SUMMARY OF MATERIAL MODIFICATIONS
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
OF THE
I.B.E.W. 292 HEALTH CARE PLAN
(2015 Restatement)

IMPORTANT NOTICE TO PLAN PARTICIPANTS AND BENEFICIARIES

The Board of Trustees has amended the Plan. This notice summarizes the change and its effective date.

Amendment No. 8, Effective Date April 1, 2017.

The Plan Document was amended to add a new Specialty Copayment Solutions Program offered by Prime Therapeutics. This Program offers a combination of pharmaceutical coupons, rebates, and/or other financial assistance to reduce copayment amounts for certain specialty drugs purchased through the Prime Specialty Pharmacy.

Amendment No. 9, Effective Date May 8, 2017.

The Plan Document was amended to clarify the Plan's provisions regarding the retiree Premium Credit account. The amendment makes it clear that there is a lifetime maximum of nine months' worth of Premium Credits that can be spent on retiree coverage.

Amendment No. 11, Effective Date September 1, 2017.

The Plan Document was amended to correct the coinsurance percentage or Emergency Care for In-Network Providers from 10% to 25%.

Please retain this notice with your current copy of the Plan Document and Summary Plan Description and insert the attached slip pages 3, 22, 28, 28A, 55, and 55A to replace the current page of the same number. If you have any questions about the Plan, contact the Fund Office at (763) 493-8830 or 1-800-368-9045.

Pharmacy Specialty Prescriptions Program: *To obtain a current list of these prescriptions, please call the Plan Administrator at 800-368-9045.* *For more information on the Pharmacy Specialty Prescriptions Program, please contact Prime Therapeutics at 877-357-7463* *To obtain a current list of the specialty drugs on the Specialty Copay Solutions Program list, call the Plan Administrator at 800-368-9045.*	Certain drugs will be subject to a prior authorization and some will also be subject to step therapy (this requires an Eligible Individual to try less expensive alternatives prior to authorization of specialty drugs), split fills (i.e. a 30-day prescription will be filled in two 15-day increments to determine whether the drug is tolerated by the Eligible Individual to reduce waste) and quantity level limits (dispensing only quantities that will actually be used). If your doctor recommends prescription quantities that exceed the limit, your doctor will need to submit a prior authorization (PA) request that will include the medical reasons supporting that request to Prime Therapeutics. Your doctor can visit MyPrime.com to download the PA form. **Specialty Coupon Assistance Program** – Beginning April 1, 2017, Eligible Individuals will be enrolled in the Prime Therapeutics' Specialty Coupon Assistance Program if they obtain a drug on the Specialty Copay Solutions Program from the Prime Specialty Drug Pharmacy. This Program offers a combination of pharmaceutical coupons, rebates, and/or other financial assistance to reduce copayment amounts for certain specialty drugs purchased through the Prime Specialty Pharmacy. An Eligible Individual's net copayment for a specialty drug on the then current Specialty Copay Solutions Program list and purchased through the Prime Specialty Pharmacy (based upon the Eligible Individual's out-of-pocket cost for copayments) will not be greater than the specialty drug copayment amount would have been if the Specialty Coupon Assistance Program were not in place. Any coupon, rebate, and/or other financial assistance applied directly towards an Eligible Individual's copayment at the time of purchase under Prime's "Specialty Coupon Assistance Program" will not be applied towards satisfying such Eligible Individual's maximum copayment or annual Out-of-Pocket costs. Eligible Individuals should refer to the current list of the specialty drugs eligible for Prime Therapeutics' Specialty Coupon Assistance Program and the applicable copayments. **Specialty Drug Copayments** - The copayment a Eligible Individual will be responsible for a specialty drug not covered under the Prime Therapeutics' Specialty Coupon Assistance Program is as follows: Retail Brand Name Drugs - $9.00 minimum co-pay or 20% of the cost over $9.00 up to a maximum of $50.00 total per prescription for up to a 90-day maximum supply (subject to the Pharmacy's ability to fill a 90-day maximum supply). Retail Generic Drugs - $5.00 minimum co-pay or 20% of the cost over $5.00 up to a maximum of $25.00 total per prescription for up to a 90-day maximum supply (subject to the

