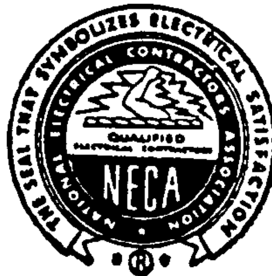
SUMMARY PLAN DESCRIPTION
OF THE
HEALTH & WELFARE FUND IBEW LOCAL 96

As Amended through December 2017



HEALTH & WELFARE FUND IBEW LOCAL 96

10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Telephone (800) 446-8646

BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
Thomas Maloney	Matthew L. Ostrow
George Carpenter	Susan C. Mailman (as of January 2018)
Brian Clarke	Kevin J. Menard

LEGAL COUNSEL

Segal Roitman, LLP

FUND AUDITOR

Buckley, Frame, Boudreau & Co., P.C.

CONSULTANTS AND ACTUARIES

Sibson Consulting
(formerly Touchstone Consulting)

CONTRACT ADMINISTRATOR

Zenith American Solutions
(formerly Insurance Programmers, Inc.)

Health & Welfare Fund IBEW Local 96
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Telephone (800) 446-8646

To All Participants:

The Health & Welfare Fund IBEW Local 96 group insurance plan ("Plan") was originally effective January 1, 1955, and has been modified many times since then. This December 2017 Summary Plan Description supersedes and replaces all previous versions of the Plan Description and Summary Plan Description issued by the Plan, and is the governing Plan document, along with the applicable insurance subscriber certificates.

The Plan is financed through contributions made by Contributing Employers under the terms of IBEW Local No. 96 collective bargaining agreements and participation agreements. At certain times persons covered by the Plan may also contribute to the cost of coverage under the Plan.

The Health & Welfare Fund IBEW Local 96 is administered by a Board of Trustees whose members are designated in equal numbers by IBEW Local No. 96 and the employers through The National Electrical Contractors Association. The Board of Trustees is the fiduciary of the Plan, and has the right and discretion to amend or terminate the plan of benefits at any time subject to applicable insurance contract provisions and applicable law.

Questions regarding the Plan and this SPD can be directed to the plan administrator through Zenith American Solutions, 10 Technology Drive, P.O. Box 5817, Wallingford, CT 06492, Telephone (800) 446-8646.

A general description of the principal features of the Plan is found on the following pages.

Very truly yours,

Board of Trustees
Health & Welfare Fund IBEW Local 96

IMPORTANT TO REMEMBER

Please save this Summary Plan Description Booklet ("PLAN DESCRIPTION"). Put it in a safe place.

Tell your family, particularly your spouse, about this PLAN DESCRIPTION and where you keep it filed.

If you lose your copy, you should ask the Fund Office for another PLAN DESCRIPTION.

If you have worked in employment covered by the Health & Welfare Fund IBEW Local 96 and you are leaving that Covered Employment, you should call the Fund Office to ask whether your coverage will be continued.

It is **YOUR** responsibility to notify the principal office of the Health & Welfare Fund IBEW Local 96 of any changes in your mailing address in order to avoid any delay in receiving information.

Additionally, when you are employed outside of IBEW Local No. 96's jurisdiction - even if it is for a Local 96 contractor - it is **YOUR** responsibility to take the actions necessary for the other local union to reciprocate your contributions to the Health & Welfare Fund IBEW Local 96 (your "Home Fund") using the Electronic Reciprocity Transfer System (ERTS).

The Trustees have engaged a contract administrator to administer the benefits provided by the Fund. The Contract Administrator is:

Zenith American Solutions
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Telephone (800) 446-8646
Fax (203) 679-4258

The Contract Administrator administers the Fund Office at the above address.

FUND OFFICE

The Fund Office receives employer and Participant contributions, keeps eligibility records, coordinates processing and/or payment of certain claims, pays premiums, and provides information about the Plan.

The Fund Office is located at:

Zenith American Solutions
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Telephone: (800) 446-8646
Fax: (203) 679-4258

The Plan Administrator is, collectively, the Board of Trustees. The Board of Trustees can be contacted at the following address:

Board of Trustees
Health & Welfare Fund IBEW 96
c/o Zenith American Solutions
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Telephone (800) 446-8646
Fax (203) 679-4258

ADDITIONAL IMPORTANT INFORMATION

The Board of Trustees of the Health & Welfare Fund IBEW Local 96, acting as a body, and only the Board of Trustees, has full authority and discretion to interpret and construe the terms of the Plan and the Trust, as well as any other documents or policies established by the Board of Trustees, including ambiguous and disputed terms and meanings, and such things as provisions establishing eligibility for benefits, the manner in which hours of work are credited for eligibility, the continuance or discontinuance of benefits, the status of any person as a covered or non-covered Participant or dependent, and the level and type of benefits, as well as all other matters. Any determination made by the Board of Trustees with respect to your rights or benefits will be entitled to the maximum deference permitted by law and will be conclusive upon all Participants, eligible dependents, covered persons, or others having an interest in the matter. The Board of Trustees, acting as a body, and only the Board of Trustees, has the right to amend, suspend, modify or terminate the Plan of Benefits in whole or in part at any time, subject to the applicable provisions of any insurance policy in effect or applicable law.

No local union, local union officer, business agent, local union employee, employer or employer representative, association or association representative, individual trustee, Fund administrative office personnel, contract administrator, consultant, attorney or any other person is authorized to speak for, or on behalf of this Fund, or to commit or to legally bind the Board of Trustees of this Fund in any matter whatsoever relating to the Fund, unless such person shall have been given express written authority from the Board of Trustees to act in such matter. All Participants are warned not to rely upon any opinion or interpretation expressed by any such individual without express authority to act on behalf of the Board of Trustees. All inquiries and requests for rulings, interpretations and decisions must be directed in writing to the full Board of Trustees in care of the Fund Office.

No benefits or rules described in this PLAN DESCRIPTION are guaranteed (vested) for any Participant, retiree, spouse or dependent. All benefits, including but not limited to retiree benefits, and rules may be changed, reduced or eliminated at any time by the Board of Trustees, at its discretion.

In reading this document, please remember that whenever a pronoun or other word describes a masculine person, the word also includes a feminine person, unless the context clearly indicates otherwise. In addition, the words used in the singular person also include plural persons, unless the context clearly indicates otherwise. The term "you" refers solely to the individual Participant.

DEFINITIONS

Accumulation Period (for Credited Hours)

Accumulation Period means each calendar six-month period (that is, January 1 through June 30, or July 1 through December 31). The Accumulation Period determines eligibility for each Insurance Period for Coverage.

Authorized Representative

Authorized Representative means the individual who has been designated by a Claimant to receive information from the Plan with respect to any claim for benefits that entails notification of the Plan's action on a claim as set forth in Section 9 of this PLAN DESCRIPTION. An Authorized Representative shall be named by the Claimant by filing a written designation to that effect with the Fund Office, except that in a situation involving urgent care, the designation may be made orally and a health care professional with knowledge of the Claimant's medical condition shall be recognized as the Claimant's Authorized Representative.

Banked Surplus Hours

During each Accumulation Period any hours worked by the Participant for a Contributing Employer that are in excess of 800 hours are credited to the Participant's Banked Surplus Hours. Non-collectively bargained Participants are not eligible to accumulate Banked Surplus Hours after leaving Covered Employment. However, hours already accumulated may be retained by a non-collectively bargained Participant.

NOTE: See Section 1(G) (Eligibility) for information on the maximum number of hours that may be banked and see Sections 1(Q) and 1(R) regarding the impact of Competing Service and/or Unavailability to Work on banked hours.

Beneficiary

The person named by the Participant to receive the life insurance death benefit.

NOTE: If the Participant does not name a Beneficiary, or if the named Beneficiary is no longer living at the time of the Participant's death, the life insurance death benefit is paid to either the Participant's estate or the Participant's relatives, based on the insurance company's selection.

Claimant

Claimant means any Participant or eligible dependent of a Participant who has filed a claim for benefits under the Plan. A claimant also includes a Beneficiary of a Participant for any Life Insurance or Accidental Death & Dismemberment benefits.

Claims Reviewer(s)

Claims Reviewer means the person or entity designated to review claims under Section 9 of this PLAN DESCRIPTION. The Claims Reviewer for most medical claims is presently Tufts Health Plan for the Tufts HMO Choice Copay Plan and the Tufts Health Plan Advantage PPO Plan. This insurer is the named fiduciary of the Plan for purposes of medical claim appeals for the Tufts HMO and PPO Plans. The Claims Reviewer for the Medicare Supplement Plans is the selected Medicare Supplement Provider. The Claims Reviewer for short-term temporary disability income benefits and most vision, temporomandibular joint dysfunction (TMJ), and hearing aid claims is presently Zenith American Solutions.

The Claims Reviewer for dental and orthodontic claims is Delta Dental of Massachusetts. The Claims Reviewer for life insurance claims and for accidental death and dismemberment (AD&D) benefits is presently Aetna. Aetna is also the named fiduciary of the Plan for purposes of life insurance and AD&D claim appeals.

Contributing Employer

All employers signatory to an IBEW Local No. 96 collective bargaining agreement or a participation agreement requiring contributions or periodic payments to the Fund.

Covered Employment

Covered Employment means employment, including self-employment, with an employer, business or entity that is signatory to a collective bargaining agreement with IBEW Local No. 96, a participation agreement or a reciprocating IBEW local.

Credited Hours

Credited Hours are the actual number of hours worked, including hours worked or credited and received under a reciprocal agreement, during each Accumulation Period by the Participant for a Contributing Employer who shall, as required, report those hours monthly to the Fund Office to be credited to the Participant's record.

ERISA

ERISA means the Employee Retirement Income Security Act of 1974, as amended, which is the federal law governing this Plan.

Fund

The Fund is the Health & Welfare Fund IBEW Local 96, the entity established by the Declaration of Trust which holds the assets to support the Plan and is controlled by the Board of Trustees.

Insurance Period for Coverage

Insurance Period for Coverage means each calendar six-month period (that is, January 1 – June 30, July 1 – December 31). Eligibility to maintain coverage each insurance period is determined by the hours worked during each Accumulation Period.

NOTE: The hours recorded for each six-month Accumulation Period are used to provide the Participant's coverage for the next six-month Insurance Period for Coverage. Thus, for example, the hours recorded for the January 1 – June 30 Accumulation Period are used to provide coverage for the subsequent July 1 – December 31 Insurance Period for Coverage.

Participant

Any employee or former employee of a Contributing Employer who satisfies the eligibility requirements in Section 1 of this Summary PLAN DESCRIPTION, and his or her eligible dependents.

Plan

The benefits of the Health & Welfare Fund IBEW Local 96, as designated herein.

Plan Year

The Plan Year is the consecutive 12-month period beginning on each January 1 and ending on the following December 31.

Providers

Tufts Health Plan (HMO Choice Copay Plan and Advantage PPO Plan) for active participants, and Blue Cross Blue Shield of Massachusetts for retirees over age 65 who elect the Medicare Supplemental Plan.

Reasonable and Customary

The charges incurred for the services, treatment, and supplies that are medically necessary, to the extent that such charges are within the median range of charges made by physicians of similar training and experience for the same services, treatment, and supplies. The determination of whether a charge meets these requirements shall take the following factors into consideration: (a) fees and prices charged; (b) treatment rendered; (c) therapeutic practice followed; (d) supplies furnished according to the usual practice of physicians; (e) locality where the treatment is rendered.

Trustees or Board of Trustees

The Board of Trustees is responsible for the administration of this Fund and its Plan of Benefits.

Urgent Care Claims

Urgent Care Claim(s) means any claim for medical care or treatment (including dental care) with respect to which the application of time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or (ii) in the opinion of a physician with knowledge of the Claimant's medical condition would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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1. ELIGIBILITY

A. How Do I Become Eligible for Coverage?

To be initially covered, you must be credited with 300 hours contributed to the Fund by any Contributing Employer within the previous six months (or less). Your coverage will become effective on the first day of the month immediately following the month in which you accumulated 300 hours.[1] For example, if you have accumulated 300 hours on January 25, 2017, you will become initially eligible for coverage effective February 1, 2017.

B. How Do I Enroll in a Medical Plan Sponsored by the Medical Provider?

When you become eligible for health coverage available through the medical Provider, the Fund Office will send you a package of information containing summaries of the health benefits and applications for coverage. Completed applications should be sent to the Fund Office. Do NOT send a completed application form to the Provider.

C. Can I Waive Medical Insurance if I Have Medical Coverage Through My Spouse's Medical Plan?

Yes, if you are an active Participant (and not a retiree), you can waive medical coverage offered through the medical Provider for an annual period during which you are eligible for coverage, provided that you complete an application and Waiver of Medical Coverage Form to certify that you have other medical coverage such as through your spouse's medical plan. You will need to provide proof of your other coverage to the Fund Office as part of the application process. If you choose to waive medical coverage offered through the medical Provider, you will remain eligible for the Plan's dental, orthodontic, temporomandibular joint dysfunction (TMJ), vision, hearing aid, short-term temporary disability income, life insurance and accidental death and dismemberment benefits. [Only you as the Participant will be eligible for this credit. You will not receive the credit if your spouse opts out of the medical coverage. Additionally, if you opt-out of dental and vision coverage only, you will not be eligible for the credit.]

Participants who complete the application and waive medical coverage offered through the medical Provider will be entitled to receive up to $2,500 per calendar 12-month period for the reimbursement of eligible out-of-pocket medical, dental, and/or vision and hearing aid expenses, as long as they maintain eligibility by accruing the required hours under Covered Employment in a six-month time period.

Eligible expenses are expenses that are not covered by your spouse's medical plan, and that would be considered eligible deductions on your federal income tax return. Eligible expenses, which may be incurred by you or your eligible dependents include, but are not limited to:

[1] Reciprocity hours will only be credited when contributions are received by the Fund.

- Deductibles
- Coinsurance
- Co-payments
- Prescription drugs
- Dental expenses
- Eyeglasses
- Contact lenses and lens solution

In order to be eligible for reimbursement, you must submit appropriate documentation, such as receipts, to the Fund Office. If you waive medical coverage, 50 of your Banked Surplus Hours will be deducted for each six-month Accumulation Period during which you do not have any active hours.

D. If I Do Not Return a Completed Provider's Enrollment/Disenrollment Form to the Fund Office, Will This Affect My Entitlement to the Other Benefits Provided to Participants?

Regardless of whether you return the Provider's enrollment/disenrollment form to the Fund Office, you will be entitled to benefits offered by the Plan on a self-insured basis, as long as you meet the eligibility rules described in 1(A) above. These benefits for which you will be eligible include dental, orthodontic, temporomandibular joint dysfunction (TMJ), vision, hearing aid, and short-term temporary disability income benefits. However, if you do not enroll, you will not be eligible for benefits offered by either the Tufts HMO or PPO Plan. Benefits are described in Section 3 of this Summary PLAN DESCRIPTION. The Fund Office will deduct 50 hours from your Hour Bank for these self-insured benefits. You will not, however, be eligible for the $2,500 "opt out" benefit if you do not waive medical insurance and certify that you have other coverage such as through your spouse.

E. How Do I Maintain My Coverage?

Your eligibility to maintain coverage after you initially become eligible is determined each Accumulation Period, which consists of a calendar six-month period.

For example, you must work at least 600 hours during the six-month period of January through June in order to maintain your coverage for the next six-month period of July through December. [2]

You must also work at least 600 hours during the six-month period of July through December in order to maintain your coverage for the next six-month period of January through June.

F. What If I Work More than 600 Hours But Less Than 801 Hours During an

[2] Reciprocity hours will only be credited when contributions are received by the Fund.

Accumulation Period?

