TWIN CITY IRONWORKERS HEALTH AND WELFARE FUND
C/O Wilson McShane Corp
3001 Metro Drive
Bloomington, MN 55425
(952) 854-0795

SUMMARY OF MATERIAL MODIFICATION

June 23, 2016

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan changes effective September 1, 2016.

Elimination of Inpatient Out-of-Network Benefits

Effective for inpatient stays beginning on or after September 1, 2016, inpatient expenses incurred at facilities not participating in any Blue Cross and Blue Shield Association affiliate or Blue Card network of preferred providers will be excluded: therefore, the Plan will no longer include an inpatient out-of-network benefit. The plan continues to cover all Emergency Medical Conditions as defined below:

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to effect a safe transfer to another hospital before delivery, or
- That transfer might pose a threat to the health or safety of the woman or the unborn child.

If you or your dependent is admitted to a hospital or any other facility for any reason, be sure to confirm that the facility is a ***participating provider*** in the Blue Cross and Blue Shield network of providers. Please note that confirmation that a provider ***accepts*** Blue Cross and Blue Shield insurance does not necessarily mean that the provider is a Blue Cross and Blue Shield participating provider. A provider may accept payment from Blue Cross and Blue Shield without agreeing to the contracting and credentialing requirements to participate in the network. Inpatient services billed by such providers will not be covered by the Plan.

Examples of non-participating providers that provide inpatient services include Cancer Treatment Centers of America, Passages, and many other drug and alcohol treatment facilities. Whenever you or your dependent will receive treatment for which an overnight stay is anticipated, you should call the number on the back of your card (1-800-810-2583) for assistance with finding an in-network provider.

Grandfathered Status

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Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 952-854-0795.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions, please contact the Fund Office at 952-854-0795.

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SUMMARY OF MATERIAL MODIFICATION

August, 2016

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following addition to the Definitions Section of the Summary Plan Description, effectiveSeptember 1, 2016.

Dependent includes

- An unmarried child or dependent who is age 26 or older and who is incapable of self-sustaining employment due to his or her disability, provided"
    i. The child was a covered dependent on this Plan on December 31, 1993
    ii. The child is dependent on the Active Employee or Retiree for his or her support; and
    iii. Proof of the child's disability, from his or her physician, is furnished to the Fund Office no later than 31 days after the child reaches age 26. The Fund Office may request proof of continued disability once per year.

Grandfathered Status
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SUMMARY OF MATERIAL MODIFICATION

August 17, 2016

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan changes effective January 1, 2017.

Services related to Gender Identity and Gender Transition:

In accordance with Department of Health and Human Services rules, the Plan will not discriminate on the basis of race, color, national origin, sex (including gender identity), age or disability. The Plan's exclusion of services related to sex transformation and/or gender dysphoria is therefore eliminated.

Grandfathered Status

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SUMMARY OF MATERIAL MODIFICATION

November 2016

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following clarification to the Summary Plan Description.

The situations where a participant may opt out of coverage in the Twin City Ironworkers Health and Welfare Fund are as follows:

For Active or Retired Participants:

Opt Out for Participation in High Deductible Plan with Health Savings Arrangement

An eligible Spouse and/or Dependent(s) may opt out of this Plan on an annual basis if he or she participates in another plan with a Health Savings Arrangement. Exercising the right to this opt out does not change the hourly contribution rate for the participant and any Dependents who remain in this Plan. A Spouse or Dependent who opts out of this Plan may return to the Plan in the month immediately following termination of coverage in the Plan with the Health Savings Arrangement.

For Retired Participants:

Employer Sponsored Coverage

A retiree and his or her eligible Spouse and/or dependents may opt out if there is other employer sponsored coverage available, such as through a Spouse's employer.

Once you opt out of Plan coverage, you and your Spouse will have limited rights to re-enroll. In order to opt out, you must complete the Opt Out Application form and provide the Fund Office with the following documentation of the other health insurance at least 30 days prior to the effective date of the opt out:

- The effective date of the other coverage
- The names of those enrolled for the other coverage
- Any other documentation requested by the Fund Office.

