For Participants in the EIT Health & Welfare Plan for Communication Members

EIT BENEFIT FUNDS
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IBEW 228

BENEFITS UPDATE

January 2017

Changes to your Health Care Benefits

The Trustees have made the following important changes to the Electrical Insurance Trustees Health and Welfare Plan for Communication Members ("Plan") as described in the Summary Plan Description for the Plan, dated as of January 1, 2008.

This Benefits Update supplements the information contained in that Summary Plan Description.

Please keep these documents together for your records and future reference. If you have any questions about the benefit changes described in this Benefits Update, please contact the EIT Benefit Funds Office at 312-782-5442.

Behavioral Health & Substance Abuse Benefits

Change of Benefit Provider from Cigna to Blue Cross Blue Shield of Illinois (BCBSIL)

Effective for eligible claims incurred on and after January 1, 2017, BCBSIL is the new Behavioral Health and Substance Abuse benefits provider. All other provisions and limitations contained in the Plan are unchanged and continue to be applicable.

For questions about the BCBSIL network, preauthorization for inpatient behavioral health or substance abuse care and your transition of care needs, you may contact BCBSIL Behavioral Health customer service at **(800) 851-7498**.

Member's Assistance Program (MAP)

Effective January 1, 2017, Employee Resource Systems, Inc. (ERS) will be the new MAP provider. The MAP provides consultation services for such needs as mental health, alcoholism, drug dependency, retirement, child care, legal, financial and ID recovery.

For questions regarding the services provided by the MAP contact ERS' customer service at **(800) 292-2780** or visit www.ers-eap.com.

Prescription Drug Benefits

Copay Increase

Effective for eligible claims incurred on and after January 1, 2017, the prescription drug copays are increased as described below:

	Any Network Pharmacy *(up to a 30-day supply*)*	**Maintenance Choice® Mail-Order or CVS Pharmacy** *(up to a 90-day supply**)*
Generic	$10 copay	$20 copay
Preferred Brand	You pay 25% *($30 min., $50 max.)*	You pay 25% *($60 min., $100 max.)*
Non-Preferred Brand	You pay 30% *($50 min., $100 max.)*	You pay 30% *($100 min., $200 max.)*
Out-of-Network Pharmacy		No Coverage

**Two fill limit on maintenance/long-term prescriptions*
***No fill limit*

Generic Substitutions

Effective for eligible claims incurred on and after January 1, 2017, your prescription for brand-name drugs will automatically be filled with a generic drug unless your prescription specifies that it is medically necessary for you to use the brand-name drug. If your doctor indicates it is medically necessary, you will be responsible for paying the appropriate brand-name drug copay with no penalty.

If it is not medically necessary for you to fill your prescription with a brand-name drug and a generic drug is available, you will be responsible for the difference in cost between the generic drug and brand-name drug, plus the generic drug copay, if you choose to fill the prescription with a brand-name drug.

Maintenance Choice® for Maintenance/Long-Term Prescriptions Only

Effective for eligible claims incurred on and after January 1, 2017, if you take a prescribed maintenance or long-term drug(s) (medications you fill each month for longer than two (2) months), you can obtain them from the CVS mail-order program or through a CVS Pharmacy. When you purchase up to a 90-day supply of maintenance or long-term drugs, the Plan pays 100% after you pay the appropriate copay.

If you have a maintenance drug prescription filled at a retail pharmacy other than a CVS Pharmacy, the Plan will only cover the first two (2) 30-day fills. All subsequent 30-day fills of maintenance drugs after the second 30-day fill will only be covered by the Plan if you use the CVS mail-order program or a CVS Pharmacy.

Maintenance Choice does not apply to drugs that are not considered maintenance or long-term.

If you have questions about whether your prescription is considered a maintenance drug, you may call CVS/Caremark customer service at **(800) 566-5693.**

Specialty Drugs

Effective for eligible claims incurred on and after January 1, 2017**,** the Plan has made the following changes to the specialty prescription drug provisions**:**

CVS Specialty Pharmacy: Specialty drugs are prescriptions used to treat complex and chronic health conditions. To receive coverage for specialty drugs, you must purchase your specialty drugs through the CVS Specialty Pharmacy. The CVS Specialty Pharmacy is a mail-order pharmacy that will ship your specialty medications directly to you or, if you prefer, to a CVS Pharmacy. The copay amounts for specialty drugs are the preferred brand or non-preferred brand copays, as appropriate.

If you do not purchase your specialty drugs through the CVS Specialty Pharmacy, the cost of your prescription specialty drugs will not be covered by the Plan.

CVS Specialty Preferred Drug Program: If you use specialty drugs, you may be asked by the CVS Specialty Pharmacy to try a preferred, lower-cost drug. If you are asked to try a preferred, lower-cost drug, and it is determined to be medically necessary for you to continue to use a non-preferred specialty drug, you will be responsible for paying the non-preferred drug copay.

If it is determined that it is not medically necessary for you to continue to use a non-preferred specialty drug and you do not try the recommended preferred specialty medication, you will be responsible for paying the full cost of the non-preferred specialty drug.

For further information and support relating to your specialty prescriptions, please visit **www.CVSspecialty.com** or call CVS Caremark customer service at **(800) 237-2767.**

Disability Benefits

Long-Term Disability

When determining your eligibility for purposes of long-term disability benefits, the Plan requires that you are continuously covered for the 12-month period prior to the date of your injury or illness. The Plan does not include COBRA continuation coverage when determining if you have been continuously covered during the 12-months preceding your injury or illness.