If you work more than 600 but less than 801 hours in an Accumulation Period (January 1 through June 30 or July 1 through December 31), the additional hours will not be added to your Banked Surplus Hours or hour bank. However, if you work more than 800 hours in an Accumulation Period, any and all hours credited in excess of 800 will be added to your Banked Surplus Hours, up to the maximum specified below in I(G).

NOTE: See I(Q) and I(R) below regarding the impact of work in Competing Service or Unavailability for Work on your Banked Surplus Hours.

G. What Is the Maximum Number of Hours I May Have in My Hour Bank?

If you are under the age of 55, the maximum Banked Surplus Hours you may accumulate in your hour bank is 1,800 hours.

If you were under the age of 55 on July 1, 2004, however, and had more than 1,800 Banked Surplus Hours in your hour bank on that date, you will be able to use all hours contained in your hour bank until they run out. Once hours in the bank fall below 1,800, your Banked Surplus Hours cannot again exceed 1,800.

When you reach age 55, the maximum number of Banked Surplus Hours you may accumulate increases to 3,000.

NOTE: See I(Q) and I(R) below regarding the impact of work in Competing Service or Unavailability for Work on your Banked Surplus Hours.

H. What If I Work Less than 600 Hours During an Accumulation Period?

If you work less than 600 hours during any Accumulation Period, the hours needed to equal 600 will be withdrawn from your Banked Surplus Hours to maintain your eligibility for coverage.

I. What Happens If I Have More than One Hour in My Banked Surplus Hours But Work Less Than 600 Hours in the Accumulation Period, and I Am Not Eligible to Retire Under Our Pension Fund?

If you have more than one hour but less than 600 hours in your Banked Surplus Hours, and you work less than 600 hours in the Accumulation Period, so that the total combined number of worked hours and Banked Surplus Hours totals less than 600, you will receive a notice from the Fund office informing you that you may "buy-in" hours up to the required 600 hours at the contribution rate then in force to continue your medical coverage and life insurance benefits only. Alternatively, the Fund Office may convert your Banked Surplus Hours to dollars based on the contribution rate then in force, and apply the dollar value of those hours against the monthly Provider premium. You will be

billed 100% of the premium charged the Fund by Tufts Health Plan, less the dollar value of any hours banked or worked. Note that your Banked Surplus Hours were valued in October 2017 at $9.16 per hour; the rate changes periodically pursuant to the collective bargaining agreement. (This provision pertains to active Participants, retirees, and surviving spouses.) If you do not respond to the buy-in notice, you will be offered COBRA continuation coverage for a maximum of 18 months. See Section 12 for details about COBRA coverage.

J. What If I Do Not Want to Pay or Have My Hours Converted to Continue My Coverage?

Your coverage will be terminated as of the first day of the month after you fail to maintain coverage by working 600 hours during an Accumulation Period or by buying-in or converting hours to continue coverage (as described in the immediately preceding answer to Question I), and you will be given the opportunity to elect COBRA continuation coverage (see section 12 - COBRA coverage).

K. How Can I Have My Coverage Reinstated?

If your coverage is terminated, you will have to re-establish your eligibility by working the required number of hours (300) in Covered Employment under the terms of the applicable IBEW Local No. 96 collective bargaining agreement or under the terms of a reciprocity agreement of another IBEW construction local union. Your coverage will be reestablished or reinstated on the first day of the month immediately following the month in which you accumulated 300 hours.[3]

L. When I Retire Under the Pension Fund IBEW 96, What Happens to My Coverage?

If you have retired under the Pension Fund IBEW 96 and have Banked Surplus Hours, those hours will be used to maintain your eligibility for coverage.

When your Banked Surplus Hours are depleted, you will be given the opportunity to pay your premiums directly to our Health & Welfare Fund to maintain your coverage.

The cost of your direct self-payment premiums will be determined based on the actual premiums charged by the Providers and any credit you may have for hours. The “hours credit” is changed to a “dollars credit” as determined by the Board of Trustees. The self-payment rate for retirees under age 65 and ineligible for Medicare is the same as the COBRA rate for continued coverage, or the cost of the premium for the Tufts HMO or PPO Plan, as well as the applicable premium for life insurance. These premiums will only cover your medical, prescription drug, and life insurance benefits, and you will not receive the other benefits under the Plan. If you are over age 65 and eligible for Medicare, you must notify the Fund, and you will be eligible to pay for coverage under a Medicare Supplement as described in Section 8 (Retiree Benefits).

[3] Reciprocity hours will only be credited when contributions are received by the Fund.

M. Can My Coverage Be Continued for My Spouse If I Retire and Then Die?

Yes. If you have Banked Surplus Hours when you retire and then die, those hours will be used to maintain coverage for your spouse until your hours run out. Your spouse will then be offered self-payment coverage and may continue coverage under the Plan by assuming responsibility for all applicable health care premiums.

If you do not have Banked Surplus Hours and you are a direct self-payment Participant when you die, your spouse will then be offered self-payment coverage and may continue coverage under the Plan by assuming responsibility for all applicable health care premiums. Premiums will be charged at the full cost. A surviving spouse of a deceased retiree who is not eligible for Medicare is eligible to self-pay 100% of the cost of the premium charged by the Provider, and a surviving spouse of a retiree who is eligible for the Medicare Supplement was billed in 2017 at 90% of the premium charged by the Provider for the supplemental coverage. The Trustees decide annually the percentage of the premium to be charged by the Provider for the supplemental coverage and notify the retirees of their decision; the percentage could be less than 90%.

N. Can People Not Working Under a Collective Bargaining Agreement Participate in the Plan?

Yes, provided the employer is signatory to a participation agreement approved by the Board of Trustees and makes the required contributions for the designated employees.

The cost of coverage for these Participants is determined by the Board of Trustees, consistent with the collective bargaining agreements and the requirements of applicable law. You should contact the Fund Office with questions about this provision.

O. What Are My Rights Under the Family and Medical Leave Act ("FMLA")?

If you are on a leave of absence under the provisions of the Family and Medical Leave Act of 1993 ("FMLA"), your employer may have an obligation to continue your medical coverage. In order to continue your coverage through this Fund, your employer must continue hourly contributions on your behalf while you are on an employer approved leave. Under the FMLA, you have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member. The military service member must (1) be your spouse, son, daughter, parent or next of kin; (2) be undergoing medical treatment, recuperation, or therapy for a serious illness or injury that occurred in the line of duty while in military service; and (3) be an outpatient or on the temporary disability retired list of the armed services.

If you qualify, during your FMLA leave your medical coverage will be maintained under the Fund. You may be eligible for FMLA leave if you:

- Have worked for a covered Employer for at least 12 months;

- Have worked at least 1, 250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the Employer within 75 miles.

Contact the Fund Office if you plan to take FMLA leave so that the Health & Welfare Fund is aware of your employer's responsibility to make contributions during your absence. The Board of Trustees cannot enforce collection of contributions from your employer while you are out on leave, but federal authorities may assist you regarding your extended health coverage.

P. Am I Eligible for Coverage During Military Service?

If you are inducted into the military service of the armed forces of the United States of America, or if you enlist in the military service, including part-time National Guard service, or if because of membership in a reserve component of the armed forces you are called into active military service, your health coverage will be continued by the Fund during your first 31 days of active military service. In addition, your dependents may be eligible for health care coverage under a government program known as TRICARE. The Fund will coordinate coverage with TRICARE. The Fund will not cover any injury or illness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

If you were eligible for benefits with the Health & Welfare Fund at the time you entered military service and if you continue to serve in the military in full-time active duty beyond 31 days, you will have the right to continue your health coverage for a period of 24 months. You can do this in the following ways:

- Continue to maintain coverage through the Health & Welfare Fund based on the eligibility rules and run out your Banked Surplus Hours. Once your Banked Surplus Hours run out your family will be offered COBRA continuation benefits; or

- You may also chose to have your coverage suspended and freeze the hours worked prior to your military service and have them applied when you return to work in Covered Employment, and your family will be offered COBRA continuation coverage to maintain coverage.

If you were not eligible for coverage with the Health & Welfare Fund at the time you entered military service, different rules will apply.

If you were eligible for health coverage based on your Credited Hours immediately before you entered military service, then you will be eligible for coverage immediately when you return, regardless of whether you have any hours remaining in your bank, provided you were discharged under honorable conditions. However, you must make

yourself available for work in Covered Employment within the time period required by applicable federal law. Therefore, it is imperative that you contact the Fund Office immediately if you enter military service, the reserves, or active duty to ensure that your coverage continues and that you understand the rules that apply upon your return. Under USERRA, an active employee is also required to notify his or her Employer that s/he is leaving for military service unless circumstances make notification impossible or unreasonable. Your employer is required to notify the Fund within 30 days after you are reemployed following military service.

After receiving an honorable discharge, your full eligibility in the Fund will be reinstated on the day you return to work if you return to employment within one of the following time frames:

- 90 days from the date of discharge if the period of military service is more than 180 days;
- 14 days from the date of discharge if the period of military service was more than 31 days but less than 180 days; or
- At the beginning of the first regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

These time limits may be extended for up to two years if you are hospitalized or convalescing from an injury resulting from active duty. You should direct questions regarding entitlement to USERRA to your employer. You should direct questions regarding continuing your health coverage from this Fund while on USERRA to the Fund Office.

Q. Can My Eligibility for Coverage Be Terminated If I Engage in Competing Service?

Yes. Your eligibility for coverage, and that of your eligible dependents, can be terminated by the Trustees at the end of the month if you engage in Competing Service. If you engage in Competing Service, you will not be able to use your Banked Surplus Hours because they will be forfeited. You are required to notify the Trustees if you are engaging in Competing Service. "Competing Service" means employment (including self-employment) with an employer, business or entity that is not signatory to a collective bargaining agreement with IBEW Local No. 96 or a reciprocating IBEW local, and the Participant's employment or self-employment is in the same trade or craft or the same industry practiced by any participating employer with the Fund. It shall include employment or ownership which competes in the same labor market in the jurisdiction of Local No. 96. The Trustees may, in their discretion, waive this rule if they determine, in a uniform manner applied to similarly-situated Participants, that Competing Service is *de minimis*.

R. Will I Be Able to Access My Banked Surplus Hours If I Am Unavailable for Work in Covered Employment?

No. If you are *not* an active employee, a retiree, disabled, or on leave under the FMLA or USERRA, and you are deemed unavailable for work in Covered Employment under the referral procedures of IBEW Local No. 96, you will be deemed unavailable for work and you will not be able to access your Banked Surplus Hours. Your coverage (and coverage for eligible dependents) will terminate at the end of the month in which you were deemed unavailable for work. You may no longer rely on Banked Surplus Hours that were withdrawn to provide six months of coverage if, during that six-month period, you are deemed unavailable for work in Covered Employment. Your Banked Surplus Hours will be forfeited unless you return to work in Covered Employment and re-establish your eligibility to participate in the Plan within 24 months of the date your coverage was terminated, in which case your Banked Surplus Hours will be restored.

If you return to work in Covered Employment you must re-establish eligibility for coverage under the Fund as if you are a new employee before you may access your Banked Surplus Hours. You cannot use Banked Surplus Hours to reinstate your eligibility. Only after eligibility is reinstated within 24 months from the date your coverage previously terminated will you again be able to use restored Banked Surplus Hours. Once you are deemed unavailable for work in covered employment, the termination of your coverage will occur even if prior to termination you sign the referral book or return to Covered Employment.

> *Example:* Joe is laid off from Covered Employment on November 5, 2017. At that time, he has 2,000 Banked Surplus Hours. He fails to sign the referral book and is deemed unavailable for work in Covered Employment under the referral procedures of IBEW Local 96. He cannot access his Banked Surplus Hours as a result. Joe's coverage under the Plan terminates on November 30, 2017, the last day of the month in which he was deemed unavailable for work in Covered Employment. If Joe returned to Covered Employment and works sufficient hours to reinstate his eligibility by November 30, 2019 (i.e., within 24 months of the date his coverage terminated), the 2,000 Banked Surplus Hours will be restored with such eligibility. If Joe reinstates his eligibility after November 30, 2019, the 2,000 Banked Surplus Hours will not be reinstated but are permanently forfeited.

2. DEPENDENT ELIGIBILITY

A. Who Are My Eligible Dependents?

Your lawful spouse is an eligible dependent under the Plan. In order for an individual to be considered your "lawful spouse," you must be legally married under the laws of a state or commonwealth. Domestic partnerships are <u>not</u> recognized.

With regard to benefits that are offered by the Plan on a self-insured basis, your spouse is an eligible dependent until the last day of the month in which a divorce, annulment, or legal separation is obtained. The benefits that are offered on a self-insured basis consist of dental, orthodontic, temporomandibular joint dysfunction (TMJ), vision, and hearing aid benefits.

With regard to benefits offered through the Providers on a fully-insured basis, if you become divorced, your former spouse may remain covered under the Plan. Coverage may continue unless: (1) your divorce decree does not require (or no longer requires) you to maintain health insurance coverage for your former spouse, or (2) either you or your former spouse re-marry. In the event that you or your spouse re-marry, the former spouse may have the right, if provided in the judgment, to continue to receive benefits as are available to you by means of the addition of a rider to your family plan or the issuance of an individual plan, either of which may be available at additional premium rates in accordance with applicable law.

Eligible dependents under the Plan also include your biological children, adopted children, children placed with you for lawful adoption, or stepchildren for whom no other insurance coverage is provided under a divorce decree, acknowledgement, paternity order, or other state order, and for whose health insurance a biological parent is not otherwise responsible, until the last day of the month in which the child attains age 26..

Eligible dependent also includes an unmarried child over age 26 who is permanently and totally disabled and for whom you provide more than half of the support during the calendar year, provided proof of such disability or incapacity is provided to the Fund Office within 30 days of the child's 26th birthday.

B. When Do My Eligible Dependents Become Eligible for Coverage?

Generally, your eligible dependents become eligible for coverage when you become covered under the Plan.

If you are eligible to participate in the Plan and you marry, you (if you are not already enrolled) and your spouse are eligible to enter the Plan as of the date of your marriage. To enroll, you must contact the Fund Office within 30 days of the marriage. For additional information, refer to the Change in Family Status rules in Section 3(D) and (E).

If you are eligible to participate in the Plan and you become a parent by birth, adoption, placement for adoption, or marriage, you (if you are not already enrolled) and your new eligible dependent(s) are eligible to enter the Plan immediately. To enroll, you must contact the Fund Office within 30 days of becoming a parent. For additional information, refer to the Change in Family Status rules in Section 3(D) and (E).

C. When Does Coverage for My Eligible Dependents Terminate?

Your eligible dependents' coverage will terminate on the earliest of the following dates:

- The date your coverage under the Plan ends;
- The last day of the month during which your dependent no longer meets the definition of or eligibility rules for an eligible dependent; or
- The date the Plan terminates.

D. What Are Qualified Child Support Orders ("QMCSOs")?

The Plan is required by law to recognize a state court order that the Trustees determine to be a "Qualified Medical Child Support Order" (or "QMCSO"), as that term is defined by ERISA. A QMCSO may require a Participant to provide health benefit coverage for dependent children, even if the Participant does not have custody of the children. If you have questions about QMCSOs, or would like to obtain a copy of this Plan's QMCSO procedures, you should contact the Fund Office.

3. BENEFITS IN GENERAL

A. What Benefits Are Provided for Non-Retired Participants Who Have the Required 600 Hours for Coverage?

All non-retired Participants who have Banked Surplus Hours and/or the required number of hours for eligibility purposes are eligible for the following benefits available under the Plan:

- Medical Benefits
- Dental, Orthodontic, and Temporomandibular Joint Dysfunction (TMJ) Benefits
- Vision Benefits
- Hearing Aid Benefits
- Short-Term Temporary Disability Income Benefits
- Life Insurance/Accidental Death & Dismemberment Benefits

B. What Are My Medical Insurance Choices?

When your eligibility under the Plan begins, if you are living and/or working in Massachusetts you will receive medical insurance under the Tufts Health Plan HMO Choice Co-Pay Plan. Participants working as a traveler outside of Massachusetts may choose to receive medical insurance through the Tufts Health Plan Advantage PPO Plan. The Fund pays Tufts Health Plan a premium in return for providing medical benefits to you. Please refer to Sections 4 and 5 of this document for a summary of benefits provided. See the Evidences of Coverage provided by Tufts for detailed information on benefits. This material is available at no charge.