You may re-enroll in the Plan if you provide documentation of any of the following qualifying events within 30 days of the event:

- If the other coverage is provided through your Spouse's employer and your Spouse loses coverage due to termination, retirement or a reduction in hours: or
- The cost to you of the other coverage increases by more than 50%; or
- If the other coverage is provided through your Spouse's plan and you lose coverage due to a divorce or legal separation.

Opt Out for Participation in a Federal or State Marketplace Plan

A retiree, or his or her covered Spouse and/or Dependents, may opt out of this Plan to participate in a health plan offered on either the federal or state marketplace ("the exchange"). Participants or Dependents who opt out of this Plan for marketplace coverage may return during the next year's marketplace open enrollment period (currently November 15 through February 15 of each year). The Participants or Dependents who opt out must be able to show proof of coverage during the opt-out period. If a Participant or Dependent opts out for more than four years, he or she may not return to this Plan until the time at which he or she attains Medicare eligibility.

Opt Out for Coverage Through the Veterans' Administration (VA)

If your Spouse has VA coverage, you may maintain Plan coverage for yourself and your Dependent children. If you and your Spouse have VA coverage and opt out of this Plan, you and your Spouse may only re-enroll upon attainment of Medicare eligibility. If you and your Spouse re-enroll in Plan coverage and then leave the Plan again, you and/or your Spouse will lose Plan coverage permanently.

Grandfathered Status

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Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 952-854-0795.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions, please contact the Fund Office at 952-854-0795.

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SUMMARY OF MATERIAL MODIFICATION

May 2017

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan change effective June 1, 2017.

Preventive Dental Cleanings and Examinations

Effective June 1, 2017, Type A Dental Benefits will include four oral examinations per calendar year, subject to the benefit maximum of $3,000 per two-year period. Oral examinations include the scaling and cleaning of teeth.

Grandfathered Status

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SUMMARY OF MATERIAL MODIFICATION

June 2017

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following clarification to the Summary Plan Description.

Tobacco Cessation Benefits:

Effective July 1, 2017, prescription and over-the-counter tobacco cessation drugs are covered with a doctor's prescription. Tobacco cessation drugs are provided pursuant to the Prime Therapeutics formulary and subject to the Plan's Prescription Drug Benefit copayment requirements provided in the Schedule of Benefits. Coverage is limited to a 168-day supply in a twelve-consecutive month period of treatment. Covered tobacco cessation drugs include generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system), brand Nicotrol NS (nasal spray) brand Chantix and generic Zyban

Freezing Retiree Dollar Bank

Effective July 1, 2017, a Retiree who wishes to exercise any of the Fund's Opt Out provisions, as described below, may freeze his or her Retiree Dollar Bank. The Dollar Bank Balance in effect upon opting out of coverage will remain for future use, contingent upon the Retiree adhering to the requirements for opting out and opting back into coverage under this Fund. Failure to adhere to these requirements will result in forfeiture of the Dollar Bank balance.

The Retiree may not access the Retiree Dollar Bank Balance for any reason while he or she is in Opt Out status.

The situations where a participant may opt out of coverage were clarified in a Summary of Material Modification dated November 2016 and are as follows:

Employer Sponsored Coverage

A retiree and his or her eligible Spouse and/or dependents may opt out if there is other employer sponsored coverage available, such as through a Spouse's employer.

Once you opt out of Plan coverage, you and your Spouse will have limited rights to re-enroll. In order to opt out, you must complete the Opt Out Application form and provide the Fund Office with the following documentation of the other health insurance at least 30 days prior to the effective date of the opt out:

- The effective date of the other coverage
- The names of those enrolled for the other coverage

- Any other documentation requested by the Fund Office.

You may re-enroll in the Plan if you provide documentation of any of the following qualifying events within 30 days of the event:

- If the other coverage is provided through your Spouse's employer and your Spouse loses coverage due to termination, retirement or a reduction in hours: or
- The cost to you of the other coverage increases by more than 50%; or
- If the other coverage is provided through your Spouse's plan and you lose coverage due to a divorce or legal separation.

