ELECTRICAL WORKERS FRINGE BENEFIT FUNDS

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Dear Plan Participants:

Enclosed please find a Summary of Material Modifications (SMM) that makes several changes to the Electrical Workers Health and Welfare Fund Summary Plan Description dated January 1, 2021. The changes are effective January 1, 2023 and are summarized as follows:

1. **Amendment of Eligibility Rules to Receive Retiree Benefits:** The attached amends the eligibility provisions so they are consistent with the Electrical Workers Pension Fund-Part A and NEBF temporary amendments allowing retirees to return to work and also Medicare eligibility rules. The changes can be summarized as follows:

   a) Group I active employees (who do not first self-pay) first become eligible for benefits after their Hours Bank reaches 600 hours. The previous amount was 580 hours. This change was made so it would be consistent with the maximum hours that the Electrical Workers Pension Fund, Part A and the NEBF allow retirees to work while continuing to receive their pension benefits under their recent amendments.

   b) If you retire and then return to work under a temporary annual program that allows you to continue to receive a pension benefit, you will continue Health and Welfare coverage in the Group III or Group V retiree plan unless your Hours Bank exceeds 600 hours, in which case you will have coverage through the active plan. The limit was previously 580 hours.

   c) If you retire, return to work and then re-retire and return to the Group III or Group V retiree plan your Hours Bank is reduced to zero, unless when you returned to work following your initial retirement you still had hours in your bank and remained covered in the active plan. This change was made to encourage participants who return to work to not exceed 600 hours and remain on the retiree plan. This avoids problems that arise when a participant switches back and forth between active plan coverage and Medicare coverage.

2. **36-Month Limitation on Self-payments:** The Plan has been amended to limit the period of time in which you can make self-pay contributions to no longer than 36-months.

3. **Removal of Health Dynamics Preventive Care Incentive:** Health Dynamics has notified the Board of Trustees that it is terminating its operations, as a result, the annual preventive care examination through Health Dynamics and the $200 Visa gift card will not be available after January 1, 2023.

4. **Changes to Preventive Care:** The Affordable Care Act requires certain preventive care items and services to be covered at 100%. This SMM updates the list of items covered as preventive care in accordance with the law.

If you have any questions regarding the enclosed SMM, please contact the Fund Office.

Board of Trustees

Electrical Workers Health and Welfare Fund

SUMMARY OF MATERIAL MODIFICATIONS (NO. 5)

ELECTRICAL WORKERS HEALTH AND WELFARE FUND

EFFECTIVE JANUARY 1, 2023

The Summary Plan Description for the Electrical Workers Health and Welfare Fund dated January 1, 2021 is hereby amended effective January 1, 2023, as follows:

1. Part I, Section Two, II. Eligibility for Participation and Commencement of Benefit Coverage is amended as follows:

A. Group I Employees

1. **Initial Eligibility**: A new Group I Bargaining Unit Employee working under the Inside Construction Agreement, or a previously eligible Group I Bargaining Unit Employee who has lost coverage because the Fund received no contributions on his or her behalf for more than twenty-four (24) consecutive months, will satisfy initial eligibility and have coverage for benefits beginning as follows:

a. An Employee is first eligible to self-pay for benefits for the month in which the Fund receives or the Employee is credited with 455 hours of Employer Contributions on behalf of the employee.

b. If an employee does not self-pay, he or she will become eligible for benefits on the first day of any calendar month in which the Fund receives or the employee is credited with 600 hours of Employer Contributions, provided the employee is either employed by a contributing employer on the first day of the calendar month in which the Fund receives or the employee is credited with contributions for 600 hours of work or the employee is signed to the out of work list with the Local Union or, if an apprentice, actually participating in the apprenticeship program.

2. **Continued Eligibility**: A minimum of 145 hours is required to qualify for each month's coverage under the Plan after meeting the initial eligibility requirement. Contributions for hours worked by an Employee after he or she becomes eligible for benefits in excess of 145 hours shall be accumulated and credited to the Employee as banked hours. The maximum accumulation of banked hours for an Employee after January 1, 2022 is 2,030 hours.

