NECA-IBEW WELFARE TRUST FUND

NEWSLETTER

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A Message from the Fund

As you may know from your local-level communications with the Trustees, although income is rising through a good work picture and recent contribution rate increases, the Fund continues to operate at a financial deficit. This is because of continually rising healthcare costs and the resulting increased claims expenses. For this reason, the Trustees approved another contribution rate and premium increase for actives and pre-65 retirees, respectively, effective July 1, 2023. There are several other changes and updates the Fund will be undergoing soon. This especially includes converting to "non-grandfathered" status and partnering with a new prescription benefit manager beginning in 2024. Going non-grandfathered will provide you with better benefits and coverages for many preventative services and supplies. Please read on for details on these items as well as other important Plan highlights and modifications approved by the Trustees.

Active Contribution and Retiree Plan Premium Rates

Effective **July 1, 2023**, active contribution rates on the Base Plan will increase by $0.50 to $8.35 per hour, and contribution rates on the Alternative and Single Alternative Plans will increase by $0.10 to $5.65 and $3.80 per hour, respectively. There will be changes in the self-pay rates for Retirees under 65 on all plans effective July 1, 2023. The Fund Office has mailed a letter to those Retirees with the new rates. There will be no premium increase for retirees 65 and over for the remainder of 2023 and 2024.

Non-Grandfathered Status under the Affordable Care Act (ACA):

Effective **January 1, 2024**, the Fund will be recognized as a "non-grandfathered" plan according to the federal law known as the Affordable Care Act ("ACA"). For dates of service on and after January 1, 2024, certain preventive care services and supplies delivered by a provider **in the Fund's medical or prescription drug retail pharmacy network** (i.e., "In-Network") will be covered by the Fund at 100% with no "Cost-sharing" to Participants and Dependents covered under the Plan. "Cost sharing" includes deductibles, coinsurance, copayments, or similar charges. "Cost-sharing" does not include premiums, balance billing amounts for out-of-network providers, or charges for services not covered by the Plan.

Preventative care services and supplies include many vaccines, physicals, tests, certain prescription drugs, and screenings for numerous conditions (including for mental health/substance abuse, and numerous women's health and children's preventative care services). For more information on specific listings and categories of the designated preventative services and supplies that will be covered for free after the effective date, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

Becoming "non-grandfathered" also means covered Persons under the Plan will have an additional layer of out-of-pocket protection under the ACA, called the "maximum out-of-pocket limit" ("MOOP") for "Cost-sharing" (as defined earlier) beginning in calendar years 2024 and after. **Importantly, the Plan's existing Out-of-Pocket Maximums, which are based on the Coinsurance paid by the covered Person or family, will remain in place.** The Plan's existing Out-of-Pocket Maximums, however, do not include medical deductibles and copayments nor prescription drug deductibles and copayments. The MOOP is an absolute limit to certain costs a Participant, Dependent, or family can incur in a calendar year, including medical and prescription drug deductibles and copayments. Please note the MOOP does not include premiums, balance billing amounts for out-of-network providers, Dental or Vision expenses, or charges for services not covered by the Plan.

Effective January 1, 2024, the Plan will follow the annual MOOP limits set forth by the Department of Health and Human Services (HHS). The MOOP limits for 2024 for all Fund Plan types and tiers will be:

- **Medical MOOP** - $4,725 per individual / $9,450 per family
- **Prescription Drug MOOP** - $4,725 per individual / $9,450 per family

Starting in 2024, the Plan's "non-grandfathered" status will also bring coverage for covered Persons participating in certain approved clinical trials, as well as an opportunity for an additional external review on certain appeals by an Independent Review Organization ("IRO").

Additional information regarding the change to "non-grandfathered" status will follow later this year in the Summary of Benefits and Coverage ("SBCs") and in a Plan amendment that will be displayed on the Fund's website. Please also note that the above changes have no effect on the current Calendar Year and will not become effective until on and after **January 1, 2024.**

Prescription Benefit Manager Change

Effective January 1, 2024, the Fund will change prescription benefit managers from CVS Caremark to **MedImpact** for both the active/pre-65 retiree and over-65/Medicare-eligible retiree Plans. Over-65 and Medicare-eligible retirees and their Medicare-eligible dependents will move from SilverScript Employer PDP sponsored by NECA-IBEW to **VibrantRx™ (PDP) sponsored by NECA-IBEW.** Except for the benefit improvements from becoming a non-grandfathered plan, there will be no changes to overall prescription drug benefit levels. There will be some minor changes to the formulary (list of covered drugs) for certain covered prescription drugs. Covered Persons who will be impacted by any changes will be mailed a special letter later in the year explaining the changes and drug coverage process. Covered Persons who may be negatively impacted by formulary changes will be allowed one grace/ temporary refill of their existing medication covered by the CVS Caremark or SilverScript formulary within the first 90 days of 2024.

