IMPORTANT NOTICE ABOUT CHANGES TO YOUR HEALTH AND WELFARE PLAN

CEDAR RAPIDS ELECTRICAL WORKERS LOCAL #405 HEALTH AND WELFARE FUND

December 2018

Dear Participant:

This Summary of Material Modifications (referred to hereinafter as the "Notice") summarizes recent changes to the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund (the "Plan").

You should keep this Notice with your Summary Plan Description ("SPD") for future reference.

Please note that the receipt of this description of Plan modifications is not a guarantee of coverage. You will only be eligible for the benefits described herein if contributions are required to be made to the Plan on your behalf.

The following changes to the Plan are effective January 1, 2019:

ELIMINATION OF BROWN PLAN

The Plan will no longer offer the Brown Plan. You will need to choose either the Orange Plan or the Yellow Plan during open enrollment for your coverage effective January 1, 2019. If you enrolled in the Brown Plan for 2018 and do not choose a plan during open enrollment, Auxiant will enroll you in the Orange Plan effective January 1, 2019.

The elimination of the Brown Plan is reflected in Insert A – Changes to Schedule of Medical Benefits, included in this SMM.

In addition, the following replaces the "Employer Contributions" subsection under the "Continuation of Eligibility" subsection within the "Eligibility – Bargaining Unit Employees" section of the SPD:

Employer Contributions
Once you meet the initial eligibility requirements, set forth above, your eligibility to participate in the Plan will continue by deducting the monthly benefit plan premium charge, as determined by the Trustees, from your HRA, for as long as you remain actively at work, or available for work, at covered employment with a Contributing Employer that contributes to the Plan on your behalf.

Example: Eligibility for coverage under the Plan in the month of April will be determined based on contributions paid to the Plan for hours worked in January. Contributions for hours worked in January are required to be paid to the Plan by February 15th.

There are two Plan coverage options: Orange and Yellow. The default Plan option is the Orange Plan, in which you shall be enrolled for the remainder of the Plan Year in which you initially become eligible, unless you have filed an enrollment form requesting coverage in the Yellow option in advance of becoming eligible. You may elect to change Plan options at the next annual enrollment period to begin as of the following Plan Year (January 1). If you do not elect to make a change during the annual enrollment period, you will stay in the Plan option in which you are currently enrolled.

FREE AND EXPANDED DOCTOR ON DEMAND

You currently have access to Doctor On Demand, a telehealth benefit that lets you have online video visits with a doctor, 24 hours a day, any day of the year, and get treatment and prescriptions for common illnesses and injuries. Effective January 1, 2019, your Doctor On Demand visits will be free (no copay, coinsurance or deductible). Also, you will be able to use Doctor On Demand for both medical and mental health treatment. Register at DoctorOnDemand.com, then download the free app. Your regular cost-sharing amounts still apply for prescriptions or other services (like recommended lab work).

Free and expanded Doctor On Demand coverage is reflected in Insert A – Changes to Schedule of Medical Benefits, included in this SMM.

TELEHEALTH BY OTHER PROVIDERS

The Plan will cover telehealth visits with a provider (other than through Doctor On Demand) at the same cost to you as if you had visited that provider for an in-person office visit. Your regular cost-sharing amounts will still apply for prescriptions or other services. The Plan's limitations and exclusions will also still apply.

Coverage of telehealth visits by other providers is reflected in Insert A – Changes to Schedule of Medical Benefits, included in this SMM.

In addition, the following replaces the "Telehealth Services Copayment" subsection under the "Copayment" subsection within the "Medical Benefit Payment Structure" section of the SPD:

Other Telehealth Services Copayment

The Other Telehealth Services copayment:

- Applies to covered Telehealth Services received from practitioners other than those contracting through Doctor on Demand.
- Is taken once per provider per date of service.

Also, the following replaces the "Telehealth Services" section within the "Medical Benefit Description – Covered and Not Covered" section of the SPD:

Telehealth Services
Covered: Covered medical services delivered to you by a provider who meets state standards for providing telehealth services or who contracts through Doctor on Demand via interactive audio-visual technology or web-based mobile device or similar electronic-based communication network. Doctor on Demand is available at https://www.doctorondemand.com.

$200 EMERGENCY ROOM COPAY

Your copay for visiting the emergency room will increase to $200. This copay will be waived and your regular deductible and coinsurance amount will apply if you are admitted.

The increased copay is reflected in Insert A – Changes to Schedule of Medical Benefits, included in this SMM.