Opt Out for Participation in a Federal or State Marketplace Plan

A retiree, or his or her covered Spouse and/or Dependents, may opt out of this Plan to participate in a health plan offered on either the federal or state marketplace ("the exchange"). Participants or Dependents who opt out of this Plan for marketplace coverage may return during the next year's marketplace open enrollment period (currently November 15 through February 15 of each year). The Participants or Dependents who opt out must be able to show proof of coverage during the opt-out period. If a Participant or Dependent opts out for more than four years, he or she may not return to this Plan until the time at which he or she attains Medicare eligibility.

Opt Out for Coverage Through the Veterans' Administration (VA)

If your Spouse has VA coverage, you may maintain Plan coverage for yourself and your Dependent children. If you and your Spouse have VA coverage and opt out of this Plan, you and your Spouse may only re-enroll upon attainment of Medicare eligibility. If you and your Spouse re-enroll in Plan coverage and then leave the Plan again, you and/or your Spouse will lose Plan coverage permanently.

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SUMMARY OF MATERIAL MODIFICATION

September 2017

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan change effective January 1, 2018. This change applies to participants in Active, Pre-Medicare Retiree and COBRA status.

Fitness Center Discount Program

Effective January 1, 2018 the Fund will participate in Blue Cross Blue Shield of Minnesota's fitness center discount program. Enrolled participants who use a covered fitness center will receive a credit of $20 per month for each month in which they use the fitness center twelve or more times. Up to two adults (aged 18 or older) per household may receive this benefit. You will be able to enroll once you receive your updated 2018 ID card.

Grandfathered Status

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SUMMARY OF MATERIAL MODIFICATION

February 2018

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan change effective May 1, 2018. This change applies to participants in Active, Pre-Medicare Retiree and COBRA status, as well as Medicare-Eligible retirees enrolled in the self-funded medical plan.

Hearing Aid Benefit

Effective May 1, 2018 the Hearing Aid Expense benefit will increase from $2,000 every five calendar years to $4,000 every five calendar years. The increased limit will apply only to claims incurred on or after May 1, 2018, and no more than $4,000 will be paid during your current five calendar year hearing aid benefit period.

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Twin City Iron Workers Fringe Funds

3001 Metro Drive – Suite 500
Bloomington, MN 55425

Wilson-McShane Corporation
Fund Administrators

Telephone: (952) 854-0795
Fax: (952) 854-1632
Toll Free: (800) 535-6373

TWIN CITY IRON WORKERS HEALTH AND WELFARE PLAN

IMPORTANT NOTICE

To: Plan Participants

From: Board of Trustees

Date: May 15, 2018

Re: Written Notice of Benefit Determations and Appeal Procedures for Denied Medical and Disability Benefit Claims.

Effective April 1, 2018, the Plan has made changes to it's procedures with regard to providing you (1) Written Notice of Benefit Determinations, and (2) Addressing claim appeals for medical and disability benefits. The changes are outlined below.

Notice of Benefit Determination

The Claims Administrator will provide you with a written decision on the claim. If the claim is approved, you will receive a written notice of the approval. If the claim is denied in whole or in part, the written denial will include the following information:

- Inform you of the specific reasons your claim was denied;
- Reference the specific Plan provision(s) on which the determination was based;
- Describe any additional material or information for you complete the claim and an explanation of why the material or information is necessary;
- Describe the Plan's review procedures and the time limits for these procedures (which are also stated below), plus include a statement concerning your rights under federal law if your claim is denied;
- If an internal rule was relied upon by the Plan in making the decision, either a description of the rule or a notice that you can request a copy of the rule from the Plan;
- If the claim decision was based on a medical necessity or experimental treatment exclusion, either an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided to you upon your request; and
- If the claim is an urgent care claim, a description of the review process applicable to urgent claims (which is also discussed above).

- If the claim is a disability claim, a description of the review process applicable to disability claims and a discussion of the decision including an explanation, if applicable, of the basis for disagreeing with or not following:

    - The views presented by your health care and vocational professionals;

    - The views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and

    - Your disability determination from the Social Security Administration.

