October 31, 2016
(Revised to include changes made on 1/16/2017)

First Last
Add1 add2
City state zip

IMPORTANT NOTICE

CHANGES TO YOUR HEALTH FUND PLAN OF BENEFITS EFFECTIVE JANUARY 1, 2017

To All Active and Retired Participants:

As you may know, one of the most significant economic problems facing America is the high cost of health care. Because of the rising cost of health care, the Benefits Fund must make changes immediately to strengthen the financial condition of the Fund. Dramatic increases in medical costs have made it more expensive for the Fund to provide medical coverage to all Participants.

The Trustees continually review all the aspects of the plan of benefits, including the benefits offered, hourly and monthly contribution rates, copayments, and the provider networks. The Trustees recently concluded that, due to a variety of economic factors, the Benefits Fund is not as financially strong as the Trustees believe it needs to be. Therefore, the Trustees reluctantly decided to make significant changes to many parts of the plan, **effective January 1, 2017**.

These changes follow:

CHANGES TO COPAYMENTS - MEDICAL

Attached to this Notice is a list of the benefits offered by the Fund, showing both the current plan of benefits and the new plan of benefits. The changes are highlighted, to make it easy for you to see what has, and what has not, changed for 2017.

The most significant change will be to the "copayments" under the Fund. A "copayment" is the amount that you pay when you visit a physician, hospital, or other medical provider.

In general, **all copayments that have been $20 will increase to $30.** This will be the amount that you should expect to pay when you visit a medical professional who is "in-network". However, "preventive care" visits for you and your eligible dependents will continue to have no copayment.

For hospital stays, the copayment will increase from $150/day to **$200/day** (at "in-network" facilities). But, for hospital stays of more than three days, you will only have to make a copayment for each of the first three days, and no copayment for any additional days. This is true for each

person covered under the Plan and is determined each calendar year. For example, if you are in the hospital for four days, you will pay **$200** for the first, second, and third day, and nothing for the fourth day. For a family, the number of days (at most) that you'll have to make a copayment in a year will remain at six.

CHANGE TO YOUR APPEAL RIGHTS – EXTERNAL APPEAL

Because of these necessary changes, the Plan is no longer "grandfathered," as that term is defined in the Patient Protection and Affordable Care Act (ACA). This means that the Plan will now have to comply with some ACA rules that it was not required to comply with before. However, the Plan was mostly complying with these requirements already. The only change required because of the loss of grandfathered status is to allow for external appeals of adverse benefit decisions.

If you have a claim denied (or any other adverse benefit decision), you have the right to appeal to the Board of Trustees under the rules that are currently in the Plan's Summary Plan Description. Now, if the Board denies your appeal, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

For questions about your rights or for assistance, you can contact: the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

With the current economic difficulties, we are all facing, the Trustees understand that these increases are not easy for some participants. Please understand that the Trustees must look at what is best for the financial future of the Fund, and must – from time to time – make difficult decisions such as those described in this letter.

If you have questions about these changes, please feel free to call the Fund Office.

BOARD OF TRUSTEES

New England Electrical Workers Benefits Fund
Plan Design for IBEW Local 104
In-Network Benefits

	Current	Effective 1/1/17
Preventative Care		
All "Preventive Care" (per ACA)	No copay	No copay
Prescription Drug Coverage - Copayments		
Retail pharmacy (30 day)		
Generic	$10	$10
Preferred brand name	$25	$25
Non-preferred brand name	$60	$60
Mail Order Pharmacy (90 day)		
Generic	$10	$10
Preferred brand name	$25	$25
Non-preferred brand name	$90	$90
Provider Services - Copayments		
Hospital inpatient	$150 /day	$200 /day
◦ Maximum # days/visit (per person)	3 (max $450/visit)	3 (max $600/visit)
◦ Maximum # days/year (per family)	6 (max $900/visit)	6 (max $1,200/visit)
Maternity services	$20	$30
Diagnostic labs & x-rays	No copay	$30
Major Imaging (MRI, CAT, PET)	$100	$125
Medical Facilities (excluding hospitals) - Copayments		
Emergency room	$75	$150
Walk-in centers	$50	$50
Ambulatory surgical centers	$100	$125
Skilled nursing facility	$100	$100
Home health care (80 visits)	$20	$30
Hospice	$100 one time	$100 one time
Professional Services - Copayments		
Office visit (non-preventive)	$20	$30
Outpatient facility	$100	$125
Diagnostic labs & x-rays	No copay	$100
Surgery	Covered by 'Inpatient' ($150) or 'Outpatient' ($100)	Covered by 'Inpatient' ($200) or 'Outpatient' ($125)
Radiation therapy	No copay	No copay
Chemotherapy	No copay	No copay

***Diagnostic labs & x-rays Copayments were changed from $100 to $30 on 1/16/17, retroactive to 1/1/17**