3. Working after Retirement:

A. Temporary Annual Program. If after retirement you return to work for a contributing employer under a temporary annual program of the Electrical Worker Pension Fund, Part A that allows you to continue to receive a pension benefit, your retiree coverage in the Plan continues unless you satisfy the requirements for initial eligibility as a Group I participant by working 600 hours or more. The 600-hour requirement for initial eligibility applies to retirees who return to work, regardless of whether active contributions were made on your behalf in the previous 24 months.

B. Working Less than 40 Hours a Month. If after retirement you return to work for a contributing employer but you work less than 40 hours per month and you continue to receive a pension benefit from the Electrical Workers Pension Fund, Part A, your retiree coverage in the Plan continues until you satisfy the requirements for initial eligibility as a Group I participant. The 600 hours requirement for initial eligibility applies to retirees working less than 40 hours per month, regardless of whether active contributions were made on your behalf in the previous 24 months.

C. If you attain eligibility as a Group I Participant, you will return to being eligible as a Group III or Group V participant when you re-retire. If you re-retire, your hours bank will be reduced to zero, unless following your initial retirement you return to work while still having hours in your bank and you remained covered as a Group I participant. In that case, the contributions made on your behalf during your reemployment will be credited to your hours bank.

D. You will lose eligibility for retiree health and welfare benefits if you are performing work in the electrical contracting industry and employer contributions would be due to the Plan on account of the type of work your employer performs but your employer is not signatory to a collective bargaining agreement requiring contributions to this Plan. “Performing work” includes signing a permit or license for any electrical work, signal wiring or other building activities. If you are not sure whether a job you are considering will cause you to lose eligibility, please call the Fund Office. If the Fund learns that you have engaged in non-union work as described above, the Fund Office will send you a notice that the Fund intends to permanently terminate your eligibility for benefits. You are entitled to a review of any such determination and within 60 days after receiving such a notice may file a written request at the Fund Office to have the Board of Trustees review any contemplated employment to determine whether it will be prohibited under the rules of this Plan. Working as an instructor in an apprenticeship program recognized by NECA and Local 242 or 294 or working as an electrical inspector for a government agency will not cause you to lose eligibility for retiree benefits.

4. **Continued Coverage by Self Contribution**: Your Plan coverage is lost when your Employer no longer makes contributions on your behalf to the Fund. You may continue coverage by drawing on your Hours Bank the required number of hours needed to be covered under the Plan, provided your Hours Bank is not exhausted.

   Only after your Hours Bank is exhausted may you continue coverage by making self-contributions to the Fund at rates established by the Trustees. It is your responsibility to notify the Fund Office when you are not working and to verify when self-contributions must start. You will lose eligibility if you do not make timely self-contributions; the Fund does not accept retroactive or late contributions to the Fund.

   In order to make self-contributions for a duration longer than established by COBRA, you must be signed and available for work as defined by your Local Union rules. Effective February 1, 2023, in no event may you self-pay for a period longer than 36 months, and self-pay periods prior to February 1, 2023, count towards the 36 month limit. To again self-pay under a new 36-month period you must return to work and establish Initial Eligibility as described in Section II.A.1. set forth above.

5. **Termination of Coverage**: If any required contributions are not made for the following month (either through employer contributions, Hours Bank, or employee self-payments) coverage under the Plan will cease at midnight on the last day of the month for which the Fund receives contributions. If your employer is delinquent or otherwise fails to make required contributions on your behalf, your coverage will terminate unless Hours Bank or self-payments are made to the Fund.

6. **Limited Energy Employees**: Initial Eligibility, Continued Eligibility, and Termination of Eligibility are determined by the terms of the applicable Collective Bargaining Agreement.

7. **Forfeiture of Hours Bank and Self-Pay Coverage:** You will forfeit your Hours Bank and eligibility for self-payments if you stop working under a collective bargaining agreement requiring contributions to the Plan and all of the following occur:

   a. You go to work for an employer in the geographical area covered by the Plan; and,

   b. You are performing work in the electrical contracting industry and employer contributions would be due the Plan on account of the work you are performing but the employer is not signatory to a collective bargaining agreement requiring contributions to this Plan.

   If your eligibility is terminated under the above rule, you will forfeit your Hours Bank and will not be eligible for self-pay coverage. Any period of

time that you were covered via self-pay or your Hours Bank will be counted against any remaining COBRA continuation coverage to which you may be entitled. A participant will not forfeit their Hours Bank or eligibility for self-payments if they work for a non-union employer as part of an organizing campaign.