A packet with new ID cards and information about the new prescription drug program will be mailed to all Participant households in early December 2023. Over-65 and Medicare-eligible retirees can expect their initial pre-enrollment information from VibrantRx to arrive in late October 2023. Additional information regarding the change will follow later this year in the Summary of Benefits and Coverage (SBCs), in a Plan amendment that will be displayed on the Fund's website, as well as in additional Medicare-required notices for over-65 and Medicare-eligible retirees.

Coinsurance Percentage Changes

Effective January 1, 2024, the following changes to Coinsurance will apply:

- **Base Plan:** The Fund's share of the **out-of-network** (Non-PPO Provider) Coinsurance percentage will decrease from 75% to 70%. Covered Persons in the Base Plan will be responsible for paying 30% Coinsurance on applicable Covered Medical Expenses up to the applicable annual Out-of-Pocket maximum.
- **Alternative Plan:** The Fund's share of the **in-network** (PPO Provider) coinsurance percentage will increase from 70% to 80%. Covered Persons in the Alternative Plan will be responsible for paying 20% Coinsurance on applicable Covered Medical Expenses up to the applicable annual Out-of-Pocket maximum.

Upcoming New Blue Cross Blue Shield Network for Wisconsin Members

Effective January 1, 2024, Participants and Dependents who are residents of Wisconsin will be covered under a new in-network arrangement, called the **"Wisconsin Blue Preferred POS." Applicable covered Persons** should be aware of the following:

- New Blue Cross Blue Shield medical **identification cards** with a new plan ID prefix will be mailed to Participant households toward the end of 2023.
- You should let your medical provider(s) know you have a new network and present your new Blue Cross Blue Shield Card to them.
- The transition is expected to be mostly seamless, however, there are a very small number of providers in Wisconsin who

participate in the existing PPO network but not in the Wisconsin Blue Preferred POS. There will be adequate alternative providers in the new network for any affected Persons to select. The Fund Office will make outreach to any known affected Persons to assist with options.

- To preview the provider directory for the new network, please visit https://www.bcbsil.com/find-care/providers-in-your-network/find-a-doctor-or-hospital then search as a *Guest*, then select plan: "Blue Preferred POS (Wisconsin)."

Employee Assistance Program (EAP) Update & Reminder

TELUS Health formerly LifeWorks

The Fund's EAP partner, LifeWorks, recently changed names to **TELUS Health**. TELUS Health is a consultative resource for Fund Participants and Dependents for mental and behavioral health, substance abuse, and other life stressors, such as financial wellbeing. The Fund covers up to three (3) free EAP visits per year through the TELUS Health Employee Assistance Program. After initial EAP visits, TELUS Health can refer you to local providers to continue your care under standard Fund coverage. There is no cost and EAP visits are completely confidential. Information on how to access the TELUS Health EAP is posted on the NECA-IBEW website, https://www.neca-ibew.org/lifeworks, or you can call them toll-free at 888-456-1324, 888-732-9020 (en Español), or 800-999-3004 (TTY) to begin the path to getting the help you need.

COVID-19 Emergency End – Plan Updates

The Public Health Emergency (PHE) and National Health Emergency due to COVID-19 ended May 11, 2023. Effective May 11, 2023, costs related to over-the-counter COVID-19 test kits will no longer be covered by the Fund. Laboratory COVID-19 tests administered by a physician will be subject to the Plan's standard cost-sharing provisions, similar to how a flu test would be covered. COVID-19 vaccinations will continue to be covered at 100% through the Prescription Drug Benefit or from your doctor under the Medical Benefit. Vaccinations and inoculations are covered under the Base, Alternative and Supplemental Retirement Plans, as well as under the prescription drug plan for Medicare-Eligible Retirees.

The end of the National Emergency also means that as of July 10, 2023, the temporary extensions of certain deadlines will cease, and **standard Plan rules** are effective again for the following periods or dates:

- The period to request special enrollment (standard is within 60 days of an applicable event),
- The 60-day election period for COBRA Continuation Coverage,
- The date for making COBRA Continuation Coverage premium payments (standard is 45 days after the 60-day election period),
- The date for individuals to notify the Plan of a qualifying event or the determination of disability (standard is within 60 days of the date you would lose coverage due to the qualifying event),
- The date within which individuals may file a benefit claim under the Plan's claims procedures (standard is claim and all requested information must be received within one year of the date of service), and
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedures (standard is generally 180 days after receiving notice of a claim denial or 60 days for a claim for Accidental Death and Dismemberment benefits).