VISION

After a diligent review of various vision network providers, the Plan's Board of Trustees decided that the Plan will no longer use the EyeMed network. Auxiant will administer your vision benefits at the "Non-Network Provider" level and reimburse you for covered costs. You will have the option to use a DeltaVision discount program.

Changes to vision benefits are reflected in Insert B – Changes to Vision Care Benefits, included in this SMM.

In addition, the discount on hearing exams and hearing aids that were available through EyeMed are no longer available. The following replaces the "Hearing Services" subsection within the "Medical Benefit Description – Covered and Not Covered" section of the SPD:

Hearing Services
Covered: • Hearing examinations (covered at Office Visit level) • Cochlear implants • Hearing aids **Benefit Maximums:** • One routine hearing examination covered per Plan Year • One pair of hearing aids covered up to a maximum benefit of $2,500 every 36 months

Sincerely,

Board of Trustees of the
Cedar Rapids Electrical Workers
Local #405 Health and Welfare Fund

This announcement, which serves as a Summary of Material Modifications, contains only highlights of recent changes to the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

CEDAR RAPIDS ELECTRICAL WORKERS LOCAL #405
HEALTH AND WELFARE FUND

Summary of Material Modifications
Effective January 1, 2019

Insert A

Changes to Schedule of Medical Benefits

Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.

AllianceSelect℠

Cedar Rapids Electrical Workers Local 405 Health and Welfare Fund

Orange and Yellow Plans

NOTICE

This group health plan is sponsored by the Board of Trustees of the Cedar Rapids Electrical Workers Local 405 Health and Welfare Fund (the "Plan"). The Plan is funded by Contributing Employers pursuant to collective bargaining or other written participation agreements. The Plan has a financial arrangement with Wellmark under which the Plan is solely responsible for claim payment amounts for covered medical services provided to you. Wellmark provides administrative services and provider network access only and does not assume any financial risk or obligation for claim payment amounts.

QUESTIONS

If you have questions about your group health plan, or are unsure whether a particular medical service or supply is covered, call the Wellmark Customer Service number on your ID card or the Administrative Manager.

Schedule of Medical Benefits

This section is intended to provide you with an overview of your payment obligations under the Plan. This section is not intended to be and does not constitute a complete description of your payment obligations. To understand your complete payment obligations you must become familiar with this entire SPD, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

Payment Summary
This chart summarizes your payment responsibilities. It is only intended to provide you with an overview of your payment obligations. It is important that you read this entire section and not just rely on this chart for your payment obligations.

Orange Plan (Default Plan)		
	PPO Providers	**Non-PPO Providers**
Deductibles and Out-of-Pocket Maximums		
Deductible - you pay: **Per person** **Per family**	 $500 per Plan Year $1,000 per Plan Year	 $1,000 per Plan Year $2,000 per Plan Year
Out of Pocket Maximum - you pay: **Per person** **Per family**	 $1,000 per Plan Year $2,000 per Plan Year	 $2,000 per Plan Year $4,000 per Plan Year
Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. Deductibles, benefit maximums and out-of-pocket maximums that are identified as "PPO" or "Non-PPO" cross accumulate, which means that amounts paid for "PPO" services will be applied toward the deductibles and maximums in the "Non-PPO" category, and vice versa. Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered charges for the remainder of the Plan Year, except for the following charges, which do not count towards the Out-of-Pocket Maximums: ineligible charges, amounts that exceed the Maximum Allowable Fee and hearing aids.		
Copayments		
Emergency Room - you pay:	$200 per date of visit	$200 per date of visit
Office Visit - you pay:	$20 per visit	None

Orange Plan (Default Plan)		
	PPO Providers	**Non-PPO Providers**
Doctor on Demand Telehealth Services – you pay:	None	None
Other Telehealth Services - you pay:	$20 per visit	None
Urgent Care - you pay:	$20 per visit (copayment waived for chemical dependency treatment and mental health services)	None
Coinsurance		
Preventive Care - you pay:	0% (deductible waived)	0% (deductible waived)
Voluntary Sterilization - you pay:	0% (deductible waived)	0% (deductible waived)
Emergency Room - you pay:	20% after deductible	20% after deductible
Office Visits - you pay:	0% (deductible waived)	30% after deductible
Doctor on Demand Telehealth Services – you pay:	0% (deductible waived)	Not covered
Other Telehealth Services - you pay:	0% (deductible waived)	30% after deductible
Urgent Care - you pay:	0% (deductible waived)	30% after deductible
Chiropractic Services - you pay:	30% after deductible	40% after deductible
Hearing Aids - you pay:	50% (deductible waived)	50% (deductible waived)
Self-administered Injectable Drugs - you pay:	20% after deductible	20% after deductible