	Pharmacy's ability to fill a 90-day maximum supply). Mail Order Brand Name Drugs - $18.00 minimum co-pay or 20% of the cost over $18.00 up to a maximum of $100.00 total per prescription for up to a 90-day maximum supply. Mail Order Generic Drugs - $10.00 minimum co-pay or 20% of the cost over $10.00 up to a maximum of $50.00 total per prescription for up to a 90-day maximum supply.
Compound Drug Control Program: *For more information on the Compound Drug Control Program, please contact Prime Therapeutics at 877-357-7463*	Compound drug prescriptions will be subject to prior authorization and rejection if they contain components of the following high priced compounds: Baclofen powder; Cyclobenzaprine powder; Diclofenac powder; Flurbiprofen powder; Fluticasone propionate powder; Gabapentin powder; Ketamine powder; Ketoprofen powder; Ketorolac powder; Lansoprazole powder; Meloxicam powder; Mometasone powder; Omeprazole powder; Testosterone powder; Testosterone propionate powder; and Testosterone micronized powder.
NOTE: Diabetic supplies such as glucose monitors, insulin, insulin hypodermic needles and syringes which can be purchased either directly and reimbursed by the Plan, or through the prescription drug program are subject to the prescription drug benefit limitations.	

BENEFIT ELIGIBILITY

Initial Eligibility – Initial eligibility is established either through being: (1) a Bargaining Unit Employee; or (2) an actively-employed Non-Bargaining Unit Employee of an Employer who has signed a contribution agreement with the Plan.

The following charts show the Plan's initial eligibility rules for various groups. The information in these charts applies to medical, dental, prescription drug, vision, loss of time, accidental dismemberment, and life insurance benefits. In all of the following situations, coverage begins on the first of the month after the Fund Office receives the required premiums.

See the following list and the "Definitions" Section of this booklet for definitions applicable to this Section:

Bargaining Unit Employee – An Employee who is a member of a collective bargaining unit represented by the Union and who is an Employee of an Employer who has agreed to make Contributions to the Plan on the Employee's behalf.

Non-Bargaining Unit Employee – An Employee who is not a member of any collective bargaining unit represented by the Union and is employed full-time by an Employer.

Premium Credits – The amount of dollars contributed and reported by an Employer for the hours worked by a Member in accordance with the Inside Agreement. Premium Credits are applied to provide eligibility for Members and their Dependents. Premium Credits cannot be converted to cash. The amount of Premium Credits include up to four hours per day credit that is provided by the Plan on behalf of apprentices with verified attendance at the apprenticeship school.

Premium Credit Account – A bookkeeping account established for all Members under the Inside Agreement in order to determine eligibility and to determine if premium payments are required in order to continue Employee Benefits. If a Member works *more* than the required hours to maintain coverage under the Plan, the contribution dollars in excess of that required amount are put into the Premium Credit Account of the Member, up to a maximum of nine months' of premium. **Note**: There is a lifetime maximum of nine months' worth of Premium Credits that can be spent on retiree coverage (see the "Using Your Premium Credit Account for Retiree Coverage" heading in the "Retiree Coverage" Section for more information).

Benefit Month – A period of one calendar month during which time an Employee is eligible for benefits as a result of having met the Initial Eligibility or Continuing Eligibility rules during the corresponding Eligibility Month.

Eligibility Month – A period of one calendar month during which an Employee meets the Initial Eligibility rules to provide eligibility for Plan benefits during the corresponding Benefit Month.

- If you are Medicare-eligible, the cost of your Self-Contribution will be determined annually by the Board of Trustees.

- The Fund Office must receive each Self-Contribution payment no later than the first day of the benefit month for that month's coverage. For example, to be covered for Retiree Benefits during the March benefit month, your Self-Contribution payment must be received no later than March 1st.

- If your Self-Contribution is not received by the Fund Office on or before its due date, your Retiree Benefits will terminate at the end of the benefit month for which you have already paid. You will not be allowed to make any future Self-Contributions.

- Once a Self-Contribution payment has been accepted by the Fund Office, it will not be returned.

Using Your Premium Credit Account for Retiree Coverage

The amount of any particular month's Self-Contribution will be reduced if you have a Premium Credit Account balance at the time that Self-Contribution is due. The amount of the reduction will be equal to the percentage of the Self-Contribution otherwise due. The percentage will be equal to the percentage of one month's active employee coverage that the balance would have covered, and your Premium Credit Account will be reduced as if paying for such active Employee coverage.