What is Not Covered

Expenses to treat a participant's injury or illness arising from any electrical work or any other paid work *finally adjudicated to be payable under any Workers' Compensation or occupational disease law* and expenses for a dependent paid or payable under any Workers' Compensation law (whether performed for pay or not) *or occupational disease law* will not be covered under the provisions of the Plan.

Coordination with Workers' Compensation

Effective November 1, 2015, you must notify the Fund Office of all Workers' Compensation claims you file within 90 days of the later of: (1) the date you last worked contributed hours, or (2) the date of your injury or illness, including contested Workers' Compensation claims. Your employer is also obligated to notify the Fund Office if you file a Workers' Compensation claim with its insurance carrier.

Disability Hours Crediting with Workers' Compensation

If you become disabled because of an occupational injury or illness and have been awarded Workers' Compensation benefits (even if you contest the amount of the Workers' Compensation benefits), you are not eligible to receive disability payments. You may, however, be eligible to receive disability hours credited towards coverage under the Plan. You will receive disability hours credited for up to 14 weeks if:

- You submit your Workers' Compensation Disability Statement within 90 days of the later of (1) the date you last worked contributed hours, or (2) the date of your injury or illness; and
- You were covered under the Plan at the time of your injury or illness (not including COBRA continuation coverage); and
- You provide the Fund Office with proof of payment from the Workers' Compensation insurance carrier.

After 14 weeks, you will receive disability hours credited for up to an additional 104 weeks if:

- For the 12-month period immediately before the date of your injury or illness, you were continuously covered under the Plan (not including COBRA continuation coverage); and
- You provide proof of continued payments from the Workers' Compensation insurance carrier.

Contested Workers' Compensation Claims

If you filed a claim for Workers' Compensation that has been denied, are not receiving any Workers' Compensation benefits from such claim and are appealing the denial with the applicable court or government agency (referred to in this document as "WCCGA"), you may be eligible to received reduced short-term disability benefits and long-term disability benefits until your claim is ultimately denied or awarded by the WCCGA.

In such cases, you would be eligible to receive 50% of the short-term disability payment for up to a maximum of 13 weeks and 50% of the long-term disability payment for up to an additional 104 weeks if:

- You submit your application for short-term disability benefits within 90 days of the later of: (1) the date you last worked contributed hours, or (2) the date of your injury or illness; and
- For short-term disability payments, you were covered under the Plan at the time of your injury or illness (not including COBRA continuation coverage); and
- For long-term disability payments, you were continuously covered

under the Plan for the 12-month period immediately preceding the date of your injury or illness (not including COBRA continuation coverage); and

- You execute a reimbursement agreement with the Trustees, which requires, upon receipt of any recovery whatsoever for your injury or illness from whatever source, you agree to reimburse any short-term disability payments, long-term disability payments and medical expenses paid by the Plan on account of the injury or illness, and you agree that no reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e., the Illinois Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by the Plan provisions under ERISA); and
- You provide proof of the denial by the Workers' Compensation insurance carrier, proof of the appeal to the WCCGA; and quarterly proof that you are unable to return to work; and
- Your Workers' Compensation claim is still pending before the WCCGA; and
- You satisfy all other requirements to qualify for short-term or long-term disability benefits, as appropriate, under the terms of the Plan.

During the time that your Workers' Compensation claim is contested and pending a final and non-appealable decision, you will be credited disability hours for coverage under the Plan, which will cover medical expenses for the injury or illness until a final and non-appealable decision is made as to whether your injury or illness is determined to be work-related.

If your claim is ultimately denied by the WCCGA, your claim will be converted to a short-term disability benefit and/or long-term disability benefit, as appropriate, and you will be paid the balance of disability benefits not previously paid to you.

If, however, you are awarded any Workers' Compensation benefits, regardless of classification, by any WCCGA, you must reimburse the Plan for the disability payments made and the medical expenses covered for treatment of the injury or illness, consistent with the terms of the reimbursement agreement.

If you fully reimburse the Plan for the disability and medical expense payments made on your behalf during the time your Workers' Compensation claim was contested, the period of short-term disability benefits paid to you during the time your Workers' Compensation claim was contested will not count towards one of your two periods of short-term disability benefits permitted within any rolling, or consecutive, 60-month period.

If you do not fully reimburse the Plan, amounts due to the Plan will be offset from any future benefit amounts otherwise payable to you by the Plan to the extent permitted by law, including suspension of health benefits. In the event health benefits are suspended, benefits will not be reinstated until you demonstrate that you have incurred future medical, dental and prescription drug expenses equal to the amount you owe to the Fund. The Trustees will base reimbursement on 80% of billed charges for proven medical expenses that would have otherwise been covered under the Plan. Any recoupment obtainable through a vision claim will be based on the applicable out-of-network reimbursement offered under our vision care provider. In addition, the period of short-term disability benefits paid to you will count toward one of your two periods of short-term disability benefits permitted within any rolling, or consecutive, 60-month period.

IMPORTANT INFORMATION

This Benefits Update is intended to serve as a Summary of Material Modifications for the Electrical Insurance Trustees Health & Welfare Plan for Communication Members (the "Plan"). If any conflicts exist between the terms of this Benefits Update and the official Plan document, the terms of the official Plan document will control. The Trustees reserve the right to amend, modify or terminate the Plan at any time. Receipt of this Benefits Update does not confer any eligibility or entitlement to any benefits under the Plan.

Electrical Insurance Trustees Health & Welfare Plan for Communication Members
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