Appeal of a Denied Claim

If all or part of your claim is denied after the Plan has received all necessary claim information, you have the right to appeal the decision and request a review of the claim. The procedures for appealing a claim decision are:

- Compose a claim appeal which explains why you believe your claim should be reviewed.

- Attach any additional information you think will help a favorable decision to be made on your claim.

- Return your completed appeal, along with any additional information you are submitting, to the Claims Administrator:

    Wilson-McShane Corporation
    3001 Metro Drive, Suite 500
    Bloomington, MN 55425

Your claim appeal must be filed in writing at the Claims Administrators office within 180 days of the date the claim denial was mailed to you.

When appealing a claim, you have certain rights under federal law. These include:

- You will have the opportunity to submit written comments, documents, records and other information relating to the claim.

- You will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

- The review by the Plan will take into account all comments, documents, records, and other information submitted by you related to your claim, whether or not the information was submitted or considered in the initial benefit determination.

- If your appeal is for disability benefits, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim and further, will provide you with such rational as soon as possible and sufficiently in advance of the date of review of the denial by the Plan so as to give you a reasonable opportunity to respond prior to that date.

Applicable Time Frames for Deciding Claim Appeals

- *Urgent* Care *Claims* - If your appeal is for an urgent care claim (defined above), the Plan will review your appeal and notify you of its decision with 72 hours of the time you file the appeal with the Plan.

- *Preauthorization (Pre-Service) Claims* - If your appeal is for a denial of a claim requiring preauthorization, the Plan will notify you of its decision on appeal within 30 days of the Plan's receipt of your appeal.

- *All Other Claims* - For all other claims, the Board of Trustees will review your appeal at its next regularly scheduled meeting; however, if your appeal was received by the Plan within 30 days of the Board of Trustees meeting, the your appeal will be reviewed at the Board's second regularly scheduled meeting following the Plan's receipt of your claim appeal. If special circumstances require, such as the need to hold a hearing, the review of your appeal may be delayed until the Board's third meeting following your request for an appeal. If this extension is required, the Plan will notify you of the extension and of the special circumstances requiring the extension.

After a decision is made concerning your appeal, you will be notified of the decision by the Plan within 5 days of the decision being made.

Notice of Decision on Appeal

The decision on any appeal of your claim will be provided to you in writing. The notice of a denial of a claim on appeal will state:

- The specific reason(s) for the determination.

- Reference to the specific Fund provision(s) on which the determination is based.

- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline, or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on Medical Necessity, or because the treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

If the decision involved disability benefits, you will receive a written explanation providing for the basis for disagreeing with or not following (1) the views presented by your health care and vocational professionals; (2) the views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and (3) your disability determination from the Social Security Administration.

GRANDFATHERED STATUS

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Clarification of Plan Benefits

August 2018

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following clarification to the Plan. This clarification applies to participants in Active, Pre-Medicare Retiree and COBRA status, as well as Medicare-Eligible retirees enrolled in the self-funded medical plan.

Private Duty Nursing (PDN)

PDN is defined as – *Extended hours of skilled nursing care provided in a participant's home which is more complex and skilled care than can be provided by a Home Health Care Agency.*

The extended hours of skilled nursing must help to assist the participant with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize the participant's health status and outcomes. The nursing tasks must be required so frequently that the need is continuous. The duration of extended hours of skilled nursing services is temporary in nature and is not intended to be provided on a permanent basis.

PDN is covered without any days limit under the following conditions:

- Participant has skilled nursing needs and the participant's condition is unstable requiring frequent nursing assessments and changes in the plan of care;
- Placement of the nurse is done to meet the skilled nursing needs of the participant only and not for the convenience of the family; and
- PDN Care must be approved by the participant's treating physician, with a written treatment plan that includes long and short term goals.

Grandfathered Status

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TWIN CITY IRON WORKERS HEALTH AND WELFARE PLAN

IMPORTANT NOTICE

To: Plan Participants

From: Board of Trustees

Date: January 2019

Re: Written Notice of Benefit Determations and Appeal Procedures for Denied Medical and Disability Benefit Claims.