C. Can I Make Changes In My Medical Insurance Provider?

Not if you are an active Participant because Tufts Health Plan is the only medical Provider. The Plan's anniversary date with the medical insurance Provider for active participants is July 1 of each year, and at that time you may be able to switch from the Tufts HMO Plan to the Tufts Advantage PPO Plan if you become a traveler outside of Massachusetts. If you are a retiree who is eligible for Medicare and has elected to receive coverage under a Medicare Supplement through the Medicare Providers, you will have a chance to make changes in your Provider, effective January 1st each year, during the previous October 15th through December 7th.

D. Can I make Changes to My Coverage During the Year?

Yes. Certain Changes in Family Status may occur during the course of a year that allow for changes to be made in your coverage during the year.

E. What Are Changes in Family Status and Special Enrollment Events?

"Changes in Family Status" include:

- Your marriage, divorce, legal separation or annulment.
- The birth, death, or adoption of a child, or the placement of a child in your home for adoption.
- Your death or the death of your spouse or other dependent.
- A change in your employment status or that of your spouse or a dependent that results in a loss of coverage. Such changes in employment status include the termination or commencement of employment, the commencement of or return from an unpaid leave of absence, a change in worksite, or a strike or lockout.
- A dependent ceases to be eligible for coverage under the Plan.
- You, your spouse, or your dependent has a change in residence.

You must notify the Fund Office of a Change in Family Status within 30 days of the date of such change. Otherwise, the necessary changes to your coverage may not be made effective until the next July 1 anniversary date. **For instance, if you marry while covered by the Plan, it is your responsibility to notify the Fund Office within thirty days of the date of your marriage in order to add your new spouse to the Plan.** It is your responsibility to promptly provide certifying documentation (such as marriage certificates, birth certificates, divorce decrees) before the Fund Office can process any changes to your coverage based on a Change in Family Status.

Other special enrollment events:

If you did not enroll yourself or your spouse or any dependent(s) for coverage within 31 days after the date on which they first became eligible for coverage because you or they had health care coverage under any health insurance policy or program or employer plan, COBRA continuation coverage, individual insurance, Medicare, Medicaid or other public program, and you, your spouse and/or any dependent children cease to be covered by that other health insurance policy or plan, then you may enroll yourself and/or that spouse and/or dependent children within 31 days of the termination of their coverage under that other health insurance plan or policy if that other coverage terminated because:

- Of the loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or
- Of the termination of employer contributions toward that other coverage; or
- A covered individual reaches the lifetime limit for all benefits under the other health plan; or
- If that other coverage was COBRA Continuation Coverage, the coverage was "exhausted." COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim). For

example, COBRA coverage is considered "exhausted" when the 18- or 36-month maximum coverage period expires; or

- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual.

An individual also may be eligible for special enrollment even if they did not have other health coverage when they initially refused to enroll in the Fund. This may occur if, after subsequently obtaining other health coverage, they later lose that other health coverage.

If you have any questions about any special enrollment events, contact the Fund Office.

F. What Are the Dental Benefits?

The Tufts Health Plan HMO Choice Copay and PPO Plans cover some dental services for children under age 12 in addition to the dental services covered by the Plan. Benefits available through the Provider for these children under age 12 are paid first, and the Plan will pay any additional covered charges second.

For details regarding dental coverage not provided by the Tufts Health Plan HMO Choice Copay and PPO Plans, refer to the Benefits Summaries in Section 6 of this PLAN DESCRIPTION. The Plan also covers Orthodontic benefits, which are described Section 6 as well. The dental benefits described in Section 6 are self-funded by the Health & Welfare Fund but provided and administered through Delta Dental of Massachusetts. Self-funded or self-insured means that all claims are paid by the Fund and are not insured by any Provider.

G. What Are the Vision Benefits?

The Tufts Health Plan HMO Choice Co-Pay Plan offers limited vision benefits (of one routine vision exam per calendar year), in addition to the benefits offered under this Plan, which are described in Section 6 of the Benefits Summaries in this summary PLAN DESCRIPTION. Benefits available through the Provider are paid first, and the Plan will pay any additional covered charges second.

The vision benefits described in Section 6 are self-funded by the Health & Welfare Fund. This means that all claims are paid by the Fund and are not insured by any Provider.

H. What Is the Short-Term Temporary Disability Income Benefit?

The short-term temporary disability income benefit is a $650 weekly income benefit (less FICA) that covers non-job related injury or illness. For the purposes of short-term temporary disability income benefits, "disability" means you cannot perform the essential functions of your job. The Trustees may require you to demonstrate to their satisfaction that you are disabled.

After you submit the required medical form(s), which you may obtain from the Fund Office, your eligibility for benefits will be determined. An outside reviewer may be utilized to determine your eligibility for benefits, based on medical documentation submitted. This benefit is payable from the first day you are absent from work for a non-job related injury and from the eighth day you are absent from work for a non-job related illness. The maximum benefit period is 26 weeks, payable once in any period of 52 consecutive weeks. In no instance will the benefit be payable for more than 26 weeks in such 52-week period.

This benefit is self-funded by the Health & Welfare Fund. This means that all claims are paid by the Fund and are not insured by any Provider.

This benefit is not payable if you are receiving workers' compensation, Social Security Disability Income, or unemployment compensation benefits or receiving a pension from an IBEW Fund. *Note*: If you are collecting unemployment benefits and you become disabled under this section while collecting such benefits, thereby disqualifying you for such benefits, you *may* be eligible for benefits under this section.

I. Is the Short-Term Temporary Disability Income Benefit Available to All Participants?

No. This benefit is not available to individuals who are continuing their coverage through COBRA, who do not have the required 600 eligibility hours, or who are retired. This benefit is also not available to eligible dependents.

J. What Are the Life Insurance and Accidental Death & Dismemberment Benefits?

The life insurance and accidental death and dismemberment benefits are:

- For All Covered Non-Retired Participants As Of May 1, 1998:
  $30,000 life insurance benefit
  $30,000 maximum accidental death and dismemberment benefit
- For Covered Participants Retiring After May 1, 1998:
  $7,500 life insurance benefit

K. How Do I Designate a Beneficiary for the Life Insurance and Accidental Death & Dismemberment Coverage?

When you initially enroll in the Plan, you will be provided with the appropriate Beneficiary designation form.

L. Can I Change My Beneficiary?

Yes. If you need to update your primary or your contingent (alternate) Beneficiary, simply call the Fund Office to request a Beneficiary designation change form, which you must complete and return to the Fund Office.

M. What Happens If I Submit a False or Fraudulent Claim?

The Plan does not cover any claims for benefits containing misrepresentations or false, fraudulent, incomplete or misleading information. Moreover, if a false or fraudulent claim is filed, full restitution plus interest and reimbursement of any expenses incurred by the Plan will be required, including, to the extent allowed under applicable law, through offset of any benefits payable under the Plan. The Trustees may suspend the benefits to which you and your eligible dependents would otherwise be entitled for a period up to three (3) years, or until full restitution is made, whichever is longer. Your coverage also may be rescinded as allowed by applicable law if you perform an act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or applicable insurance coverage. The Trustees reserve the right to turn any such matter over to the proper authorities for prosecution.

N. Women's Health and Cancer Rights Protection

If you had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prosthesis; and (4) treatment of physical complications of the mastectomy, including lymphedemas.

O. Newborn's and Mother's Health Protection Act

This Plan complies with the federal law that prohibits restricting benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section. This law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods.

4. TUFTS HEALTH PLAN HMO CHOICE CO-PAY SUMMARY OF BENEFITS

With the Tufts Health Plan HMO Choice Copay Plan ("Tufts HMO Plan"), you and your covered dependents are entitled to the benefits summarized below. For more detailed information about your benefits, please refer to the plan's Evidence of Coverage, which is incorporated into this document by reference. This information is available to you from Tufts at no charge. To request a copy of the Evidence of Coverage, call (800) 462-0224 or refer to the member benefit document in your secure account at tuftshealth plan.com. To access your secure account, go to www.tuftshealthplan.com, click on Get Started Now, enter the requested information to create a username and password, and then log in to use the secure online account.

As an HMO Choice Copay member:

- You must choose a PCP from the Tufts Health Plan network. Visit the Tufts Health Plan web site at www.tuftshealthplan.com and click on Find a Doctor.
- In most cases, your network PCP must give or refer your care.
- Any emergency medical care you need is covered at any hospital in the world, without your PCP's approval or a referral.

This plan allows you to choose between two copay levels when you receive certain types of care:

- Provider visits: The copay for a specialist office visit may be higher than the copay for a PCP visit.

A list of network hospitals is included in your plan information. To review a list of providers and hospitals in our network, please check our Provider Directory or website, tuftshealthplan.com, and click on Find a Doctor.

Co-Premium for Family Coverage

Participants who receive family coverage under the Tufts HMO Plan are required to pay a co-premium of $25 a month. If you receive such coverage and fail to pay the monthly co-premium, coverage will be terminated the last day of the month for which the co-premium was received. You will then not be eligible to participate in the Tufts HMO Plan unless you once again meet the eligibility requirements for coverage and make the required monthly co-premium payment.

You can pay your co-premium of $25 electronically. Please call the Fund Office for more information.

Out-of-Pocket Maximum

You are protected under the Tufts HMO Plan by an out-of-pocket maximum of $1,000 per member (or $2,000 per family), per calendar year. This out-of-pocket maximum includes copays (including Rx copays) and any coinsurance you pay out of pocket. You will still have to pay any costs that are not included in the out-of-pocket maximum.

Primary Care Physician, Referrals, and Prior Approval

You and each of your dependents must select a Primary Care Physician ("PCP"). To find a PCP who participates in the Tufts HMO Plan, visit the Tufts Health Plan web site at tuftshealthplan.com and click on "Find a Doctor", or call (800) 462-0224 to request a provider directory or ask if a doctor participates in the Plan.

Your PCP is generally the first person you will call when you need routine or non-emergency care. If you and your PCP decide you need to see a specialist, your PCP will refer you to the participating specialist he or she determines is most appropriate to treat your condition. For some services, you may also need prior approval from Tufts Health Plan. **You should check with your PCP, your specialist, or Tufts Health Plan Member Service to find out if a referral or prior approval is required for the services or supplies you seek, and to be sure that any required referral or prior approval has been obtained, BEFORE the services or supplies are provided. If you fail to obtain a required referral or prior approval, you will pay all charges for those services and supplies.**

Emergency Care and Urgent Care – Wherever You Are

You do not need a referral from your PCP or prior approval from Tufts Health Plan to obtain emergency medical care, or to obtain urgent care for an unforeseen illness, injury, or medical condition that arises while you are temporarily outside the plan's service area (i.e., Massachusetts). You should go directly to the nearest medical facility or call 911 (or other local emergency phone number). You pay a $150.00 copayment for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. If you are outside the plan's service area, you are covered for the urgent or emergency care visit and one follow-up visit outside the service area. Any additional follow-up must be arranged by your PCP.

Prescription Drug Information

You may find up to date information about a specific prescription medication by visiting the Tufts Health Plan website - www.tuftshealthplan.com - and click on the prescription tab under member or employer. You can also download the Prescription Formulary to a PDF. The formulary lists widely prescribed medications and their associated "Tiers"; however, that list can change at any time. Therefore, to be sure your medication is covered and to know if your prescription medication will be considered Tier 1 with a $15 co-payment, Tier 2 with a $30 co-payment, or Tier 3 with a $50 co-payment, please visit the web site before either filling your prescription at a pharmacy or using the mail order program. Note: effective July 1, 2017, co-pays for mail order prescriptions (for 90 day supply) are $30 for Tier 1; $60 for Tier 2; and $100 for Tier 3.

Please note that this is a summary of benefits only. For complete benefit information, please refer to your annual Summary of Benefits Coverage (SBC), evidence of coverage, or member benefit document, available in your secure account at tuftshealthplan.com as described above.

This health plan meets Minimum Creditable Coverage and Essential Health Benefits standards and will satisfy the state and federal individual mandates that you have health insurance.

Your Medical Benefits (Tufts Health Plan HMO Choice Copay Plan)

Copayment Maximums **(per calendar year)**	**Individual**	**Family**
Inpatient copayment maximum	$1,000	$2,000

Preventive Services	
Routine Physical Exams, including: • preventive immunizations • preventive Pap smears and mammograms • well-child care visits • annual gynecological exams • most preventive screenings	Covered in full
Screening for Colon or Colorectal Cancer in the Absence of Symptoms	Covered in full

Outpatient Medical Care **(No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)**	**PCP**	**Specialist**
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)	$30 per visit	$40 per visit
Non-Routine Maternity Care	$30 per visit	$40 per visit
Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	$30 per visit	
Nutritional Counseling (when medically necessary and non-preventive)	$30 per visit	$40 per visit
Allergy Injections	$5 per injection	
Allergy Testing and Treatment	$30 per visit	$40 per visit
Speech Therapy (when medically necessary)	$40 per visit	
Short-term Physical and Occupational Therapy (60 visits for each type of service per calendar year)	$40 per visit	
Spinal Manipulation (12 visits per calendar year)	$40 per visit	
Non-preventive Pap Smears and Mammograms	Covered in full	
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer) – Without surgical intervention	$200 per procedure	
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer) – With surgical intervention	$200 per procedure	
Diagnostic or Preventive Screening Procedures	Covered in full	
Diagnostic Imaging - General Imaging (such as x-rays and ultrasounds)	Covered in full	
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	$100 per visit (waived for patients actively undergoing cancer treatment)	
Diagnostic Lab Tests	Covered in full	
Day Surgery	$200	

Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)	
All Hospital Services — Acute Care and Maternity Care	$350 per admission
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	Covered in full

Emergency Care	
In Emergency Room (copay waived if admitted)(call Tufts within 48 hours)	$150 per visit

Mental Health and Substance Abuse	
Outpatient Care	$30 per visit
Inpatient Care (services provided at a designated facility, including medically necessary treatment in a mental health residential treatment facility)	$350 per admission

Other Health Services	
Durable Medical Equipment	30% coinsurance
Ambulance Service	Covered in full
Hospice Care	Covered in full
Home Health Care	Covered in full
Pediatric Dental X-rays, full mouth once every 5 years. Bitewings, once every 6 months and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months.	Covered for Children under 12
Hearing aids	Under age 21 - $2,000.00 per ear, every 36 months

Your Prescription Drug Benefits

Prescription Drug Coverage	For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Tier 1	$15	$30
Tier 2	$30	$60
Tier 3	$50	$100

The Advantage is Yours

Tufts Health Plan will help you reach your wellness goals with discounts on nutrition, mind and body, fitness, and other services related to good health. To learn more about our wide range of member discounts, go to **tuftshealthplan.com** and click on Member Discounts on the "I'm a Member" tab.

Fitness centers	**20%** off annual memberships and no joining fees at almost 80 participating fitness centers. **$150** rebate per subscriber household toward your fees for a qualified health and fitness club.
Vision discount	**35%** off the price of frames, along with discounts on lenses and lens options, when you buy a pair of eyeglasses from an EyeMed network provider. **20%** off the price of non-prescription sunglasses. **5-15%** off the cost of LASIK and PRK laser vision correction.
Acupuncture and massage	**25%** off acupuncture treatments and massage therapy with participating providers.