MDLIVE Reminder

MDLIVE® MDLIVE visits, whether for **medical** or **mental/behavioral health**, are covered at 100% with no cost-sharing. For more information on MDLIVE and how to activate your MDLIVE account, please contact the Fund Office, visit https://www.neca-ibew.org/mdlive. You can also contact MDLIVE directly at www.MDLIVE.com/BCBSIL, by calling 1-888-676-4204, by texting BCBSIL to 635-483, or by accessing the MDLIVE mobile app on your device.

Price Comparison Tool Update

The Fund Office continues to work with our software partners to have an online healthcare "price comparison tool" available to Participants and Dependents through the Fund website as soon as possible. The federal Consolidated Appropriations Act and Transparency in Coverage Rules require the Fund to provide a price comparison tool for the 500 most common services beginning in 2023, and a complete list of services in mid-2024. You will soon be able to use the tool (powered by **Zelis**) to compare the prices of services across various providers, as well as to receive a real-time expectation of your out-of-pocket costs. The Fund Office will also be able to provide the same information over the phone. More information on the price comparison tool will follow soon on the Fund's website and in future notices.

Wellness Power Program Updates

WELLNESS POWER

The Trustees elected to adjust certain Wellness Power Program incentive activities and add some enhancements effective January 1, 2024. The following will be the annual HRA reward structure in 2024 for completion of these activities:

- Quarterly **Challenges** - $50/once per year
- Online or app registration or annual **log in** - $25
- **Biometric Screening** with Advising Call - $100
- **Health Risk Assessment** - $25
- **Coaching** - $100 (Completion of a wellness or disease management coaching program within a benefit calendar year)
- **Gym Usage / Independent Workouts, and/or Step Usage** - $100 (Based on 48 visits per year or equivalent for Independent Workouts. Step Usage goals are based on 7,500 steps daily for 48 days within a program year. This reward can be used twice per year. *Note: This program activity will launch and be effective October 1, 2023, with pro-rated usage and reward amounts for the 2023 program year.)*

Please note the annual maximum combined incentives cannot exceed $300 per Participant and $600 per Participant and spouse each program year (excluding retirees over age 65, their spouses, and all covered dependent children).

Detailed information about the 2024 and remaining 2023 programs will be distributed by the Fund's Wellness partner, Telligen, later this year via email, and text notice (if opted in). To access information about the health assessment, online health challenges, biometric screenings, the Telligen app, and other Wellness Power Program details, please visit the Wellness Power website at https://necaibew.totalwellbeinglife.com/

Coming Soon: New Fund Website Look!

The Fund is undergoing work on an updated website to better serve you and your providers. The updated website is expected to go live around October 2023. The website address will be the same (www.neca-ibew.org). The new website will include enhanced FAQs, easier navigation of the Fund's documents and forms, and glide path navigation for common life events.

HRA & Benny Card Updates

The Fund Office has instituted a new procedure for Health Reimbursement Arrangement (HRA) Benny Card transaction substantiation. Previously, if documentation was received to substantiate a Benny Card transaction, and the documentation did not meet the acceptance criteria, the HRA claim was denied and the Benny Card was suspended. The new procedure is called **Request for More Information (RMI)** – this procedure will request additional documentation for the Benny Card transaction without denying the claim or suspending the Benny Card. The new procedure will still follow the standard follow-up procedure - if acceptable documentation is not received within 90 days of the Benny Card transaction (when you swipe your card), the claim will be denied and the Benny Card will be suspended; however, the RMI process will allow the full 90 days for you to upload/send additional documentation to substantiate the Benny Card transaction before your card is suspended.

The Fund Office has also instituted a new feature for **HRA automatic reimbursement for Medicare Part B premiums.** Retirees can contact the Fund Office for the guidelines and a form to execute this automatic reimbursement of Part B premiums.

Plan Improvements

The Trustees also recently elected to make the following improvements to the Plan's benefits:

- The Plan's Medical Exclusion regarding leaving **"Against Medical Advice"** has been modified effective retroactive to November 21, 2021, to only exclude coverage for ***future complications*** that result from leaving an inpatient facility against medical advice. Coverage will now be provided for inpatient stays even if the covered Person leaves a facility against medical advice.
- The Plan's definition of **"Experimental and/or Investigational"** has been modified effective retroactive to January 1, 2023 to allow coverage of routine costs for patients participating in **clinical trials**. Routine costs include costs normally covered by the Plan for individuals who are not in clinical trials, including, but not limited to, room and board charges, administration of the service or supply, lab work, and physician charges. Routine costs for clinical trials do not include services or supplies (1) under investigation, (2) to satisfy data collection, or (3) inconsistent with widely accepted standards of care.