Note: there is a lifetime maximum of nine (9) months' worth of Premium Credits that may be spent on Retiree Benefits. For purposes of this subsection, this lifetime maximum begins to run upon the Participant's commencement of pension benefits from the Electrical Workers Local No. 292 Pension Plan.

For example, imagine Jane retires with nine (9) months' worth of Premium Credits. Jane then uses those credits to pay for four (4) months of Retiree Benefits (reducing her Premium Credit Account to five (5) months' worth of Premium Credits). If Jane goes back to work, Jane cannot earn any more Premium Credits to bring her Premium Credit Account back to nine (9) months, as she has already reached her lifetime maximum.

However, imagine Joe retires with six (6) months' worth of Premium Credits. Joe then uses those credits to pay for four (4) months of Retiree Benefits (reducing his Premium Credit Account to two (2) months' worth of Premium Credits). If Joe goes back to work, Joe can earn up to three (3) additional months' worth of Premium Credits (bringing his Premium Credit Account to five (5) months' worth of Premium Credits). This would allow Joe to earn a total of nine (9) months' worth of Premium Credits that may be spent on Retiree Benefits (the original six (6) months' worth, plus an additional three (3) months' worth). Joe could not earn more than three (3) additional months' worth of Premium Credits, because it would go over his lifetime maximum.

Termination of Coverage for Retirees and Their Dependents

Benefits for an Eligible Retiree under this Plan will end on the first to occur of the following:

- The date the Trustees terminate this Plan;

- The date the Trustees terminate Plan benefits for Retirees;
- The last date of the benefit month preceding the benefit month for which you do not make a proper and on-time Self-Contribution;
- The date the Eligible Retiree fails to comply with any condition of participation or Plan rules;
- The date the Eligible Retiree makes a fraudulent misstatement regarding eligibility or claims;
- The date the Eligible Retiree's coverage is effectively rescinded;
- The date on which the Retiree's eligibility for Plan coverage would terminate under the Plan for any other reason; or
- The date of your death.

Benefits for your Eligible Dependents will end on the first to occur of the following dates:

- The date the Trustees terminate this Plan;

Emergency Care	$60 plus coinsurance equal to 25% of Covered Expenses, but only if you are not admitted	None – but subject to deductible and coinsurance

Coinsurance

Coinsurance is the percentage of the cost of Covered Expenses that each Eligible Individual must pay over and above any applicable deductibles and copayments before the Plan begins to pay benefits.

	In-Network	Out-of-Network
What the Plan Pays	85% of Reasonable and Customary Covered Expenses	75% of Reasonable and Customary Covered Expenses
What You Pay	15% of Reasonable and Customary Expenses, and Charges the Plan Does not Cover	25% of Reasonable and Customary Covered Expenses, and Charges the Plan Does not Cover

Maximum Out-of-Pocket Expense

Maximum out-of-pocket expense is the maximum dollar amount an Eligible Individual must pay in a Calendar Year for deductibles and coinsurance (other than coinsurance for prescription drugs). Neither coinsurance for prescription drugs nor copayments of any kind count toward reaching this maximum. After the Calendar Year maximum out-of-pocket amount is reached, the Plan pays 100% of covered medical expenses for the rest of that year.

	In-Network	Out-of-Network
Per Person	$1,500	$3,500
Per Family	$4,500	$10,500

If you satisfy any portion of the out-of-network out-of-pocket expense, it may be applied toward any in-network out-of-pocket expense. However, you may not apply any in-network (Blue Cross Blue Shield) expense toward your out-of-network out-of-pocket expense.

Coinsurance for the following covered services will not be included in the maximum out-of-pocket expense:

- Prescriptions;
- Dental and orthodontia services;
- Vision care; and
- Routine exams.

Maximum Benefit Limits

Once the lifetime maximum benefit for Non-Essential Health Benefits has been paid, no further medical expenses for Non-Essential Health Benefits will be paid for that person from this Plan. Only Non-Essential Health Benefits will be considered in determining whether the Non-Essential Health Benefits lifetime maximum has been reached.

If an Eligible Individual changes from an Eligible Employee to an Eligible Dependent status, Medical Expense Benefits paid by the Plan on behalf of the Eligible Individual as an Eligible Employee will be used in determining whether such individual has reached the lifetime