Nutritional counseling	**25%** off the cost of visits with a registered dietician or licensed nutritionist in our network.
Choosehealthy.com	Receive free shipping and up to **40%** off suggested retail prices on a variety of products including over 2,400 dietary supplements, homeopathic remedies, diet & sports nutrition, books, DVDs, and more.
Fitness Together	**10%** off a personal training package and a free fitness evaluation.
New Balance	**15%** off fitness-related clothes, footwear, and other items at New Balance retail stores in Burlington and Mashpee.
Appalachian Mountain Club	**20%** off membership, plus discounts on lodging, subscriptions, and programs.
Nurseline	Experienced RNs answer questions and offer reliable information around the clock at **866-201-7919.**
Keepingyouhealthy.com	You'll find a variety of discounts and coupons here, mobile apps, tips, information, and videos on health and fitness topics.

There are some services that the plan does not cover. This is a brief list of some of the services not covered. Most cosmetic procedures; experimental or investigational drugs, services, and procedures; personal comfort items; custodial care; most routine foot care and foot orthotics; private-duty nursing; hearing aids; most dental services; non-emergency services received outside the United States; any drug, service or supply that doesn't meet Tufts Health Plan medical necessity guidelines. **Please be sure to read your benefit document for the complete list of services the plan limits or does not cover.**

This is a summary only. Please refer to your plan's member benefit document for more detailed information. If there is a difference between the information in this benefit summary and your member benefit document, the member benefit document is legally binding. If you have additional questions, please call a Member Specialist at 1-800-462-0224.

5. TUFTS HEALTH PLAN ADVANTAGE PPO PLAN SUMMARY OF BENEFITS

Participants **who work as a traveler outside of Massachusetts** may choose to have their medical insurance coverage under the Tufts Health Plan Advantage PPO Plan ("Tufts PPO Plan"). Under this Plan, you and your covered dependents are entitled to the benefits summarized below. For more detailed information about these benefits, refer to the Tufts Health Plan Advantage PPO Plan Evidence of Coverage. This information is available from Tufts Health Plan at no charge. To request a copy of the Evidence of Coverage, or member benefit document, which is incorporated by reference into this document, call (800) 462-0224 or check in your secure account at tuftshealth plan.com. To access your secure account, go to www.tuftshealthplan.com, click on Get Started Now, enter the requested information to create a username and password, and then log in to use the secure online account.

As an Advantage PPO member:

- You do not have to choose a primary care provider (PCP).
- You can seek covered services from most licensed providers in or out of the Tufts Health Plan network.
- No referrals are needed.
- Any emergency medical care you may need is covered at the in-network level of benefits. You pay 20 percent co-insurance per visit and there is no deductible.

How services are covered with Advantage PPO

The Advantage PPO plan covers preventive and medically needed health care services and supplies in the following ways:

In-network benefits - Apply when you receive care from a provider in the Tufts Health Plan network. A $100 deductible (per member, per calendar year - $300 per family) applies to most in-network services. After you meet your deductible for the calendar year, you will pay 20% coinsurance for further in-network services. To find a preferred provider, you may visit the Tufts Health Plan web site at tuftshealthplan.com and click on "Find a Doctor", or call (800) 462-0224 to request a provider directory or ask if a doctor is in the Tufts Health Plan Network.

- **Covered subject to the plan's deductible:** Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. The deductible is the amount you need to pay out of your own pocket before the health plan begins to pay for covered services. Once you meet your deductible, services are subject to coinsurance, which is your share of the cost for some covered medical services. Note: Services subject to the plan's deductible may also be performed at the same time you are having a preventive office visit with your provider. Please see the chart below for information about your specific deductible.

- **Covered with a copay:** You pay a certain copay at the time you receive covered services, including non-routine office visits.

- **Covered in full:** This plan covers preventive services in full—they are not subject to the deductible or a copay. Preventive services, for the most part, are the services your provider offers to help you stay healthy. These are needed at all

ages. They might be office visits for routine checkups for children and adults, tests (also called screenings), immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life. Also, once you have met your plan's out-of-pocket maximum, or yearly limit, Tufts Health Plan pays for covered services for the rest of your plan's year.

- **Out-of-network benefits -** Apply when you receive care from a provider who is not in the Tufts Health Plan network. When you receive care at the out-of-network level of benefits, you pay a deductible and then coinsurance until you reach your out-of-pocket maximum. Once you reach your limit, you are covered in full for all eligible out-of-network covered services for the rest of the year. You may also have to pay the difference between what the plan covers and what the out-of-network provider charges for a service. You may need to submit a claim form for each covered service you receive. The deductible and out-of-pocket maximum for this plan are listed on this benefit summary. A $300 deductible (per member, per calendar year) applies to most out-of-network services. After you meet your deductible for the year, you will pay 40% coinsurance for most out-of-network services.

Please note that this is a summary of benefits only. For complete benefit information, please refer to your member benefit document, which is incorporated into this document by reference. To request a copy of the member benefit document or evidence of coverage, call (800) 462-0224 or check in your secure account at tuftshealth plan.com

Out-of-Pocket Maximum

The co-insurance maximum applies to in-network and out-of-network covered services combined. When the money you pay for the 20 or 40% co-insurance plus any copays (including Rx copays) or other out-of-pocket expenses equals $3,000 for an individual member in a calendar year ($6,000 for a family), benefits for that member will be provided in full for those covered services, based on the allowed charge, for the rest of that calendar year. You still have to pay any costs that are not included in the out-of-pocket maximum.

This health plan meets Minimum Creditable Coverage standards and will satisfy the state individual mandate that you have health insurance.

Your Medical Benefits (Tufts Health Plan Advantage PPO Plan)

Deductible and Out-of-Pocket Maximums (per calendar year)	**Individual**	**Family**
In-network Deductible	$100	$300
Out-of-network Deductible	$300	$600
Out-of-pocket Maximum (includes deductible, coinsurance, and copayments over $100)	$3,000	$6,000

Preventive Services	**In-Network**	**Out-of-Network** (after deductible)
Routine Physical Exams, including: • preventive immunizations • preventive Pap smears and mammograms • well-child care visits • annual gynecological exams • most preventive screenings	Covered in full	20% coinsurance
Screening for Colon or Colorectal Cancer in the Absence of Symptoms	Covered in full	20% coinsurance

Outpatient Medical Care	**In-Network**	**Out-of-Network** (after deductible)
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)	$20 per visit	20% coinsurance
Non-routine Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)	$20 per visit	20% coinsurance
Routine eye exams (1 visit every 12 months)—you must use an EyeMed Vision Care provider to be covered at the in-network level of benefits	$20 per visit	20% coinsurance
Nutritional Counseling (when medically necessary)	$20 per visit	20% coinsurance
Allergy Testing and Treatment	20% coinsurance after deductible	40% coinsurance
Speech Therapy (when medically necessary)	20% coinsurance after deductible	40% coinsurance
Short-term Physical and Occupational Therapy (30 visits for each type of service per calendar year)	20% coinsurance after deductible	40% coinsurance
Spinal Manipulation (12 visits per calendar year)	20% coinsurance after deductible	40% coinsurance
Non-preventive Pap Smears and Mammograms	20% coinsurance after deductible	40% coinsurance
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer)	20% coinsurance after deductible	40% coinsurance
Diagnostic Procedures	20% coinsurance after deductible	40% coinsurance
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	20% coinsurance after deductible	40% coinsurance
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	20% coinsurance after deductible	40% coinsurance

Diagnostic Lab Tests	20% coinsurance after deductible	40% coinsurance
Day Surgery	20% coinsurance after deductible	40% coinsurance

Inpatient Hospital Care **(semiprivate room, unless private room is medically necessary)**	**In-Network**	**Out-of-Network (after deductible)**
All Hospital Services — Acute Care and Maternity Care	20% coinsurance after deductible	40% coinsurance
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	20% coinsurance after deductible	40% coinsurance

Emergency Care	
In Emergency Room	20% coinsurance

Mental Health and Substance Abuse	**In-Network**	**Out-of-Network (after deductible)**
Outpatient Care	$20 per visit	20% coinsurance
Inpatient Care	20% coinsurance after deductible	40% coinsurance

Other Health Services	**In-Network**	**Out-of-Network (after deductible)**
Durable Medical Equipment	30% coinsurance	40% coinsurance
Ambulance Service	20% coinsurance after deductible	40% coinsurance
Hospice Care	20% coinsurance after deductible	40% coinsurance
Home Health Care	20% coinsurance after deductible	40% coinsurance

Your Prescription Drug Benefits

Prescription Drug Coverage	**For up to a 30-day supply at a participating retail pharmacy**	**For up to a 90-day supply through our mail order service**
Tier 1	$10	$10
Tier 2	$25	$25
Tier 3	$45	$45

The Advantage is Yours

Tufts Health Plan will help you reach your wellness goals with discounts on nutrition, mind and body, fitness, and other services related to good health. To learn more about our wide range of member discounts, go to **tuftshealthplan.com** and click on Member Discounts on the "I'm a Member" tab.

Fitness centers	**20%** off annual memberships and no joining fees at almost 80 participating fitness centers. **$150** rebate per subscriber household toward your fees for a qualified health and fitness club.
Vision discount	**35%** off the price of frames, along with discounts on lenses and lens options, when you buy a pair of eyeglasses from an EyeMed network provider. **20%** off the price of non-prescription sunglasses. **5-15%** off the cost of LASIK and PRK laser vision correction.

Acupuncture and massage	**25%** off acupuncture treatments and massage therapy with participating providers.
Nutritional counseling	**25%** off the cost of visits with a registered dietician or licensed nutritionist in our network.
Choosehealthy.com	Receive free shipping and up to **40%** off suggested retail prices on a variety of products including over 2,400 dietary supplements, homeopathic remedies, diet & sports nutrition, books, DVDs, and more.
Fitness Together	**10%** off a personal training package and a free fitness evaluation.
New Balance	**15%** off fitness-related clothes, footwear, and other items at New Balance retail stores in Burlington and Mashpee.
Appalachian Mountain Club	**20%** off membership, plus discounts on lodging, subscriptions, and programs.
Nurseline	Experienced RNs answer questions and offer reliable information around the clock at **866-201-7919.**
Keepingyouhealthy.com	You'll find a variety of discounts and coupons here, mobile apps, tips, information, and videos on health and fitness topics.

There are some services that the plan does not cover. This is a brief list of some of the services not covered. Most cosmetic procedures; experimental or investigational drugs, services, and procedures; personal comfort items; custodial care; most routine foot care and foot orthotics; private-duty nursing; hearing aids; most dental services; non-emergency services received outside the United States; any drug, service or supply that doesn't meet Tufts Health Plan medical necessity guidelines. **Please be sure to read your benefit document for the complete list of services the plan limits or does not cover.**

This is a summary only. Please refer to your plan's member benefit document for more detailed information. If there is a difference between the information in this benefit summary and your member benefit document, the member benefit document is legally binding. If you have additional questions, please call a Member Specialist at 1-800-462-0224.

6. VISION/DENTAL/ORTHODONTIC/TMJ/HEARING AID BENEFITS SUMMARY

A. What Are the Dental, Orthodontic, and Temporomandibular Joint Dysfunction (TMJ) Benefits?

The following benefits are payable in accordance with the provisions of the Plan in addition to any benefits payable through the Providers. These benefits will be subject to the deductibles, limitations, exclusions and maximums where applicable.

Benefits Payable	This Plan Pays
Dental Care Benefit	
Calendar Year Maximum Benefit (per person) (effective July 1, 2011 children up to age 19 are excluded from this limitation for oral care considered to be an essential health benefit under the Affordable Care Act)	$1,000.00*
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontic Benefit	
Dependent Children Through Age 19	
Lifetime Maximum	$2,000.00
Coinsurance	50%
Temporomandibular Joint Dysfunction (TMJ) Expense Benefit	
Lifetime Maximum	$500.00

*Subject to Reasonable and Customary limitations

Children Under Age 12

Tufts Health Plan affords dependent children under the age of 12 a dental cleaning once every six months, examinations, x-rays and fluoride treatments. All other dental services described herein are afforded to those dependent children by the self-funded Plan of Benefits.

Dental Benefits

Benefits are payable for Reasonable and Customary incurred covered charges for such dental services subject to any coinsurance. Benefits shall be payable while coverage is in force, for the treatment of non-occupational accidental injury or disease of the teeth, gums or jaw. The dental benefits are administered by Delta Dental of Massachusetts, but claims are self-insured by the Plan.

If two or more dental services are rendered, payment will be made for each dental service, subject to the Reasonable and Customary amount for a particular combination of dental services.

For many dental conditions, there is more than one method of satisfactory treatment. If this is the case, the covered dental expenses will not exceed the Reasonable and Customary charges for the services and supplies that are usually employed nationwide in the treatment of the disease or injury and which are recognized by the profession to be appropriate methods of treatment, in accordance with broadly accepted nationwide standards of dental practice, taking into account the overall current oral condition of the individual.

Calendar Year Maximum

The calendar year maximum for dental benefits is $1,000 for each participant. Children up to age 19 are excluded from this limitation and no annual maximum applies to them for oral care considered to be an essential health benefit under the Affordable Care Act.

In certain circumstances, you are allowed to roll over up to $350 of your unused annual plan maximum (excluding orthodontia) to increase your plan maximum the next year, and beyond. This is called a Rollover Max. You must have less than $500 in claims in a calendar year and at least one cleaning or one oral exam in the calendar year in order to be eligible to roll over any of your benefit to the following year. Your accumulated rollover total is capped at $1,000.

Preventive Care Dental Services

This dental benefit pays 100% of the Reasonable and Customary dental fees for the following Preventive Care Dental Services:

- Oral examinations, including x-rays, once every six consecutive months;
- Prophylaxis (cleaning of teeth) once every six consecutive months;
- Space Maintainers, including all adjustments within six months after installation and is limited to the initial appliance only and children under age 16;
- Fluoride Treatments once every six consecutive months for children over age 12, as Fluoride Treatments for children under age 12 are covered and paid by the Provider; and
- Sealants.

Basic Dental Services

- This dental benefit pays 80% of the Reasonable and Customary dental fees for the following Basic Dental Services: Non-Routine Visits: Emergency palliative treatment per visit; consultation by other than the attending dentist;
- Extractions: Uncomplicated (single); each additional tooth; surgical removal of

erupted tooth (including tissue flap and bone removal);

- Impacted Teeth: Removal of tooth, impacted soft tissue; partially by bone, completely by bone;
- Alveolar or Gingival Reconstructions: Alveolectomy, per quadrant; excision of pericoronal gingiva, per tooth; removal of palatal torus; removal of mandibular tori, per quadrant;
- Cysts and Neoplasms: Removal of cyst or tumor;
- Drugs: Injectable antibiotics;
- Anesthesia: General, in conjunction with oral surgical procedures only;
- Periodontics: Gingivectomy (including post-surgical visits) per quadrant; gingivectomy, treatment per tooth (fewer than six teeth); subgingival curettage, root planing, per quadrant (not prophylaxis); occlusal adjustment, related to periodontal surgery, per quadrant;
- Endodontics: Pulp capping, direct, excluding final restoration; vital pulpotomy, excluding final restoration; apicoectomy (performed as a separate surgical procedure); apicoectomy (performed in conjunction with endodontic procedures);
- Amalgam Restorations Primary or Permanent Teeth: Cavities involving one surface, two surfaces, three or more surfaces;
- Synthetic Restorations: Silicate cement filling; acrylic or plastic filling; composite: resin -one surface;
- Crowns: Stainless steel (when tooth cannot be restored with a filling material);
- Recementation: Inlay; crown; bridge;
- Denture Relinings and Rebasings: Upper or lower denture duplication jump case per denture (limited to one in any 36 consecutive months); denture reline (includes full and partial); office cold cure (limited to one in any 12 consecutive months); laboratory (limited to one in any 12 consecutive months);
- Denture Adjustments: Adjustment to denture more than six months after installation or if by dentist other than the original provider; and
- Osseous Surgery.