Effective January 1,,2019, the Plan has been clarified to note that there is (and always has been) an applicable exclusion under which the Plan will deny payment for future medical charges that are related to an event for which a participant or beneficiary has received a settlement from Workers' Compensation coverage or from any other third party.

The Following provisions are added as Exclusion 37 on Page 54 of the 2016 Supmmary Plan Description:

37. Any loss, expense or charge incurred as a result of any injury, occurrence, condition or circumstance for which the injured Family Member or individual:

    a. Has the right to recover payment from a third party. At the discretion of the Trustees, losses, expenses and charges excluded by this General Exclusion may be paid subject to the Fund's right of subrogation and reimbursement;

    b. Has recovered from a third party; or

    c. Has not submitted a claim for such loss, expense or charge prior to resolution of the third-party claim.

    This exclusion applies to any recovery received by a Family Member or individual regardless of how it is characterized, including, but not limited to, any apportionment to a Spouse for loss of consortium.

    The term "third party" as used in this section includes any individual, insurer, entity, or federal, state or local government agency, who is or may be in any way legally obligated to reimburse, compensate or pay for an individual's losses, damages, injuries or claims relating in any way to the injury, sickness, occurrence, condition or circumstance for which the Fund has paid medical, dental or disability benefits. This includes but is not limited to insurers providing liability, medical expense, wage loss, no-fault, uninsured motorist, underinsured motorist and workers'compensation coverage.

GRANDFATHERED STATUS

The Twin City Iron Workers Health and Welfare Plan believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, 952-854-0795. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

TWIN CITY IRONWORKERS HEALTH AND WELFARE FUND
C/O Wilson McShane Corp
3001 Metro Drive
Bloomington, MN 55425
(952) 854-0795

SUMMARY OF MATERIAL MODIFICATION

September 2019

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan change effective January 1, 2020.

Deductible for Dental Benefits

Effective January 1, 2020, the deductible for Dental Benefits will change from $50 every calendar year to $70 every two calendar years, beginning on January 1, 2020 and all subsequent even calendar years. The deductible is applicable to Type B, C, and D Dental Services.

For example, if you go to the dentist and fulfill your $70 deductible in March 2020, that satisfies your dental deductible for the period January 1, 2020 to December 31, 2021. You will not have to satisfy a dental deductible until the period resets on January 1, 2022.

Grandfathered Status

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SUMMARY OF MATERIAL MODIFICATION

November 2019

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan change effective January 1, 2020.

Elimination of Limit on Tobacco Cessation Coverage

The 168-day limit on tobacco cessation products covered by the Plan has been removed.

Elimination of Fitness Discount

The administrator of the fitness discount program, Blue Cross Blue Shield, has decided to stop offering the program. Therefore, the fitness discount program (which provided a $20 reimbursement for fitness center membership fees to those that met certain requirements) will be discontinued at the end of 2019.

Grandfathered Status

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TWIN CITY IRONWORKERS HEALTH AND WELFARE FUND

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SUMMARY OF MATERIAL MODIFICATION

March 2020

The Trustees of the Twin City Ironworkers Health and Welfare Fund announce the following plan change.

Initial Eligibility -

Effective April 1, 2020, the Eligibility Period for Initial Eligibility has been extended from any three-consecutive-month period to **any six-consecutive-month period**.

For example, hours contributed for the six-month period beginning September 1, 2019 and ending February 29, 2020 will be considered for April 1, 2020 initial eligibility.

Please note: the extended Eligibility Period for Initial Eligibility described above does not apply to Continuing Eligibility.

Gene Therapy Coverage –

(Applies to participants in Active, Pre-Medicare Retiree and COBRA status, as well as Medicare-Eligible retirees enrolled in the self-funded medical plan – Does not apply to Senior Gold Medicare Retirees)

Effective January 1, 2020, the Plan will cover the costs associated with gene therapy performed by an in-network provider where the therapy has been approved by the U.S. Food and Drug Administration (FDA) and the Plan's medical management service provider has determined that the therapy is medically necessary. This coverage will be provided under the Plan's medical benefit and the Plan's deductible and coinsurance provisions will apply.