8. **Dependent Special Enrollment:** Group I Employees may add new dependents following initial eligibility by submitting to the Plan a written request for enrollment along with any enrollment information the Plan may require (for example, copy of marriage certificate, proof of loss of other coverage, etc.). If you are adding a new dependent because of:

- marriage, birth, adoption, or placement for adoption;
- termination of other health coverage due to loss of eligibility, or exhaustion of COBRA coverage under another health plan; or
- loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or eligibility to participate in a financial assistance program through Medicaid or CHIP;

you must submit a written request for enrollment along with any required enrollment information so that it is received by the Plan within 90 days of the event (for example, marriage, birth, loss of coverage, etc.) for coverage to be effective on the date of the qualifying event. If the written request for enrollment and required enrollment information is not received by the Plan within 90 days of the qualifying event, or if you are enrolling a new dependent for a reason other than those listed above, new dependent coverage will be effective on the first day of the month following the date the Plan receives the request for enrollment and the required enrollment information.

B. Group II Employees

1. **Eligibility**: Coverage is available to Office employees and others not covered under a collective bargaining agreement that have employer contributions made on their behalf pursuant to participation agreements with the Fund.

2. **Commencement and Continuation of Coverage**: The effective date of coverage for a Group II Employee is the first day of the month that follows 60 calendar days after the Fund first receives an employer contribution on the employee's behalf. In order to continue coverage, the Employer contribution must be paid in advance for each month.

3. **Termination**: Coverage terminates on the last day of the month for which a contribution is received on the Employee's behalf.

4. **Self-Payment**: A Group II employee's only self-pay contribution rights are COBRA Continuation Coverage set forth in Section Two, Part III of this Plan.

5. **Dependent Special Enrollment**: Group II employees may add new dependents following initial eligibility by submitting to the Plan a written request for enrollment along with any enrollment information the Plan may require (for example, copy of marriage certificate, proof of loss of other coverage, etc.). If you are adding a new dependent because of:

- marriage, birth, adoption, or placement for adoption;
- termination of other health coverage due to loss of eligibility, or exhaustion of COBRA coverage under another health plan; or
- loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or eligibility to participate in a financial assistance program through Medicaid or CHIP;

you must submit a written request for enrollment along with any required enrollment information so that it is received by the Plan within 90 days of the event (for example, marriage, birth, loss of coverage, etc.) for coverage to be effective on the date of the qualifying event. If the written request for enrollment and required enrollment information is not received by the Plan within 90 days of the qualifying event, or if you are enrolling a new dependent for a reason other than those listed above, new dependent coverage will be effective on the first day of the month following the date the Plan receives the request for enrollment and the required enrollment information.

C. Group III, IV, V, and VI Employees

1. **Eligibility**: Coverage is available to:

a. Retired employees receiving a monthly pension benefit from the Electrical Workers Pension Fund, Part A, Defined Benefit Plan, who were covered by the Electrical Workers Health and Welfare Fund at the time of their retirement; and

(i) have either twenty (20) years of vesting service with the Electrical Workers Pension Fund, Part A; or

(ii) work a minimum of 1250 hours per year (according to Electrical Workers Pension Fund Part A records) in four (4) out of the last seven (7) plan years immediately prior to retirement.

Or,

b. Persons who were covered for benefits with the Electrical Workers Health and Welfare Fund for at least ten (10) years immediately prior to retirement and are 62 years of age or older on the date of retirement, and who are no longer actively employed nor actively self-employed.

2. **Commencement and Continuation of Coverage**: Coverage begins and is continued by paying the monthly rate established by the Board of Trustees in advance of the month of coverage. Rates for Groups III, IV, V, and VI are established based on each Participant's or dependent's eligibility for Medicare. Upon initial retirement a Group III retiree must exhaust his or her Hours Bank before making self-payments. When your Hours Bank is less than 145 and there are not enough hours for a full month of coverage, any balance remaining is forfeited. Application must be made to obtain retiree coverage prior to the later of either the date of the first pension check from the Electrical Workers Pension Fund, or the date of retirement. In order to continue coverage, the full monthly cost at rates established by the Trustees must be paid in advance for each month.