Major Dental Services

This dental benefit pays 50% of the Reasonable and Customary dental fees for the following Major Dental Services:

- Restoration Inlays: One, two, three or more surfaces; only, in addition to inlay allowance;
- Restorative Crowns: Acrylic; acrylic with gold; porcelain; porcelain with gold; gold (full cast); gold (3/4 cast); cast post and core (in addition to crown);
- Pontics: Cast gold (sanitary); case with semi-precious metal (sanitary); slotted facing; slotted pontic; porcelain fused to gold; porcelain fused to semi-precious metal;
- Removable Bridge (Unilateral): One piece chrome casting clasp attachment (all

types) per unit including pontics;

- Denture and Partial Dentures: Complete Maxillary denture; complete Mandibular denture; Upper or lower partial with two chrome clasps with rests, acrylic base; with chrome lingual bar and clasps, acrylic base;
- Adding Teeth to Partial Denture: First tooth; first tooth with clasp; each additional tooth and clasp, and
- Implants or occlusions for the replacement of missing teeth.

Limitations and Exclusions

In addition to excluding any services not set forth herein, no benefits are payable under this Section for the following dental care or services:

- Charges for any dental procedures which are included as covered medical expenses under the Health Fund's medical benefits;
- Charges for treatment by other than a dentist, except that cleaning or scaling of teeth may be performed by a licensed Dental Hygienist, if such treatment is rendered under the supervision and direction of the Dentist;
- Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures;
- Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while you or your dependents were not eligible under the Plan or which were ordered while you or your dependents were insured under the Plan, but which are finally installed or delivered more than 60 days after termination of coverage;
- Charges for the replacement of a lost or stolen prosthetic device;
- Charges in connection with an occupational accidental bodily injury or disease;
- Consultations if the dentist is or will be performing additional treatment;
- The replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five years of the date of the last placement of such appliance, crown, inlay or onlay restoration or fixed bridge, unless such replacement is required as a result of accidental bodily injury;
- Charges in connection with temporomandibular joint dysfunction (TMJ) – TMJ benefits are a separate benefit under the Plan;
- Any orthodontic services received before your dependents were eligible for such coverage under this Plan; and

Pre-Determination of Benefits

- This Plan contains a pre-determination of benefits provision. The intent of this provision is to determine, in advance, the likely expenses and how much of these expenses will be covered for a "course of treatment." **It is important to note that a pre-determination of benefits does not guarantee eligibility for dental benefits.**

- Before beginning a course of treatment for which dental charges are expected to exceed $500, a description of the proposed services and supplies and the estimated charges should be submitted to the Fund Office. You and your dentist will then be notified by the Fund Office of the amount of the benefit payable for the proposed course of treatment. Emergency treatment, oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment for the purpose of pre-determination, but these services may be rendered before a pre-determination of benefits is made. Failure to submit a request for pre-determination may result in benefit payments of less than what you might otherwise expect.

Orthodontic Services

For eligible dependent children through age 19, the orthodontic benefit pays 50% of the Reasonable and Customary dental fees for Orthodontic Services required by one or more of the following conditions:

- overbite or overjet of at least four millimeters;
- maxillary (upper) or mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp;
- cross bite, or
- an arch length discrepancy of more than four millimeters in either the upper or lower arch.

The orthodontic benefit will be paid for your eligible dependent through age 19. Covered charges will be payable as billed, i.e., monthly, quarterly, etc. at 50% of the Reasonable and Customary charges incurred throughout the estimated duration of the treatment plan, up to the Lifetime Maximum. However, the periodic reimbursement provision is waived if a Participant submits proof that payment in full was made to the orthodontist. These Participants will be reimbursed in full, in one payment, up to the Lifetime Maximum benefit.

Orthodontic Lifetime Maximum

The Lifetime Maximum benefit for Orthodontic Services is $2,000.

Treatment Plan

An orthodontic treatment plan must be submitted to the Fund Office before any expenses will be considered for payment. After the Fund Office has reviewed the treatment plan, you and your orthodontist will be advised of an estimate of benefits payable under the Plan. A treatment plan consists of:

- a description of the malocclusion classification;
- recommended and prescribed treatment;

- an estimate of the duration of treatment (completion date);
- an estimate of total charges for appliances and active treatment; and
- supportive evidence such as cephalomistric x-rays, study models or other material the Fund Office deems necessary.

Temporomandibular Joint Dysfunction (TMJ) Benefit

In addition to any benefits offered by your Provider, the Health Fund will provide payment for diagnosis, x-rays, consultation, appliances and treatment for temporomandibular joint dysfunction (TMJ), subject to an all-inclusive Lifetime Maximum (for dental and medical diagnosis combined). The Lifetime Maximum includes services which are provided at a hospital or a free standing surgical facility.

Temporomandibular Joint Dysfunction (TMJ) Lifetime Maximum

The Lifetime Maximum benefit for temporomandibular joint dysfunction (TMJ), for dental and medical diagnosis combined, is $500.

Dental, Orthodontic and TMJ Benefits

Whether or not you have submitted a course of treatment for pre-determination of benefits, you are responsible for furnishing all diagnostic and evaluative material, as may be required by the Fund Office to evaluate its liability. This material may include, but is not limited to dental x-rays, models, charts and other reports. A pre-determination does not guarantee payment of the claim unless you are eligible when services are provided.

Extended Benefits Upon Termination

No payment will be made by the Fund Office for dental services or supplies furnished on or after the date of termination of an individual's coverage hereunder, whether such termination is on an individual basis or upon termination of the group plan, except under the following specified circumstances:

- in the case of appliances or modification of appliances not related to orthodontic treatment, if the master impression was taken by a dentist while coverage was in force under the dental benefits, covered charges will be payable if the appliance was delivered or installed within 60 days after the termination of coverage;
- in the case of a crown, bridge or inlay or onlay restoration, if the tooth or teeth were prepared while coverage was in force under the dental benefits, covered charges will be payable if such crown, bridge or cast restoration was installed within 60 days after the termination of coverage;
- in the case of root canal therapy, if the tooth or teeth were prepared while coverage was in force under the dental benefits, covered charges will be payable if such root canal therapy is completed within 60 days after the termination of coverage;

- in the case of orthodontic treatment commencing while coverage was in force under the orthodontic benefit, benefits will be payable through the end of the month in which coverage terminated, based on the proration of the applicable quarterly installment, if applicable.

Dental, Orthodontic and TMJ Benefits

The above benefits are subject to all other conditions, limitations and exclusions of the Health Plan.

B. What Are My Vision Expense Benefits

You may receive, in addition to any vision benefits available through your Provider, reimbursement for up to the dollar amounts listed below for the expenses of one eye examination and corresponding set of eyeglasses or contact lenses during each calendar year.

Examinations
Eligible Participant, Spouse, and Dependent Child(ren)

One examination every calendar year..$50.00
(for children up to age 19, the Fund will pay for the reasonable and customary cost of an annual eye examination, and not apply the $50.00 maximum)

Lenses (Including safety lenses)
Eligible Participant, Spouse, and Dependent Child(ren)
One set of lenses every calendar year subject to the benefit maximums below
Single Lenses $65.00
Bifocal Lenses..$125.00
Trifocal Lenses...$145.00

Frames
Eligible Participant, Spouse, and Dependent Child(ren)
One set of frames every calendar year..$100.00

Contact Lenses
Eligible Participant, Spouse, and Dependent Child(ren)
Calendar Year Maximum...$200.00

Limitations and Exclusions
No payment will be made for the replacement of broken, lost or stolen lenses, contact lenses and/or frames.

C. What Are My Hearing Aid Benefits?

Hearing Aid and Repair Benefit

The Plan has a hearing aid benefit for Participants and dependents.

This benefit is payable at an 80% co-insurance up to a maximum benefit paid of $2,500.00 per aid and/or repair(s) in a three-year window. Hearing aids would be considered an eligible expense if purchased once every three years. Repairs, of course, would be eligible at any time during the three-year period as long as you have not been paid the maximum benefit.

Example 1: You purchase your hearing aids in February 2017, and each aid costs $2,000. You are reimbursed 80% of the $4,000 charge, or $3,200. Sometime in 2018, your hearing aids need repair. The cost to repair both aids is $800. You are reimbursed 80% of the charge, or $640, bringing the total benefit paid to $3,840. You would be eligible for new hearing aids in March 2020.

Example 2: You already own hearing aids. In February 2017, they need repair. The cost to repair both aids is $800. You are reimbursed 80% of the charge, or $640. In March 2018, you purchase new hearing aids and each aid costs $2,000. You are reimbursed 80% of the $4,000 charge, or $3,200, bringing the total benefit paid to $3,840. In March 2021, you would be eligible to purchase new hearing aids.

D. How Do I Submit Dental, Orthodontic, TMJ, Vision, and Hearing Aid Claims?

The Tufts HMO and PPO Plans offer limited dental coverage for children under age 12. The Plans also cover one routine eye exam per calendar year. The Tufts PPO and HMO Plans provide limited coverage for some medical services to treat TMJ dysfunction. If you receive services that are not covered by your Provider or Delta Dental, then you should file a claim form with or send a copy of the bill to the Fund Office. Otherwise:

Dental – Tufts HMO and PPO Plans– If you are insured with the Tufts HMO or PPO Plan and are utilizing an affiliated dental provider, you should submit dental claims for preventive care visits for children under age 12 to the Tufts HMO or PPO Plan first and then to Delta Dental if there is a remaining balance. For all other participants, you should present your Delta Dental identification card to your dental provider and Delta Dental will process your claim.

TMJ –Tufts HMO and PPO Plans – If you are insured with the Tufts PPO or HMO Plan and you or your dependent receives medical treatment for TMJ dysfunction that is covered by those Plans, you should submit your claims for such treatment to the Tufts Plan first. When you receive your Explanation of Benefits (EOB) from the Tufts Plan, send a copy of it to the Fund Office for consideration of any remaining balance.

Vision – Tufts HMO and PPO Plans – You are covered for one routine eye examination in each 12-month period. Please refer to the Tufts HMO or PPO Plan Benefits Summary for more details and information about how to find a participating

provider. As noted above, the same guidelines for submission of vision claims would apply.

Please be sure to follow these guidelines should you receive services from a participating Tufts HMO or PPO Plan dental or vision provider, or if you receive medical services to treat TMJ as covered by the Tufts HMO or PPO Plan. Claims forwarded to the Fund Office without an Explanation of Benefits will be pended for primary insurance payment.

For the Vision Expense Benefit (section B above) you should send a completed claim form or a copy of the bill directly to the Fund Office to receive reimbursement.

Remember: If your claim is for vision, dental, orthodontic or hearing aid benefits, or if your Provider does not cover your vision, dental, or TMJ care services or you do not use a participating provider, you should send a completed claim form or a copy of the bill directly to the Fund Office. You may obtain blank claim forms by calling the Fund Office.

7. LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

A. What Are My Life Insurance Benefits?

Life insurance benefits are currently insured through Aetna, which administers the original group policy purchased from The Paul Revere Life Insurance Company. The Trustees may, however, change insurance companies from time to time. The Plan currently will pay the following life insurance benefits for all covered Participants:

- $30,000 for non-retired Participants
- $7,500 for retired Participants

Your life insurance benefit will be paid to the Beneficiary you have designated on your Beneficiary designation form. You may change your Beneficiary at any time and as often as you desire, but you must file a new Beneficiary designation form with the Fund Office before the change becomes effective.

Life insurance benefits under the Plan are not part of the Participant's estate and will not be probated with the estate. Designation of Beneficiaries under a will shall not be honored by the Plan. Only the last designated Beneficiary on file with the Fund Office will receive a Participant's life insurance benefits. Be sure that you update your designated Beneficiary information so that it is current at all times.

1. Life Insurance During Periods of Total Disability

If you become totally disabled[4] while you are insured under the group term life insurance policy, your premium may be waived if you satisfy certain conditions. If your disability begins before your 60th birthday, you are insured on the date you become totally disabled and you are totally disabled for at least five months during which premium payments have been made on your behalf, your life insurance benefit will continue at no cost to you while you remain disabled. You must provide proof of your disability to Aetna within 12 months of the date you become totally disabled before any premiums can be waived. Each year, Aetna will request proof that you are still totally disabled, which may include a physical exam by a doctor chosen by Aetna. Premiums will stop being waived upon the earliest of the following events:

- You are no longer totally disabled; or
- You convert your group term life insurance policy to an individual policy (see below); or
- You fail to submit proof that you are still totally disabled; or
- You reach age 70; or
- You retire.

[4] Aetna defines "totally disabled" as your continuing inability, as a result of sickness or accidental injury, to perform the important duties of any job for which you are or become qualified by reason of education, training or experience.

2. Change to an Individual Policy

If your insurance terminates, you may convert your group term life insurance policy to an individual policy during the 31 days following the termination of your insurance. If you choose to convert to an individual policy, your policy will be effective at the end of the 31-day period, and the premiums will be based on your age on the date of the conversion. If you die during this 31-day period, your term life insurance will be paid whether or not you applied for an individual policy. Any premium paid during this 31-day period will be returned to the Participant's named Beneficiary in the event that the Participant dies.

If you wish to change to an individual policy, it is up to you to contact the Fund Office and to file the necessary application within 31 days after your group term life insurance terminates. If you do not do so, your life insurance benefit will automatically terminate.

Please note that, unless a Participant converts the group term life insurance policy to an individual policy, Participants who maintain their coverage under the Plan through COBRA and Participants who do not have the required 600 eligibility hours will not be eligible for life insurance benefits.

B. What Are My Accidental Death & Dismemberment Benefits?

This benefit is currently insured by Aetna. The Trustees may, however, change companies from time to time. Aetna pays accidental death and dismemberment ("AD&D") benefits if you lose your life, limb or sight due to an accident. All of the following conditions must be met:

- You are eligible for AD&D benefits under the Plan on the date of the accident.
- Loss occurs within 180 days of the date of the accident.
- The cause of the loss is not excluded.

For Loss of Life

The benefit is $30,000, paid to your Beneficiary

Loss	Benefit
Both hands	$30,000
Both feet	$30,000
Sight of both eyes	$30,000
One hand and one foot	$30,000
One hand and sight of one eye	$30,000
One foot and sight of one eye	$30,000

The benefit will be paid to you.

Loss	Benefit
One hand	$15,000
One foot	$15,000
Sight of one eye	$15,000

The benefit will be paid to you.

Aetna defines "loss of hand" or "loss of foot" as the irrecoverable loss of the hand or foot as a result of accidental injury. "Loss of sight" means total loss of sight that cannot be restored.

Exclusions

The Plan's AD&D benefit does not cover losses caused directly or indirectly by the following:

- Sickness; or
- Medical or surgical treatment; or
- Suicide or intentionally self-inflicted injury; or
- Bacterial infections generally, but infections that are due directly to an accidental cut or wound will be covered; or
- War or any act or accident of war, whether declared or undeclared; or
- Your operating or riding in an air craft as a pilot, officer or crew member; or
- Your intoxication, as defined by the jurisdiction in which the accident or loss occurs; or
- Your being under the influence of any narcotic, hallucinogen, barbiturate or amphetamine, unless administered on the advice of a doctor.

You will not be eligible for AD&D benefits if you become totally disabled and your life insurance benefit is being continued by Aetna under the premium waiver provision described above.

Please note that AD&D benefits are not available to Participants who maintain their coverage under the Plan through COBRA, Participants who do not have the required 600 eligibility hours, or dependents.

8. RETIREE BENEFITS

A. What Retiree Benefits Are Available Under the Plan?

Medical and prescription drug benefits are provided to all eligible non-Medicare eligible retirees through Tufts Health Plan as long as they have Banked Surplus Hours or pay for the cost of the premium for this coverage until age 65, at which time benefits are available to eligible retirees through a Medicare Supplement through Blue Cross Blue Shield of Massachusetts (the "Medicare Supplement Provider"). Benefits are payable for your lifetime as long as you have Banked Surplus Hours or pay the required share of the cost of this supplemental coverage (see Section 8(D) below).