Gene therapy typically involves 1) replacing a gene that causes a medical problem with one that does not; 2) adding genes to help the body fight or treat disease; or 3) turning off genes that cause medical problems. Examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) therapies, such as Kymriah and Yescarta, and other therapies like Luxturna and Zolgensma. Coverage will not be provided for gene therapy that is considered experimental or investigational by the Plan.

Grandfathered Status

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health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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If you have any questions, please contact the Fund Office at 952-854-0795.

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SUMMARY OF MATERIAL MODIFICATION

March 2020

The Trustees of the Twin City Ironworkers Health and Welfare Fund ("Fund") announce the following plan change.

(Applies to participants in Active, Pre-Medicare Retiree and COBRA status, as well as Medicare-Eligible retirees enrolled in the self-funded medical plan – Does not apply to Senior Gold Medicare Retirees)

Doctor on Demand Coverage –

Effective March 1, 2020, a new, convenient way for you and your covered dependents to access care through virtual appointments with a doctor (medical, psychologist, or psychiatrist) is available. The online service, accessed through a computer, tablet or smartphone, is provided in partnership with Blue Cross and Blue Shield of Minnesota and is called **Doctor on Demand**. Please read this letter to learn more about this service.

If you or a dependent is under the weather, getting a private, secure and convenient online medical visit through Doctor on Demand is a great option. Taking advantage of this benefit is especially helpful when you are away from home or your doctor is unavailable. Doctor on Demand doctors can answer medical questions, make a diagnosis and even prescribe medication for you in some instances, if needed. They can help with minor injuries and common medical ailments like colds, flu symptoms, fevers, allergies, infections, headaches, sore throats, minor rashes and earaches. Doctor on Demand also provides support for mental health through appointments with psychologists and psychiatrists.

The Plan covers 100% of the cost each time you visit a doctor through Doctor on Demand. The deductible will <u>not</u> apply to Doctor on Demand visits.

You can save time and get the care you need without having to schedule a doctor's appointment or be exposed to other sick people while sitting in a doctor's waiting room. It is also faster and cheaper than going to an emergency room or urgent care facility. To learn more, please visit DoctorOnDemand.com/bluecrossmn.

If you have any questions, please contact the Fund Office at 952-854-0795.

Grandfathered Status

The Twin City Ironworkers Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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March 2020

A Message From The Trustees

The spread of COVID-19 is having an unprecedented effect on our society. In this time of turmoil, healthcare is critical. Be assured that we are monitoring all relevant matters as closely as possible and working to develop and implement thoughtful and responsible policies on behalf of the Plan and its participants and beneficiaries.

In response to the spread of COVID-19, Congress recently passed the Families First Coronavirus Response Act ("FFCRA"). As described in further detail below, this law provides for coverage of COVID-19 testing and related services. The FFCRA also creates a number of programs to aid those that are economically-impacted by COVID-19. For more information about the law, visit www.congress.gov/bill/116th-congress/house-bill/6201.

We have amended the Plan in accordance with the FFCRA. We will continue to monitor the situation. If circumstances warrant, we will further amend the Plan. You will be notified promptly of any additional amendments to the Plan.

In addition, coverage of telehealth and virtual visit consultations has been temporarily approved through September 30, 2020.

SUMMARY OF MATERIAL MODIFICATION

(Applies to participants in Active, Pre-Medicare Retiree and COBRA status, as well as Medicare-Eligible retirees enrolled in the self-funded medical plan – Does not apply to Senior Gold Medicare Retirees)

COVID-19 Testing –

The Summary Plan Description and Plan Document (SPD) of the Twin City Ironworkers Health and Welfare Fund was amended by the Trustees to comply with FFCRA. This amendment becomes effective on March 18, 2020. It will automatically cease to be effective on the date that the Federal Government declares an end to the current national emergency. The modifications contained in the amendment are as follows:

- The Plan will cover 100% of the cost:
    - For in vitro diagnostic testing for the COVID-19 virus that is either:
        - authorized by the FDA, or
        - otherwise specifically authorized by federal law or regulation.

