand, **you will not add anything as your Insurance** and **you will add "Eighth District" as your Employer**.

Also, effective for visits from March 24, 2020 – March 31, 2021, the Plan will continue to cover all virtual visits provided by a Physician's office via telephone call or video chat provided by a Physician in lieu of a face to face visit in the office. Virtual visits can be for any diagnosis. If the virtual visit is provided by an In-Network provider, it will be at **no cost to you**. If the virtual visit is provided by an Out-of-Network provider, it will be paid according to the Plan's standard Out-of-Network rates, up to the Allowed Charge, including the deductible and applicable coinsurance.

The following information is an illustrative example of the average cost of care for each type of medical provider.

Lower Costs **Higher Costs**

Telehealth Doctor on Demand	Doctor's Office	Urgent Care Center	Emergency Room
Average Cost per Visit Charged to the 8th District Electrical Benefit Fund - Regular Plan			
$49 per visit*	$165 per visit**	$176 per visit**	$2,259 per visit**
Your Cost after Benefit Fund Payment for the Regular Plan (assuming In Network provider and your deductible is met):			
$0 copayment	$41.25 co-insurance	$44.00 co-insurance	$939.75 co-insurance

* provided by Doctor on Demand
**provided by Cigna