Vision, dental, orthodontic, TMJ and hearing aid benefits are self-funded and are payable only as long as you have Banked Surplus Hours.

Life insurance benefits at the retiree benefit level continue for your lifetime, or as long as you pay the applicable premium.

These benefits are not guaranteed and can be amended or terminated at any time.

B. How Do I Become Eligible for Retiree Benefits?

You will be eligible for retiree benefits if you satisfy the following eligibility requirements:

- You have worked 12,000 hours in Covered Employment during the ten-year period immediately preceding your retirement under the Pension Fund Local 96 – IBEW Pension Plan; or
- You are disabled with at least ten years of service and are entitled to Social Security Disability Income benefits.

C. What Happens to My Medical Coverage When I Reach Age 65?

Approximately three months before your 65th birthday please call the Fund Office for information regarding the available Medicare Supplemental Plan offered through the Fund. You will be mailed all information as well as the appropriate enrollment forms and a self-addressed envelope. Once you select a Medicare Supplement Provider, please mail the appropriate enrollment form to the Fund Office and NOT to the Provider.

This Summary PLAN DESCRIPTION does not discuss medical plan provisions of the Medicare Supplemental Plan in detail. Please refer to the Evidence of Coverage provided by the medical Provider for detailed information. This information is available at no charge from the Fund Office and the Provider, and is incorporated in this document by reference.

D. Is There a Cost for My Supplemental Coverage?

If you have Banked Surplus Hours, then there is no cost for your supplemental coverage until your Banked Surplus Hours run out. Then you will be charged a self-payment rate of a percentage of the premium cost, which was 90% in 2017. The Trustees decide annually the percentage of the premium to be charged by the Provider for the supplemental coverage and notify the retirees of their decision.

E. Can I Make Changes in My Supplemental Medical Provider?

Yes, you can make changes effective each January 1. If you want to make changes to your Medicare Supplemental Provider, you must notify the Fund Office during the period October 15th and December 7th, prior to the Medicare Supplement Plan's anniversary date (January 1). You should complete and return the necessary forms to the Fund Office if possible, however, before November 15th to ensure a smooth transition.

F. When Does Retiree Coverage Terminate?

Retiree coverage will terminate on the first day of the month after you fail to pay the required retiree premium. The Board of Trustees also reserves the right to terminate the benefit (and the Plan) at any time.

G. When I Retire, Is There a Cost for My Life Insurance?

If you have Banked Surplus Hours, then there is no cost for your life insurance until your Banked Surplus Hours run out. When you retire, however, the amount of your life insurance benefits under the Plan changes. See Section 7(A).

If you do not have any Banked Surplus Hours, the cost to you for your life insurance is established annually by the Board of Trustees. If you are receiving a monthly benefit from the Pension Fund Local 96-IBEW, you may have this premium deducted automatically from your pension benefit. If you wish to take advantage of this service, please contact the Fund Office to obtain a copy of the necessary authorization form, which you must complete.

Retirees who do not elect Medical coverage through the Plan may keep the Life Insurance benefit, as long as they pay the premiums timely.

H. When I Reach Age 65, What Happens to My Spouse's Coverage?

If your spouse is not yet age 65, coverage for your spouse will continue without interruption and will be in your spouse's name as long as the monthly premium cost is paid.

If you have Banked Surplus Hours, then there is no cost for your spouse's continued coverage until your Banked Surplus Hours run out. NOTE: If your spouse is also age 65,

or older, coverage for your spouse will continue without interruption under the appropriate Medicare Supplemental Plan as long as the monthly premium cost is paid.

I. When Does My Spouse's Coverage Terminate?

Your spouse's coverage will continue as long as he or she continues to pay the monthly premium or until he or she remarries.

9. FILING AND PROCESSING OF CLAIMS, DENIAL OF CLAIMS AND PROCEDURES FOR APPEAL

A. Filing of Claims in General

Any Claimant (or the Claimant's Authorized Representative) may file a claim for benefits under the Plan. The Providers have full discretionary authority to review and determine the status of claims for services covered by them (referred to by the Providers as "Covered Services"). Thus, for Covered Services claims, you must follow the claims and appeals procedures described in your Provider's Evidence of Coverage or Subscriber Certificate. To the extent any information presented in this Section 9 conflicts with the information in your Provider's Evidence of Coverage or Subscriber Certificate, that Evidence of Coverage or Subscriber Certificate shall govern.

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

Elimination of Conflict of Interest: To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and dental/vision experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination, or retention) will not be made on the basis of whether that person is likely to support a denial of benefits.

Language Services with Regard to Plan-Funded Benefits: If you are not literate in English, then, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. You may call the Fund Office at (800) 446-8646 for more information.

Medical Claims (Insured)

Generally, you should never receive a bill for Covered Services provided by a medical professional who is in your Provider network. However, if you do receive a bill for Covered Services from a medical professional, forward the bill to your Provider along with the Provider's claim form, within 90 days of the date of the service. **Bills sent to certain Providers more than 90 days after the date of service may not be considered for payment.** If you receive a bill for Covered Services provided by a medical professional who is not in your Provider network, you have 180 days from the date of service to submit the claim. You may obtain claim forms by contacting the Provider's customer service office at the telephone number on your insurance card. Bills should be sent to the medical insurance Providers at the following addresses:

Tufts Health Plan
Attn: Claims Department
333 Wyman Street
P.O. Box 9112
Waltham, MA 02454-9112
(800) 462-0224

Medicare Supplement Plan:

Blue Cross Blue Shield of MA
101 Huntington Street
Boston, MA 02199-7611
(800) 358-2227

Life Insurance and AD&D Claims (Insured)

The Plan's group term Life insurance and accidental death and dismemberment ("AD&D") benefits are fully insured by Aetna. Aetna has full discretionary authority to review and determine the status of claims for Life Insurance and AD&D benefits. In order to obtain Notice of Claim and Proof of Loss forms for term life insurance and AD&D benefits, please contact the Fund Office by phone or by mail.

In order to be eligible to receive term life insurance benefits or AD&D benefits, **you must complete a Notice of Claim form and return it to the Fund Office within 30 days of the following event, as applicable**:

- the date of the Participant's or retiree's death, with respect to a claim for life insurance benefits; or
- the date of loss, with respect to AD&D benefits.

After you have filed a Notice of Claim form with the Fund Office, **you must complete and send a Proof of Loss form to the Fund Office within 90 days of the date of death or loss. Please note that if the required information is not submitted to and received by the Fund Office within the required time limits, your claim may be reduced or invalidated.** Please note that the Fund Office will work with Aetna to have your claim paid timely, once all required documentation is received. If you do submit the required documentation after the 90 day period, and you can show that it was not reasonably possible to submit information within the required time periods and that you filed the information as soon as reasonably possible, your claim will not be reduced or invalidated.

If a Claimant's term life insurance or accidental death & dismemberment claim is denied in whole or in part, the Claims Reviewer will notify the Claimant in writing of such denial and the reason for the denial within 90 days after receipt of the claim by the Plan, unless special circumstances require an extension of time to process the claim, in which case the Claimant will be notified before the end of the initial 90-day period of the reason for the extension and the date by which the Claims Reviewer expects to make a

determination. The Claims Reviewer will then notify the Claimant of its determination within an additional 90-day period. The claims provisions in the evidence of coverage with Aetna will prevail in the case of any inconsistency with this provision.

For all other benefits, the following procedures apply:

Dental and Orthodontic Claims

The Tufts HMO and PPO Plans cover some preventive dental care for children under age 12, and one routine vision exam per calendar year as well as some medical services to treat temporomandibular joint dysfunction ("TMJ"). All other dental, orthodontic benefits are administered by **Delta Dental** of Massachusetts on a plan-funded, or self-insured, basis. **No claims will be considered for payment unless a completed claim form is submitted to Delta Dental within one year from the date of service.** Please refer to Section 6(D) of this PLAN DESCRIPTION for instructions on submitting claims for dental and orthodontic services. Delta Dental of Massachusetts may be contacted at: 465 Medford Street, Boston, MA 02129; (800) 872-0500; www.deltadentalma.com.

Temporomandibular Joint Dysfunction ("TMJ"), Vision, and Hearing Aid Claims (Plan-Funded and Administered)

All TMJ, vision, and hearing aid benefits are offered by the Plan on a self-funded basis and are administered by the Fund Office. **No claims will be considered for payment unless a completed claim form is submitted to the Fund Office within one year from the date of service.** Please refer to Section 6(D) of this PLAN DESCRIPTION for instructions on submitting claims for dental, orthodontic, TMJ, vision, and hearing aid services.

Short-Term Temporary Disability Income Benefits (Plan-Funded and Administered)

Short-term temporary disability income benefits are offered by the Plan on a self-funded basis and are administered by the Fund Office. In order to obtain claim forms for short-term temporary disability income benefits, please contact the Fund Office by phone at (800) 446-8646 or in writing at the following address:

Health & Welfare Fund IBEW Local 96
c/o Zenith American Solutions
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492

Completed claim forms, with all required medical information, must be submitted to the Fund Office within one year of the date you were injured or became ill. Please note that this benefit is not available to Participants who pay for their own coverage, Participants who do not have the required 600 eligibility hours, retirees, or dependents.

B. Time Permitted for Notification of Claims Decisions (Plan-Funded Benefits)

Urgent Care Claims

An Urgent Care Claim is a claim for care or treatment made where (1) the Claimant's life, health, or ability to regain maximum function would be seriously jeopardized if the standard Precertification Claim standards (see below) were applied, or (2) the Claimant would, in the opinion of a physician with knowledge of the Claimant's condition, be subjected to severe pain that could not be adequately managed without the care or treatment for which the approval is sought.

In the case of an Urgent Care Claim, the Claims Reviewer will notify the Claimant of the Plan's benefit determination (regardless of whether the determination is adverse) as soon as possible, recognizing the medical exigencies particular to the Claimant's situation, but not later than 72 hours after receipt of the claim by the Plan. However, if the Claimant fails to provide information sufficient to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claims Reviewer will notify the Claimant as soon as possible, but not more than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete processing of the claim.

The Claimant will have a reasonable amount of time, taking into account the Claimant's circumstances, but not less than 48 hours, to provide the necessary information. The Claims Reviewer may, as a condition to deciding a claim as an Urgent Care Claim, require the Claimant to clarify what are the medical exigencies or medical circumstances that support the claim for expedited decision making as an Urgent Care Claim.

The Claims Reviewer will notify the Claimant of the Plan's benefit determination as soon as possible but in no event more than 24 hours after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded the Claimant to provide the specified information. The Claimant may, at the Claimant's option, extend the time periods specified above for action by the Plan on an Urgent Care Claim. A notice by the Claims Reviewer of a favorable determination should contain sufficient information to apprise the Claimant of the Plan's decision to grant full approval of the Urgent Care Claim. Notice of the Claim Reviewer's decision regarding an Urgent Care Claim may initially be given orally, provided written notice of the decision is furnished not more than three days later.

In processing a claim for benefits, the Claims Reviewer will determine whether a particular claim is an Urgent Care Claim on the basis of information furnished by or on behalf of the Claimant, applying the judgment of a prudent layman with average knowledge of health and medicine, but deferring to the judgment of a physician with knowledge of the Claimant's condition.

Precertification Claims

A Precertification Claim is a claim for benefits for which prior authorization is required. The Plan will not deny benefits for procedures or services if (1) it is not possible for the Claimant to obtain prior authorization, or (2) the prior authorization process would jeopardize the Claimant's life or health.

In the case of a Precertification Claim, the Claims Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Claims Reviewer (i) determines that such an extension is necessary due to matters beyond the control of the Claims Reviewer and (ii) notifies the Claimant or the Claimant's Authorized Representative before the end of the initial 15 day period of the circumstances requiring the extension of time and the date by which the Claims Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice should describe the required information, and the Claimant or the Claimant's Authorized Representative will be given at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Review Claims

A Concurrent Care Review Claim is a claim that is reconsidered after being initially approved, such as a recertification of the number of days allowed for an inpatient hospital stay, where the reconsideration will result in reduced benefits or a termination of benefits.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that involves an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies, and the Claims Reviewer will notify the Claimant or the Claimant's Authorized Representative of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments. If the claim is not an Urgent Care Claim, the Claims Reviewer will notify the Claimant or the Claimant's Authorized Representative sufficiently before the reduction or termination to allow the Claimant to appeal (provided such claim has not been delayed by the Claimant so as to make such notice impossible), except that the foregoing shall not serve to extend the time in which the Claimant has to appeal.

Post-Service Claims

A Post-Service Claim is a claim that is not an Urgent Care Claim, a Precertification Claim, or a Concurrent Care Review Claim. Claims for dental, hearing and vision benefits are Post-Service Claims. A claim regarding a rescission of coverage (as defined in Section 9C below) will also be treated as a Post-Service Claim.

In the case of a "Post-Service Claim" – that is, a health benefit claim that is not an Urgent Care Claim, a Precertification Claim, or a Concurrent Care Review Claim – the Claims Reviewer will notify the Claimant or the Claimant's Authorized Representative of the adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Claims Reviewer for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Claims Reviewer and notifies the Claimant or the Claimant's Authorized Representative before the end of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Claims Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant or his Authorized Representative to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant or the Claimant's Authorized Representative will have at least 45 days from receipt of the notice within which to provide the specified information. The time periods in which the Claims Reviewer has to render a decision shall be tolled during periods in which the Plan is waiting for information from the Claimant.

Short-Term Temporary Disability Income Benefits

In the case of a claim for short-term temporary disability income benefits, the Claims Reviewer will have 45 days in which to notify the Claimant of its claims decision, unless such decision cannot be rendered within the 45 day period due to matters beyond the control of the Plan, in which event an extension of an additional 30 days may be taken by the Claims Reviewer. The Claimant in such event will be notified prior to the expiration of the 45 day period of the circumstances requiring the extension and when such decision is expected. An additional extension of 30 days may be required if it is determined that a decision cannot be rendered due to matters beyond the control of the Plan. The Claimant in such event will be notified prior to the expiration of the initial 30 day extension of the circumstances requiring the extension and when such decision is expected. Such notice shall also explain the standards for entitlement to short-term temporary disability income benefits, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The Claimant will have 45 days after receipt of this notice within which to provide the specified information. The time periods in which the Claims Reviewer has to render a decision shall be tolled during periods in which the Plan is waiting for information from the Claimant.

All Claims

If you do not receive notice of the Claim Reviewer's decision regarding your claim within the applicable period described above, you may assume your claim has been denied and continue to the next step in the process.

C. Adverse Benefit Determinations

An adverse benefit determination, or denial, is generally a denial, reduction, or

termination of, or a failure to pay (in whole or in part) a benefit.

With respect to dental, orthodontic, TMJ, vision, and hearing aid claims (whether they are Urgent Care, Precertification, Concurrent Care, or Post-Service Claims), this includes:

- A denial, reduction, termination, or failure to pay that is based on either a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction in or denial of a benefit resulting from the application of a utilization review decision, preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefit, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and/or
- A rescission of coverage, regardless of whether there is an adverse effect on any particular benefit at the time. (For this purpose, a "rescission" is a cancellation or discontinuance of coverage that has retroactive effect, except where the cancellation or discontinuance occurs due to a failure to timely pay required premiums or contributions toward the cost of coverage.)

With respect to short-term temporary disability income claims, this includes:

- A denial, reduction, termination, or failure to pay that is based on a determination regarding a Claimant's eligibility to participate in the Plan; and/or
- A rescission of disability coverage, whether or not the rescission results in an adverse effect on any particular benefit at that time. (For this purpose, a "rescission" is a cancellation or discontinuance of coverage that has retroactive effect, except where the cancellation or discontinuance occurs due to a failure to timely pay required premiums or contributions toward the cost of coverage.)