3. **Working after Retirement:** For the complete rules describing the coverages available to you if you return to work after retirement, see Section Two, II, A. 3 of this Summary Plan Description.

4. **Spouse Working**: If upon a retired Participant's initial eligibility for Group III, IV, V, or VI coverage the Participant's spouse has health coverage through employment, the Participant may choose to delay coverage for his or her spouse until the spouse's coverage ends. Upon enrollment in this Plan, the spouse must provide the Fund with a certificate of coverage indicating no lapse in coverage. Election of coverage for the Participant's spouse must be made within 30 days of the exhaustion or termination of the other coverage.

5. **Termination**: If a covered retired person fails to make the required contribution, coverage terminates at the end of the month for which the last contribution was made. A retired person whose coverage is terminated because of failure to make the required contribution shall not be allowed to reinstate coverage thereafter. If an eligible covered retired person dies, the widow or widower may maintain coverage by continuing to make payment of the required contribution.

6. **Dependent Special Enrollment Period**: If you are in Group III, IV, V, or VI you may add family benefits if you have a change in status that meets one of the following criteria:

a. You are married. Election of family coverage must be made within 30 days from the date of marriage. Enrollment is effective the first

calendar month beginning after the date the completed request for enrollment is received by the Plan.

b. You become legally responsible for a dependent child or children through birth, adoption, or placement for adoption. Election for family coverage must be made within 30 days of the date of birth, adoption, or placement of adoption. Enrollment is effective on the date of birth, date of adoption, or date of placement for adoption.

c. You have family coverage under another health plan under COBRA which was exhausted, or coverage was not under COBRA and was terminated due to loss of eligibility, including legal separation, divorce, death, termination of employment, or reduction in hours of employment, or termination of employer contributions. (However, lost eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or termination of coverage for cause.) Election for family coverage must be made within 30 days of the exhaustion or termination of the other coverage. Enrollment is effective the first day of the first calendar month beginning after the date the completed request for enrollment is received.

d. You have dependents who are eligible for coverage under the Fund, that are not enrolled, and either of the following occurs:

- The dependent loses eligibility under Medicaid or CHIP, and you or the dependent request coverage within 60 days after termination of Medicaid or CHIP, or

- The dependent becomes eligible to participate in a financial assistance program through Medicaid or CHIP and you or the dependent request coverage under the Fund within 60 days after becoming eligible for the assistance.

A written application must be filed specifying the change in status, along with a certified copy of the official document demonstrating such change in status, and any additional information the Trustees may require.

If you elect family benefits and then decide to terminate the benefits for some reason, you are not allowed to purchase family benefits in the future except as provided for under the special enrollment periods stated above.

7. **Requirement to Enroll in Medicare**: For those retired persons or their dependents that are Medicare eligible, plan benefit payment will be reduced by payments made by Medicare for the same disability. In order to continue

as a retired person in this Plan, you must be enrolled in both Part A and Part B of Medicare when eligible.

2. **Part I, Health Benefits, Section Three, V. Wellness/Preventive Care Benefits, paragraphs A and B, numbers 1-4, are amended as follows:** *(New Language in Italics)*

V. WELLNESS/PREVENTIVE CARE BENEFITS

In General

Pursuant to the Patient Protection and Affordable Care Act (the "Affordable Care Act"), the Fund will pay the in-network preventive items or services listed below at 100%. These benefits are provided without any cost-sharing, except with regard to physician's charges for an office visit, as discussed below.

1. Covered Preventive Services For All Adults

- Abdominal aortic aneurysm one-time screening for men between 65-75 who have ever smoked
- Diabetes (Type 2) screening for adults aged 35-70 who are overweight or obese
- Low-dose aspirin use to prevent cardiovascular disease and colorectal cancer for adults aged 50-59 with a high cardiovascular risk
- Colorectal cancer screening for adults aged 45-75 (may include fecal occult blood testing, sigmoidoscopy, colonoscopy or virtual colonoscopy)
- Depression screening
- Annual preventive eye exam
- Falls prevention exercise interventions for community-dwelling adults aged 65 years and over
- Healthy diet behavioral counseling interventions for adults with hypertension or elevated blood pressure, dyslipidemia, or those who have mixed or multiple risk factors (*e.g.*, metabolic syndrome or an estimated 10-year cardiovascular disease risk of 7.5% or greater).
- Hepatitis B virus screening in persons at high risk for infection
- Hepatitis C virus screening in adults aged 18-79
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- High blood pressure screening for adults age 18 or older
- Latent tuberculosis screening in populations at increased risk
- Lung cancer annual screening for adults 50-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Obesity screening (BMI of 30 or higher) and for those determined obese, intensive multicomponent behavioral interventions