      A covered test is referred to herein as a "COVID-19 Test";

- For evaluation by a healthcare provider to determine whether you need a COVID-19 test; and,
- For services to administer a COVID-19 test.

- At this time, there are a limited number of authorized diagnostic tests for the COVID-19 virus. Tests that are not authorized may not provide reliable results. Before you are tested for COVID-19, be sure to confirm with your healthcare provider that the recommended test is authorized. If you receive a test that is not authorized, this amendment will not apply to the test and it may not be covered. You can find a list of FDA-authorized COVID-19 tests at www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations.
- Coverage for this amendment provides applies without regard to whether a COVID-19 test is provided in-network or out-of-network. For out-of-network charges, the Plan will cover the full billed amount regardless of whether the amount exceeds the reasonable and customary amount. No prior authorization or medical management requirements apply to in vitro diagnostic testing for the COVID-19 virus. Coverage under this amendment applies without regard to the site of care (e.g., office, urgent care, emergency room, e-visits). The coverage under this amendment does not apply to any items and services you receive during a visit to a healthcare provider other than those expressly described above.

Telehealth & Virtual Consultations –

As a result of the current spread of COVID-19, many primary care providers are encouraging patients to seek consultations over-the-phone or via other virtual means to avoid having patients come into the office unless necessary. For that reason, the Plan has been amended to cover phone or other virtual visits.

During the time period March 1, 2020 through September 30, 2020, telehealth visits, regardless of vendor, and medical consultations conducted telephonically, via video-conference, or other virtual means shall be covered the same as though the visit was conducted in an office.

As a reminder, effective March 1, 2020, the Plan also covers telehealth services through Doctor on Demand free of charge and participants are encouraged to use these services.

- Doctor on Demand: Covered at 100%
- Out-of-Network Telehealth provider (any provider other than Doctor on Demand): subject to applicable deductible and coinsurance
- In-Network Phone consultation: subject to applicable deductible and coinsurance
- Out-of-Network Phone consultation: subject to applicable deductible and coinsurance

If you have any questions, please contact the Fund Office at 952-854-0795.

Grandfathered Status

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August 2020

SUMMARY OF MATERIAL MODIFICATION

(Applies to participants in Active, Pre-Medicare Retiree and COBRA status, as well as Medicare-Eligible retirees enrolled in the self-funded medical plan – Does not apply to Senior Gold Medicare Retirees)

Telehealth & Virtual Consultations –

You were previously notified that during the time period March 1, 2020 through September 30, 2020, the Health Plan will cover 100% of the cost of telehealth visits, regardless of provider, to make safe and convenient care as accessible as possible in an unprecedented environment of a highly contagious disease, general caution of personal visits to doctors' offices, and increased volume to providers.

Effective October 1, 2020, telehealth visits and medical consultations conducted telephonically, via video-conference, or other virtual means shall be covered the same as though the visit was conducted in an office. **As a reminder, the Plan covers telehealth services through Doctor on Demand free of charge and participants are encouraged to utilize this service.**

- Doctor on Demand: Covered at 100%
- Out-of-Network Telehealth provider (any provider other than Doctor on Demand): subject to applicable deductible and coinsurance
- In-Network Phone consultation: subject to applicable deductible and coinsurance
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February 2021

SUMMARY OF MATERIAL MODIFICATION

(Applies to participants in Active, Pre-Medicare Retiree and COBRA status, as well as Medicare-Eligible retirees enrolled in the self-funded medical plan)

COVID-19 Vaccines –

The Summary Plan Description and Plan Document (SPD) of the Twin City Ironworkers Health and Welfare Fund has been amended by the Trustees.

Effective December 11, 2020, FDA-approved COVID-19 vaccines will be covered at 100% of the allowable cost with no out-of-pocket cost and no deductible regardless of where the vaccine is administered.

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