Orange Plan (Default Plan)		
	PPO Providers	**Non-PPO Providers**
Prescription Drugs Purchased through the Veteran's Hospital - you pay:	10% (deductible waived)	10% (deductible waived)
All other prescription drugs are subject to the *Prescription Drug Program*, set forth in a separate section of this SPD.		
All other covered services - you pay:	20% after deductible	30% after deductible

Yellow Plan		
	PPO Providers	**Non-PPO Providers**
Deductibles and Out-of-Pocket Maximums		
Deductible - you pay: **Per person** **Per family**	 $1,500 per Plan Year $3,000 per Plan Year	 $3,000 per Plan Year $6,000 per Plan Year
Out of Pocket Maximum - you pay: **Per person** **Per family**	 $3,000 per Plan Year $6,000 per Plan Year	 $6,000 per Plan Year $12,000 per Plan Year
Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. Deductibles, benefit maximums and out-of-pocket maximums that are identified as "PPO" or "Non-PPO" cross accumulate, which means that amounts paid for "PPO" services will be applied toward the deductibles and maximums in the "Non-PPO" category, and vice versa. Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered charges for the remainder of the Plan Year, except for the following charges, which do not count towards the Out-of-Pocket Maximums: ineligible charges, amounts that exceed the Maximum Allowable Fee and hearing aids.		
Copayments		
Emergency Room - you pay:	$200 per date of visit	$200 per date of visit
Office Visit - you pay:	$30 per visit	None

Yellow Plan		
	PPO Providers	**Non-PPO Providers**
Doctor on Demand Telehealth Services – you pay:	None	None
Other Telehealth Services - you pay:	$30 per visit	None
Urgent Care - you pay:	$30 per visit (copayment waived for chemical dependency treatment and mental health services)	None
Coinsurance		
Preventive Care - you pay:	0% (deductible waived)	0% (deductible waived)
Voluntary Sterilization - you pay:	0% (deductible waived)	0% (deductible waived)
Emergency Room - you pay:	20% after deductible	20% after deductible
Office Visits - you pay:	0% (deductible waived)	40% after deductible
Doctor on Demand Telehealth Services – you pay:	0% (deductible waived)	Not covered
Other Telehealth Services - you pay:	0% (deductible waived)	40% after deductible
Urgent Care - you pay:	0% (deductible waived)	40% after deductible
Chiropractic Services - you pay:	30% after deductible	50% after deductible
Hearing Aids - you pay:	50% (deductible waived)	50% (deductible waived)
Self-administered Injectable Drugs - you pay:	20% after deductible	20% after deductible
Prescription Drugs Purchased through the Veteran's Hospital - you pay:	10% (deductible waived)	10% (deductible waived)

Yellow Plan		
	PPO Providers	**Non-PPO Providers**
All other prescription drugs are subject to the *Prescription Drug Program*, set forth in a separate section of this SPD.		
All other covered services - you pay:	30% after deductible	40% after deductible

CEDAR RAPIDS ELECTRICAL WORKERS LOCAL #405
HEALTH AND WELFARE FUND

Summary of Material Modifications
Effective January 1, 2019

Insert B

Changes to Schedule of Medical Benefits

Vision Care Benefits

Schedule of Vision Care Benefits	
DeltaVision Discount Plan[1]	
Vision Care Services	**Your Cost at EyeMed Access Network Provider**
Exam and dilation as necessary	$5 off routine exam $5 off contact lens exam
Complete pair of glasses purchase[2]: Frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard plastic lenses:	
Single Vision	$50
Bifocal	$70
Trifocal	$105
Frames	35% off retail price
Lens options:	
UV treatment	$15
Tint (solid and gradient)	$15
Standard plastic scratch coating	$15
Standard polycarbonate	$40
Standard progressive lens (Add-on to bifocal)	$65
Standard anti-reflective coating	$45
Other add-ons and services	20% off retail price
Contact lens materials: (Discount applied to materials only)	
Disposable	0% off retail price
Conventional	15% off retail price
Laser vision correction[3]: LASIK or PRK	15% off retail price or 5% off promotional price
Frequency:	
Examination	Unlimited
Frame	Unlimited