Contents of Denial Notice – Dental, Orthodontic, TMJ, Vision, and Hearing Aid Benefits (Plan-Funded)

A notice of the denial of an Urgent Care Claim, Precertification Claim, Concurrent Care Review Claim, or a Post-Service Claim will be given to the Claimant or the Claimant's Authorized Representative in either written or electronic form. (Notice that an Urgent Care Claim has been denied may initially be given orally, but a written or electronic notice will follow.) The denial notice should include:

- information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);
- a statement that, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning,

will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;

- the specific reason or reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
- references to the specific Plan provision(s) on which the determination is based;
- if applicable, a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- a description of the internal and external review procedures set out in this Section and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an adverse benefit determination concerning an Urgent Care Claim, a description of the expedited review process set forth above applicable to an Urgent Care Claim.

The notice of denial shall disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes.

Contents of Denial Notice – Short-Term Temporary Disability Income Benefits (Plan-Funded)

A notice of the denial of a claim for short-term temporary disability income benefits will be given to the Claimant or the Claimant's Authorized Representative in either written or electronic form. The denial notice should include:

- the specific reason or reason(s) for the adverse benefit determination;
- references to the specific Plan provision(s) on which the determination is based;

- if applicable, a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- a discussion of the decision, including an explanation of the Claim Reviewer's basis for disagreeing with or not following the views presented by: the Claimant; any health care or vocational professionals who treated or evaluated the Claimant; any medical or vocational experts who provided advice to the Claim Reviewer in relation to the claim, without regard to whether the Claim Reviewer relied upon such advice in making its determination; and/or any Social Security disability determination presented by the Claimant;
- a description of the appeal procedures set out in this Section 9 and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claimant's claim;
- any specific internal rule, guideline, protocol, or standard that was relied upon in making the adverse benefit determination, or a statement that no such rule, guideline, protocol, or standard exists;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Contents of Denial Notice – All Plan-Funded Benefits

The Plan will also provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of any appeal is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date. Additionally, before the Plan can deny a claim on appeal based on a new or additional rationale, it must provide the Claimant, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date.

D. Appealing an Adverse Benefit Determination

Medical Benefits (Insured)

Please follow the appeals procedures outlined in your Provider's Evidence of Coverage or Subscriber Certificate from Tufts Health Plan, as applicable. Those are the only appeals procedures available to you with respect to your medical coverage.

Life Insurance and AD & D Benefits (Insured)

A Claimant whose claim for term life insurance or accidental death and dismemberment benefits has been denied may file a written request for review with Aetna, to be received by the insurance company no later than 60 days after receipt by the Claimant of the notice of the adverse benefit determination. Only written appeals will be considered.

Dental, Orthodontic, TMJ, Vision, and Hearing Aid Benefits, and Short-Term Temporary Disability Income Benefits (Plan-Funded)

A Claimant whose Post-Service Claim concerns dental or orthodontic benefits has been denied (in whole or in part) may first file a grievance with Delta Dental within 180 days of receipt of your explanation of benefits by phone, in person or by electronic means at Delta Dental of Massachusetts: 465 Medford Street, Boston, MA 02129; 1-800-872-0500; www.deltadentalma.com. If an oral grievance has been presented, you will be asked to request the grievance in writing and send it to Delta Dental within ten (10) business days, unless that time frame is waived or extended by mutual agreement. Delta Dental will provide you the opportunity to have it reconsider its decision where relevant information is received too late to review within the 30-day time period for rendering a decision or is not received but is expected to become available within a reasonable period. Following a final decision by Delta Dental, an additional voluntary appeal is also available to the Board of Trustees, as explained below.

A Claimant whose Urgent Care Claim, Precertification Claim, Concurrent Care Review Claim or Post-Service Claim which concerns TMJ, vision, hearing aid, or whose claim for short-term temporary disability income benefits, has been denied (in whole or in part) may request review by the Plan's Board of Trustees by filing a written request for review with the Board of Trustees. Additionally, a Claimant whose Post-Service dental or orthodontic claim has been denied by Delta Dental may also file a written request for review with the Board of Trustees. This request for review must be received by the Board of Trustees no later than 180 days after receipt by the Claimant of the notice regarding the adverse benefit determination. The Claimant or the Claimant's Authorized Representative may review pertinent documents and may submit issues and comments in writing. An appeal must include any written or documentary proof which supports the claim, or any other information the Claimant wishes to submit for consideration, whether or not such proof had previously been submitted.

E. Decisions on Appeal (Plan-Funded Benefits)

Upon their receipt of a notice by a Claimant for a request for a review of an adverse benefit determination regarding a claim for dental, orthodontic, TMJ, vision, hearing aid, or short-term temporary disability income benefits, the Trustees will make a prompt decision on review. The Trustees may request, and the Claimant shall provide, such information as the Trustees may deem necessary to their full and fair review of the claim appeal.

Upon request, and without charge, the Claimant will have the right to reasonable access to and copies of documents relevant to his or her claim. A document, record or other information is relevant if: it was relied upon by the Plan in making the decision; it was submitted, considered, or generated in the course of making the decision (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service. The Claimant will have the right to submit written comments, documents, records and other information relating to his or her claim. The review will take into account all such information submitted by the Claimant, without regard to whether that information was submitted or considered in the initial benefit determination.

A different person/entity will review a claim on appeal than the one who originally denied the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the Claimant.

If the adverse benefit determination is appealed on the basis of medical judgment, the Trustees will consult with an independent healthcare professional who is qualified in the areas of dispute and who was neither involved in the initial adverse benefit determination nor a subordinate of any professional who was involved in the initial adverse benefit determination. You will be provided with the identification of medical or vocational experts, if any, who advised the Plan regarding your claim, without regard to whether their advice was relied upon in deciding your claim.

Appeals of adverse benefit determinations will be decided, and notice of the decision on appeal will provided to the Claimant or the Claimant’s Authorized Representative, according to the following timetables:

Urgent Care Claims

An appeal of an adverse benefit determination of an Urgent Care Claim by a Claimant or the Claimant’s Authorized Representative will be decided and notice issued to the Claimant or his Authorized Representative as soon as possible, but in no event later than 72 hours after the Trustees have received the request for review on appeal.

Precertification Claims

An appeal of an adverse benefit determination of a Precertification Claim by the Claimant or the Claimant's Authorized Representative will be decided and notice issued to the Claimant or the Claimant's Authorized Representative within a reasonable period but not more than 30 days after the Claims Reviewer has received the request for review.

Concurrent Care Review Claims

An appeal of an adverse benefit determination of a Concurrent Care Review Claim by a Claimant or the Claimant's Authorized Representative will be decided and notice issued to the Claimant or the Claimant's Authorized Representative as soon as possible but in no event later than: 72 hours after the Claims Reviewer has received the request for review, if the claim involves an Urgent Care Claim; 30 days, in the case of a Precertification Claim; or within the time set forth in the paragraph below, if the claim is a Post-Service Claim.

Post-Service and Short-Term Temporary Disability Income Claims

An appeal of an adverse benefit determination of a Post-Service Claim which relates to dental, orthodontic, TMJ, vision, or hearing aid benefits, or a Short-Term Temporary Disability Income Claim, by a Claimant or the Claimant's Authorized Representative, and submitted to the Board of Trustees, will be decided by the Trustees at their next regularly scheduled meeting, unless the letter requesting the appeal is received by the Fund Office within 30 days of such meeting. In such case, the Trustees will review the appeal no later than their second regularly scheduled meeting following the receipt of the request for review. If special circumstances exist that require an extension of time, the Claimant (or the Claimant's Authorized Representative) must be notified of the need for an extension and the date by which to expect a decision, and the Trustees may review the matter no later than the third regularly scheduled meeting following the receipt of the request for review. Notice of the Trustees' decision will be sent to the Claimant or the Claimant's Authorized Representative within five days of the date of such meeting.

Contents of Notice of Decision on Appeal – Dental, Orthodontic, TMJ, Vision, and Hearing Aid Benefits (Plan-Funded)

In the case of an adverse benefit determination on appeal, the notice shall set forth, in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant:

- information sufficient to identify the claim, including the date of the service, the health care provider, the claim amount (if applicable);
- a statement that, upon request and free of charge, the diagnosis code and its corresponding meaning will be provided. However, a request for this information will not be treated as a request for an external review;

- the specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
- reference to the specific Plan provision(s) on which the benefit determination is based;
- a statement that the Claimant is entitled to receive without charge reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical condition, or a statement that this will be provided without charge on request;
- a description of available external review processes, including information about how to initiate an external review;
- a statement regarding the availability of, and the contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes; and
- a required statement describing the Claimant's right to bring a civil action under ERISA Section 502(a).

Contents of Notice of Decision on Appeal – Short-Term Temporary Disability Income Benefits (Plan-Funded)

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provision(s) on which the benefit determination is based;
- a discussion of the decision, including an explanation of the Claim Reviewer's basis for disagreeing with or not following the views presented by: the Claimant; any health care or vocational professionals who treated or evaluated the Claimant; any medical or vocational experts who provided advice to the Claim Reviewer in relation to the claim, without regard to whether the Claim Reviewer relied upon

such advice in making its determination; and/or any Social Security disability determination presented by the Claimant;

- a statement that the Claimant is entitled to receive without charge reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical condition, or a statement that this will be provided without charge on request; and
- a required statement describing the Claimant's right to bring a civil action under ERISA Section 502(a), including a description any contractual limitations on the time in which the Claimant may bring suit and the calendar date on which such contractual limitation period expires.

F. External Review of Health Claims (Dental, Orthodontic, TMJ, Vision, and Hearing Aid Benefits)

This External Review process is intended to comply with the Affordable Care Act's external review requirements.

If you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the Fund Office at (800) 446-8646 for more information.

If your appeal of a claim is denied, whether it's a Precertification, Post-Service, or Urgent Care Claim, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

Note that external review is only available for the following types of denials of claims:

- A denial that involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; a determination that a treatment is experimental or investigational; a determination of whether a participant or

beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; or a determination about whether the Plan is complying with certain requirements of the Mental Health Parity and Addiction Act concerning parity in the application of medical management. The IRO will determine whether a denial involves a medical judgment; or

- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, external review is not available for short-term disability claims.

External Review of Dental, Orthodontic, TMJ, Vision, and Hearing Aid Claims

Your request for external review of a denial must be made, in writing, within four months of the date that you receive the denial. Because the Plan's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

1. Preliminary Review

   (a) Within five business days of the Plan's receipt of your external review request for a claim, the Plan will complete a preliminary review of the request to determine whether:

   - You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   - The denial does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
   - You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
   - You have provided all of the information and forms required to process an external review.

   (b) Within one business day of completing its preliminary review, the Plan will notify you in writing as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:

   - If your request is complete and eligible for external review; or
   - If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)); or
   - If your request is not complete, in which case the notice will describe the

information or materials needed to make the request complete, and allow you to perfect the request for external review within the four-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

2. Review By Independent Review Organization

If the request is complete and eligible, the Plan will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten business days).

(b) Within five business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its denial determination.

(c) If you submit additional information related to your claim, the assigned IRO must within one business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its denial that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its denial, it will provide written notice of its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the Plan's terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO may, to the extent the information or documents are available and appropriate, consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

(e) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

(f) The assigned IRO's decision notice will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial from an appeal that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a denial from an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in Section 9F1(a) above, are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in Section 9F1(b).

Review By Independent Review Organization

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, above at Section 9F2. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in Section 9F2(f), as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

After External Review

If, upon external review, the IRO reverses the Plan's denial, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's denial, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the

external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

G. Exhaustion of Plan Claim Denial and Appeal Procedures

No Claimant, or any person acting on his or her behalf, may resort to a court of law or equity, or any other judicial, administrative or other agency, without first exhausting the remedies as set forth above and providing all information or evidence in support of such claim to the Trustees in the Claimant's appeal. A Claimant will generally be deemed to have exhausted his or her remedies under these procedures if the Plan has failed to follow them. No Claimant may raise any issues not raised before the Trustees, or introduce any evidence or information in a court proceeding that was not presented to the Trustees at the time in which they rendered their decision on appeal.

10. COORDINATION OF BENEFITS

A. Duplicate Coverage of Medical, Dental, TMJ, Orthodontic, Vision, and/or Hearing Aid Expenses

This Section describes the circumstances when you or your covered dependents may be entitled to medical, dental, TMJ, orthodontic, vision, and/or hearing aid benefits under this Plan and may also be entitled to recover all or part of your medical, dental, TMJ, orthodontic, vision, and/or hearing aid expenses from some other source. It also describes the rules that apply when this happens.

The Tufts Health Plan HMO Choice Copay Plan and Tufts Advantage PPO Plan, and the Medicare Supplemental Plan are insured plans and contain their own provisions with respect to how they coordinate benefits with other plans. The Providers' coordination of benefits provisions will apply to benefits offered through the Tufts HMO and PPO Plans and the Medicare Supplemental Plan.

For the self-insured benefits provided under this Plan, the Plan will coordinate benefits under the following rules:

There are several circumstances that may result in you and/or your covered dependents being reimbursed for your medical, dental, TMJ, orthodontic, vision, and/or hearing aid expenses, not only from this Plan but also from some other source. This can occur if you or a covered dependent is also covered by:

- Another group or individual health care plan; or
- Medicare or some other government program (such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs), or any coverage either provided by a federal, state or local government or agency, or required by federal, state or local law (including but not limited to any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law); or
- Workers' Compensation.

Duplicate recovery of medical, dental, TMJ, orthodontic, vision, and/or hearing aid expenses can also occur if a third party is financially responsible for your medical, dental, TMJ, orthodontic, vision, and/or hearing aid expenses because that third party caused the injury or illness giving rise to those expenses by negligent or intentionally wrongful action.

The important thing to remember is that Coordination of Benefits is designed for just one purpose—to conserve your health care dollars. These provisions protect the entire Plan from unnecessary increases in cost, which will help protect you and your fellow workers. If you have any questions about these rules, you should contact the Fund Office.

B. Coverage Under More than One Group Health Plan

1. When and How Coordination of Benefits ("COB") Applies

For the purposes of this Coordination of Benefits subsection, the word "plan" refers to any group or individual medical, dental, or other policy, contract or plan, whether insured or self-insured, that either provides benefits for medical, dental, or other services incurred by the covered person or provides medical, dental, or other services to the covered person. A "group plan" provides its benefits or services to employees, retirees, or members of a group who are eligible for and have elected coverage. An "individual plan" provides its benefits or services to individuals or families who have purchased coverage.

Many families that have more than one family member working outside the home are often covered by more than one medical, dental, or other plan. If this is the case with your family, **you must let this Plan (or its insurer) know about <u>all</u> of your coverage when you submit a claim.**

Coordination of Benefits (or "COB," as it is usually called) operates so that one plan (called the primary plan) will pay its benefits first. The other plan or plans, (called the secondary plan(s)) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

2. Which Plan Pays First: Order of Benefit Determination Rules

An individual plan (that is, a plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, or group practice or individual practice plan, pays first; and this Plan pays second.

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform "Order of Benefit Determination Rules" in a specific sequence. This Plan uses the Order of Benefit Determination Rules established by the National Association of Insurance Commissioners ("NAIC"), which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules will be deemed to be the primary plan by this Plan.**

If Rule 1 below does not establish a sequence or Order of Benefits, the next Rule is applied, and so on, until an Order of Benefits is established. The Rules are as follows:

Rule 1: Non-Dependent/Dependent

The plan that covers a person as an employee, retiree, member, or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent; and primary to

the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee).