- Preexposure prophylaxis (PrEP) medication for the prevention of HIV infection for persons at high risk, including required testing and screening before and during use of PrEP medication, and adherence counseling.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Skin cancer prevention behavioral counseling for young adults and parents of young children about minimizing exposure to UV radiation to reduce risk for skin cancer for persons aged 6 months to 24 years with fair skin types
- Low to moderate dose statin medication for the prevention of cardiovascular disease for adults ages 40 – 75 with certain risk factors
- Syphilis screening for adults at higher risk
- Tobacco use screening, behavioral interventions, and Food and Drug Administration-approved pharmacotherapy for cessation (up to two cessation attempts per year)

2. Covered Preventive Services For Pregnant Women Or Women Who May Become Pregnant

- Asymptomatic bacteriuria screening using urine culture
- Breastfeeding: Comprehensive lactation support services from a trained provider, including counseling, education, and breastfeeding equipment, during pregnancy and the postpartum period (breastfeeding equipment requires prior authorization and is subject to specific restrictions, contact the Fund office for information)
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women at 24 weeks of gestation or after
- Healthy weight and weight gain – behavioral counseling interventions for pregnant women
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening
- Preeclampsia screening throughout pregnancy and low-dose aspirin as preventive medication after 12 weeks gestation in women at high risk for preeclampsia
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening for all pregnant women
- Tobacco use screening and behavioral interventions for cessation

3. Other Covered Preventive Services For Women

- BRCA-related cancer: One office visit risk assessment for women with a personal or family history associated with certain cancers or ancestry associated with breast cancer

susceptibility (BRCA1/2 gene mutations), and up to two sessions of genetic counseling and evaluation for BRCA testing

- Breast cancer medication: Risk reducing medications, such as Tamoxifen and Raloxifene, to women who are at increased risk for breast cancer and low risk for adverse medication effects
- Breast cancer biennial screening (mammography) for women over 40
- Cervical cancer screening
    - Pap test (also called a Pap smear) every 3 years for women 21 to 65
    - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years
- Chlamydia and gonorrhea screening for sexually active women aged 24 and younger and for older women at increased risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs)
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Interpersonal and domestic violence screening
- *Obesity prevention counseling for women aged 40 to 60 years with normal or overweight body mass index*
- Osteoporosis screening for postmenopausal women younger than 65 who are at increased risk, and all women 65 years and older
- Urinary incontinence screening for women yearly
- Well-woman visits to get recommended services for women

4. Covered Preventive Services For Children

- Alcohol, tobacco, and drug use assessments for adolescents
- Anemia risk assessment or screening, as appropriate
- Autism screening for children at 18 and 24 months
- Behavioral*/social/emotional* assessments throughout childhood
- Bilirubin concentration screening for newborns
- Blood pressure screening throughout childhood
- Blood screening for newborns
- Cervical dysplasia screening for sexually active females
- Depression *and suicide risk* screening for adolescents beginning routinely at age 12
- Developmental screening throughout childhood

- Dyslipidemia screening for children at higher risk of lipid disorders
- Annual preventive eye exam
- Fluoride varnish for all infants and children as soon as teeth are present *and thereafter every 3 to 6 months based on risk*
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing and vision screening for all children
- Height, weight and body mass index (BMI) measurements throughout childhood
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for *children* at high risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Lead screening for children at risk of exposure
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Obesity screening in children age 6 and older and up to three office visits a year for counseling and behavioral interventions
- Oral fluoride supplements for children without fluoride in their water source
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling for sexually active adolescents
- Skin cancer prevention behavioral counseling for adolescents
- *Sudden cardiac arrest risk assessment for children aged 11 and older*
- Tobacco use interventions, including education and brief counseling, to prevent initiation of tobacco use (including e-cigarette products, *i.e.*, vaping)
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for children under age 5 to detect amblyopia or its risk factors