Lenses	Unlimited
Contact lenses	Unlimited
Reimbursement Benefit (Administered by Auxiant)	
Vision Care Services	**Amount**
Eye Examination, One per Plan Year	Covered up to $50
Eyeglass Frames, Lenses and Lens Options[4]	Covered up to $150 per Plan Year
Contact Lenses (materials only)[4]:	
Conventional	Covered up to $150 per Plan Year
Disposable	Covered up to $150 per Plan Year
Medically Necessary[5]	Covered up to $210 per Plan Year
Prescription Safety Glasses (for the Employee only)	Covered up to $150 per Plan Year

[1] The DeltaVision Discount Plan discounts shown in the *Schedule of Vision Care Benefits* may not be combined with any other provider discounts or promotional offers. You will receive a 20% discount on those items purchased at participating providers that are not specifically covered by this discount, except discounts do not apply to EyeMed provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy. Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered. Retail prices may vary by location.

[2] Items purchased separately will be discounted 20% off of the retail price.

[3] Since LASIK and PRK vision corrections are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your location. For a location near you and the discount authorization, please call 1.877.5LASER6.

[4] One set of frames and lenses OR one regimen of contacts (but not both) covered in a 12 month period.

[5] The Plan provides the reimbursement benefit for medically necessary contact lenses when one of the following conditions exists:

- Anisometropia of 3D in meridian powers;
- High Ametropia exceeding –10D or +10D in meridian powers;
- Keratoconus where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses; or
- Vision Improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Vision Care Benefits under the Plan apply only when vision care charges are incurred by a Covered Person and when the charges are for vision-related services that are recommended and approved by a Physician or Optometrist or Optician. Vision Care Benefits shall be payable for vision care services and supplies as outlined in the *Schedule of Vision Care Benefits*.

DeltaVision Discount Plan Using the EyeMed Access Network

To obtain the DeltaVision Discount Plan discounts on vision services described in the *Schedule of Vision*

Care Benefits, you must use a provider participating in the EyeMed Access panel of providers. EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the Access Network or call 1-800-521-3605.

Providers

If you wish to use the DeltaVision Discount Plan, confirm the provider participates in the EyeMed Access network. Let the provider know you have a discount through DeltaVision and provide your name and your discount plan number, located on the front of your ID card. While your ID card is not necessary to receive services, it is helpful to present your ID card to identify your membership in the DeltaVision Discount Plan.

When you receive services at a participating EyeMed Access Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any discounts. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

If you receive services from an out-of-network provider, you will pay for the full cost at the point of service.

Reimbursement Benefits
Regardless of whether you use the DeltaVision Discount Plan, you will be reimbursed by the Plan up to the maximums as outlined in the *Schedule of Vision Care Benefits*. To receive your reimbursement, complete and sign a claim form, attach your itemized receipts and send to Auxiant:

Auxiant
Attn: Union Services
P.O. Box 75008
Cedar Rapids, IA 52407
800-475-2232

DeltaVision Discount Plan Limitations/Exclusions
No discounts will be available for the following:

- Charges for vision services or supplies incurred before a Covered Person was covered under the vision care benefit portion of the Plan or after coverage terminates.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Corrective eyewear required by an employer as a condition of employment and safety eyewear.
- Services provided as a result of any Workers' Compensation law.

Reimbursement Benefit Limitations/Exclusions
No reimbursement benefits will be payable for the following:

- **Before or after coverage:** Includes charges for vision services or supplies incurred before a Covered Person was covered under the vision care benefit portion of the Plan or after coverage terminates.

- **Frequency:** includes charges for vision examinations or materials received more frequently than the vision care reimbursement benefit portion of the Plan covers.

- **Medical plan:** includes charges that are covered under a medical plan that reimburses a greater amount for vision care expenses than the Plan.

- **Medical and surgical treatment:** includes charges for services, treatment or supplies related to medical or surgical treatment of the eyes or supporting structures.

- **No prescription:** includes charges for lenses obtained without a prescription.

- **Replacement:** includes charges for lenses, frames or contact lenses that are lost or broken, except at the normal intervals (i.e., Plan Year) when benefits are available.

- **Special procedures:** includes charges for special procedures such as orthoptics, vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.

- **Safety glasses:** includes charges for safety glasses for a Covered Person other than the Employee covered under the Plan.

- **Sunglasses:** includes charges for sunglasses, including prescription type.

- **Bifocal substitute:** charges for two pairs of glasses in lieu of bifocals.

- **Workers' compensation:** includes charges for services that are or would be compensable under any workers' compensation law or similar legislation.