Complete details of these Plan changes can be found in Amendment #6 to the 2020 Summary Plan Description and Plan Document, which can be found on the Fund's website, https://www.neca-ibew.org/Documents-and-Forms

Retiree Reminders

Contact the Fund Office when you're getting ready to retire. You have options when you retire, and the Fund Office can help you sort them out. Coverage under the Supplemental Retirement Plan is not automatic; you must apply for it and meet certain criteria to be accepted.

If you or one of your covered dependents is eligible for Medicare, you must enroll in Medicare Parts A and B to be covered under the Supplemental Retirement Plan. Enrollment in Medicare Parts A and B coverage is not automatic; you must apply. Once you become eligible for Medicare benefits and are covered under the Fund's Retiree Plan, you will receive information in the mail from RetireeFirst, a company dedicated to supporting the day-to-day service needs of unionized labor retirees. They will assist you in the transition to the Fund's Humana Medicare Advantage plan.

Keep Your Information Up to Date

If you do not notify the Fund Office if you get divorced, if you or another family member have other benefit plans, or if there has been a death in the family, it may result in you owing money to the Fund. If you get divorced, you may also need to update your beneficiary designations for Death Benefits and Accidental Death & Dismemberment Benefits. If you get divorced, any prior beneficiary designation naming your former spouse as beneficiary (but not any other beneficiary designations) will be null and void. If you would like to retain your former spouse as beneficiary, you must complete a new beneficiary form after your divorce, listing your former spouse as a beneficiary. If you do not have a valid beneficiary or surviving spouse, the Death and/or Accidental Death & Dismemberment Benefit will be paid to your estate. Contact the Fund Office or download a Beneficiary Form from the Fund website if you want to change or designate a beneficiary.

The Fund must also be made aware of any change in Dependent health insurance coverage. If you fail to notify the Fund Office of changes, you may be liable for benefits paid in error due to misinformation or lack of information supplied by you. The Fund has the right to recover any overpayment or mistaken payment made to you or to a third party. The Fund may recover those monies through legal action or by reducing future benefit payments.

Statement of Grandfathered Status

Until January 1, 2024, the Trustees believe that this Plan is a "grandfathered health plan" under the Affordable Care Act, which permits us to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, our Plan does not have to include certain consumer protections of the Affordable Care Act that apply to other plans (for example, providing preventive health services without any cost sharing). However, grandfathered health plans, like our Plan, must comply with other consumer protections in the Affordable Care Act (for example, the extension of coverage for dependent children to age 26). Contact the Fund Office if you have questions about what it means

for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

Nondiscrimination Notice Under Section 1557 of the Affordable Care Act

Discrimination is against the law. The NECA-IBEW Welfare Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Fund provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The Fund also provides free language services to people whose primary language is not English, such as qualified interpreters, and information written in other languages.

If you need these services, contact Mr. Kevin Cope, the Civil Rights Coordinator. If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Mr. Kevin Cope
Civil Rights Coordinator
NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue, Decatur, IL 62526-2871
Phone: 800-765-4239
Fax: 217-875-1174
Email: info@neca-ibew.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mr. Kevin Cope is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F HHH Building
Washington, DC 20201
Phone: 800-368-1019
TDD: 800-537-7697 (TDD).

Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html.

NECA-IBEW Welfare Trust Fund

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Please read this newsletter carefully and save it with your Summary Plan Description and other benefits documents. This newsletter contains only highlights of certain features of the NECA-IBEW Welfare Trust Fund. It is intended to be a Summary of Material Modifications. 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.

We're Online and Accessible 24/7!

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https://twitter.com/NECAIBEWBenefit

And Make Sure to Use the Member Benefits Portal, the Wellness Power Portal and the HRA Participant Portal!

The Member Benefits Portal, Wellness Power Portal and HRA Participant Portal are separate sites that are NOT connected. Your accounts for each site are separate. If you have not already created accounts for the portals, you will need to register for each portal. Be sure to highlight the "Login to Member Benefits" link on our website. Electronic Explanations of Benefits (EOBs) statements can be viewed and printed directly from our Member Benefits portal. If you have any questions about how you can access your eEOB or the portals, please contact the Fund Office at 800-765-4239.

Go Paperless!

If you would like to get your required correspondence, such as newsletters and Summary Annual Reports, electronically, you can sign up to go paperless on the Fund's website. We hope this option will make your life easier, save on postage costs and help the environment at the same time. If you wish to continue receiving information by mail, you do not need to do anything. EOBs (explanation of benefits) will continue to be mailed regardless of whether or not you sign up to go paperless.

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