Rule 2: Dependent Child Covered Under More than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if: the parents are married; the parents are not separated (whether or not they ever have been married); or a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for that child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second. The term "**birthday**" refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does **not** apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the Order of Benefit Determination among the plans of the parents and their spouses (if any) is: the plan of the custodial parent pays first; the plan of the spouse of the custodial parent pays second; the plan of the non-custodial parent pays third; and the plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

If the other plan does not have this Rule, and if, as a result, the plans do not agree on the Order of Benefits, this Rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the Order of Benefits is determined by Rule 1 rather than by this Rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member, or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

If the other plan does not have this Rule, and if, as a result, the plans do not agree on the Order of Benefits, this Rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the Order of Benefits is determined by Rule 1 rather than by this Rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous Rules determines the Order of Benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended. The start of a new plan does **not** include a change in the amount or scope of a plan's benefits; in the entity that pays for, provides, or administers the plan; or from one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

C. How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that were primary. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid for each claim, as it is submitted, had it been the plan that paid first. This has the effect of maintaining this Plan's deductibles, coinsurance, and exclusions. As a result, when this Plan pays second, it is possible you may not receive the equivalent of 100% of the total cost of the covered health care services.

D. Administration of COB

To administer COB, the Plan reserves the right to: (1) exchange information with other plans involved in paying claims; (2) require that you or your health care provider furnish any necessary information; (3) reimburse any plan that made payments this Plan should have made; or (4) recover any overpayment from your hospital, physician, dentist, other health care provider, or other insurance company, or from you or your dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount that the Fund Office or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical, dental, or other expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is secondary, this Plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, or otherwise reduces coverage for such services due to a non-compliance penalty, this Plan will only consider such charges to the extent they would have been payable if this Plan were the primary plan.
If this Plan is secondary, and the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same Order of Benefit Determination Rules as this Plan; and if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant shall execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan. See Section 11, subsection B, for more information regarding subrogation.

E. Coordination of Benefits with Medicare and Other Government Programs

1. Medicare

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage after a waiting period.

If you, your spouse, and/or your dependent child are covered by this Plan and by Medicare while you remain actively employed, your health care coverage will continue to provide the same benefits, and this Plan pays first and Medicare will pay second. However, if you work for a Contributing Employer who regularly employs fewer than 20 employees, your employer may elect that Medicare will pay primary for you and for your spouse, if he or she is covered by Medicare.

If you become totally disabled and entitled to Medicare because of your disability, you will continue to maintain your active coverage until your eligibility for active benefits runs out. You will then have the option to continue coverage under either COBRA or the retiree Medicare Supplemental Plan. If you are covered under Medicare and elect the retiree Medicare Supplemental Plan, Medicare pays first and this Plan pays second.

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease ("ESRD"), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of: (1) the month in which Medicare ESRD coverage begins; or (2) the month in which the individual receives a kidney transplant. Then, starting with the 31st month after such month, Medicare pays first and the Medicare Supplemental Plan pays second.

2. Medicare Private Contracts with Health Care Practitioners

Under the law, you are entitled to enter into a Medicare private contract with certain health care practitioners, under which you agree that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If you enter into such a contract, this Plan will pay benefits for health care services and/or supplies you receive pursuant to it, but those benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, medical necessity, Reasonable and Customary charges, and utilization management.

3. Medicaid

In enrolling an individual as a Participant or eligible dependent, or in determining or making any payments for benefits of such individual, the Plan will not take into account the fact that the individual is eligible for or is provided medical assistance under Title XIV of the Social Security Act (Medicaid).

4. TRICARE

If a covered individual is covered by both this Plan and TRICARE, TRICARE pays first and this Plan pays second.

5. Veterans Affairs Facility Services

If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by this Plan to the extent those services are medically necessary and the charges are Reasonable and Customary.

6. Other Coverage Provided by State or Federal Law

If you are covered by both this Plan and any other coverage provided by any state or federal law, the coverage provided by state or federal law pays first and this Plan pays second.

F. Motor Vehicle No-Fault Coverage Required by Law

If you or your dependent is involved in an automobile accident and you have or are required by state law to have basic reparation coverage, your insurance carrier will be primarily liable for lost wages, medical, surgical, hospital, and related charges.

Regardless of whether this Plan is primary or secondary, you or your dependent (if an adult) must sign a Reimbursement Agreement and Consent to Lien before any claims relating to the accident will be paid. The Reimbursement Agreement and Consent to Lien permits the Fund to receive reimbursement for expenses paid by the Fund that you recover through litigation or settlement with another party or insurance company.

11. THIRD PARTY LIABILITY AND RIGHT OF REIMBURSEMENT

A. Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Participant or eligible dependent for which a third party is or may be required to pay because of the negligence or other tortious or wrongful act of that third party. However, subject to the terms and conditions of the Plan, the Board of Trustees, in their discretion, may advance payment for some or all of a claimant's expenses after receipt of a properly executed Reimbursement Agreement and Consent to Lien, and pay claims in accordance with the Plan of Benefits, until it is determined whether a third party is required to pay for those services or supplies. In addition, acknowledgement of the Agreement must be provided to the Fund Office by the Claimant's attorney.

By accepting an advance of benefits (hereafter called an "Advance") paid by the Health & Welfare Fund, you, your spouse, and/or any of your dependent children (hereafter called "**Covered Person**") jointly and severally agree that:

- The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment, or otherwise, by the Covered Person. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

- The Plan will hold in a constructive trust that portion of the recovery that is the extent of the Advance. The Covered Person, and those acting on their behalf shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.

- Should the Covered Person, or those acting on his behalf, fail to maintain this segregated account, or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

- The Covered Person(s) will, jointly and severally, reimburse the Plan for any and all amounts paid or payable to any or all of them by any third party or that third party's insurer to the extent of the entire amount of the Advance related to the accident or injury.

- The Plan's reimbursement and/or subrogation rights will include all claims, demands, actions, and rights of recovery of all Covered Persons against any third party or insurer, including any workers' compensation insurer or governmental agency, and will apply to the extent of any and all advance payments made or to be made by the Plan. The Plan must be promptly reimbursed, in full, within 30 days of any settlement or recovery.

B. Subrogation

As used in this document, **"subrogation"** means the right of the Plan to be substituted in place of any Covered Person with respect to that Covered Person's lawful claim, demand, or right of action against a third party who may have wrongfully caused the Covered Person's injury or illness that resulted in a payment of benefits by the Plan.

The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it advanced in accordance with the Plan of Benefits, and may try or settle any such action or proceeding in the name(s) of and with the full cooperation of the Covered Person(s). However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Person with respect to that Covered Person's damages to the extent those damages exceed any advance on account of the Plan of Benefits.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Person against any third party or that third party's insurer on account of any alleged negligent, intentional, or otherwise wrongful action that may have caused or contributed to the Covered Person's injury or illness that resulted in the advance by the Plan.

C. Reimbursement and/or Subrogation Agreement

Every Covered Person on whose behalf an advance may be payable must execute and deliver any and all agreements, instruments, and papers requested by or on behalf of the Plan (Reimbursement Agreement and Consent to Lien), and must do whatever is necessary to protect the Plan in obtaining reimbursement and/or subrogation rights. As a condition of the Plan making advance payment of related claims, all Covered Persons will, upon written request and before the advance payment is made, execute a Reimbursement Agreement and Consent to Lien in a form provided by or on behalf of the Plan.

If any Covered Person does not execute any such Reimbursement Agreement and Consent to Lien for any reason, it will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's reimbursement and/or subrogation rights if the Plan, at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement and/or subrogation agreement.

The Plan's standard administrative procedure will be to ascertain the nature of any injury to determine whether a third-party could be held liable. Claims will not be

paid until this determination is made. If it is determined that the claim may be the result of a third-party's negligence, the Plan will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien, along with acknowledgement by the Claimant's Attorney.

D. Cooperation with the Plan by All Covered Persons

By accepting an advance payment for a claim related to an accident or injury, every Covered Person agrees to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights, and agrees to notify and consult with the Board of Trustees, its Fund Office, or designee, before:

- Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional, or otherwise wrongful action that may have caused or contributed to the Covered Person's injury that resulted in the Health & Welfare Fund's advance payment of related claims; or

- Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the Covered Person's injury that resulted in the Health & Welfare Fund's advance payment of claims related to such injury.

By accepting an advance payment for a claim related to an accident or injury, every Covered Person agrees to keep the Board of Trustees, its Fund Office, or designee, informed of all material developments with respect to all such claims, actions, or proceedings.

E. All Recovered Proceeds Are To Be Applied to Reimbursement of the Fund

By accepting an advance payment of claims related to an accident or injury, every Covered Person agrees to reimburse the Health & Welfare Fund for all such advances, by applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of the medical expenses for which any advance has been made by the Health & Welfare Fund. In such event the Health & Welfare Fund must be fully reimbursed within 30 days of such settlement or recovery, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorneys' fees. The right to reimbursement will apply even if: (a) the recovery is not sufficient to make the ill or injured Covered Person whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and without any reduction for legal or other expenses incurred by the Covered Person in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule); and (b) even if the recovery was reduced due to the negligence

of the covered Employee or covered dependent (sometimes referred to as "contributory negligence"), or any other common law defense.

If any Covered Person fails to reimburse the Health & Welfare Fund as required by the Plan, the Health & Welfare Fund may apply any future claims for benefits that may become payable on behalf of all Covered Persons to the amount not reimbursed to the Covered Person by the Fund.

Once the claim is settled, the Health & Welfare Fund will not pay future benefits for claims related to that injury or accident unless it is determined by the Board of Trustees that the original settlement was reasonable and the subsequent claims were not recognized in the settlement.

F. No Fault Insurance Coverage

Where the Participant or his dependent is involved in an automobile accident covered by a No-Fault Insurance policy, the automobile No-Fault Insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of:

- The maximum amount of basic reparation benefit required by applicable law; or
- The maximum amount of the applicable No-Fault Insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective plan under which you are provided health coverage. Before related claims will be paid through this Fund, the Participant or his dependent will be required to sign a Reimbursement Agreement and Consent to Lien.

If the Participant or his dependent fails to secure No-Fault Insurance as required by state law, the Participant or dependent is considered to be self-insured and must pay the amount of the basic medical reparation expenses arising out of the accident for himself and/or his dependents.

G. Refund of Overpayment of Benefits - Right of Recovery

If the Fund pays benefits for expenses incurred on account of you or your eligible dependent, you or any other person or organization that was paid must make a refund to the Fund if:

- All or some of the expenses were not paid, or did not legally have to be paid, by you or your eligible dependents;
- All or some of the payment made by the Fund exceeds the benefits to which you and your eligible dependent(s) are entitled under the Plan; or
- All or some of the expenses were recovered from or paid by a source other than this Plan, including another plan to which this Plan has secondary liability under

the Coordination of Benefits provisions. This may include payments made as a result of claims against a third party for negligence, wrongful acts, or omissions.

The refund shall equal the amount the Fund paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Fund paid.

If you or any person or organization that was paid do not promptly refund the full amount, the Fund may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Fund may have other rights in addition to the right to reduce future benefits. See also section 3(M) regarding submission of fraudulent claims, which provides that you will have to provide full restitution plus interest to the Plan and reimbursement of any expenses incurred by the Plan as a result of submission of any claims for benefits containing misrepresentations or false, fraudulent, incomplete or misleading information.

12. COBRA CONTINUATION COVERAGE

The right to continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, which requires that most employers with group health plans offer employees and their covered dependents the opportunity to temporarily continue their health care coverage at group rates when coverage under the plan would be lost. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA coverage is a temporary continuation of coverage under this Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your eligible dependent children could become qualified beneficiaries if coverage under the Plan is lost due to a qualifying event. Under the Plan, qualified beneficiaries are required to pay for COBRA continuation coverage. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred.

There may be other coverage options besides COBRA for you and your family. Key parts of the federal health care law (known as the Affordable Care Act) permit you to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees, if you request enrollment within 30 days. You can see what is available through Massachusetts' Health Insurance Marketplace by going to www.mahealthconnector.org or if you are hearing impaired you may call 1 (877-623-6765).

"**Qualifying Event**" means one of the following occurrences, which would result in a loss of coverage for you or your eligible dependent(s) in the absence of the availability of COBRA continuation coverage:

- Your loss of eligibility due to a termination or reduction of hours;
- Your death;
- Your divorce or legal separation;
- Your enrollment in Medicare benefits (Part A or B) or both; or
- With respect to your dependent child, the child's ceasing to satisfy the Fund's definition of an eligible dependent.

If you or your dependent experiences a Qualifying Event, you must notify the Plan Administrator at the following address within 60 days after the later of: (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the Plan as a result of the qualifying event:

Health & Welfare Fund IBEW Local 96
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Attention: COBRA Administration

Notice may be provided by you on behalf of your eligible dependent with respect to the Qualifying Event, or any representative acting on behalf of you or your eligible dependent. Notice from one individual will satisfy the notice requirement for all qualified beneficiaries affected by the same Qualifying Event. For example, if you, your spouse and child are all covered by the Plan, and the child ceases to be a dependent under the Plan, a single notice sent by the spouse would satisfy the requirement.

If you or your eligible dependents have provided notice to the Plan Administrator of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a dependent, or a second Qualifying Event, but are not entitled to COBRA, the Plan Administrator will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within 14 days of receiving your notice.

A. Election Period

You and/or your eligible dependent(s) must elect to continue health coverage under this Plan within 60 days of:

- The date you and/or your eligible dependent(s) would otherwise lose health coverage under this Plan due to the Qualifying Event; or
- The date you and/or your eligible dependents are notified of your right to elect COBRA continuation coverage.

Any COBRA election must be in writing, on the form provided by the Fund Office.

Elected benefits will be continued under COBRA provided:

- The election form is completed and returned to the Fund Office within the 60-day period noted above;
- The initial required premium is paid to the Fund Office within 45 days of your and/or your eligible dependent's election and is subsequently remitted to the Fund Office on a timely basis on your and/or your eligible dependent's behalf.

Once you elect COBRA continuation coverage, you may not change your election until the next open enrollment period unless you experience a Change in Family Status (i.e., once you elect single or family coverage, you are not allowed to change your election

UNLESS, for example, you get married or divorced, your spouse dies, you acquire a dependent child, or your child ceases to be an eligible dependent under the Plan). For more information about Changes in Family Status, see Section 3(E).

B. Continuation Period

Coverage may continue on a self-pay basis as follows:

Qualifying Events and Maximum Periods of Continuation Coverage

Qualifying Event	You	Spouse	Dependent Child(ren)
Your loss of eligibility due to termination of reduction in hours	18 months	18 months	18 months
Your death	N/A	36 months	36 months
You become divorced or legally separated	N/A	36 months	36 months
You become enrolled in Medicare, part A or B, or both	N/A	36 months	36 months
Dependent child ceases to have dependent status	N/A	N/A	36 months

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If the loss of coverage is due to the Participant's loss of eligibility, then the 18-month period of continuation coverage may be extended for the covered spouse and dependents to 36 months if there is a second Qualifying Event before the end of the original 18-month period of continuation coverage. This extension may be available to the spouse and dependent children (only) who are receiving continuation coverage if: the employee or former employee dies, becomes entitled to Medicare (under Part A, Part B or both); the former employee gets divorced or legally separated; or the dependent child stops being eligible as a "dependent" under the Plan - but only if the event that occurred would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event (i.e., termination of employment or reduction in work hours) not taken place. Note: Employees or former employees cannot experience "second qualifying events." In no event is a COBRA beneficiary entitled to more than 36 months of continuation coverage.

C. A New Child in Your Household

If you have a newborn child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add this child to your coverage for the balance of the COBRA coverage period. You must notify the Fund Office in writing, at the address given above, within 30 days of the birth or placement in order to add the child to your coverage. Adding a child to your coverage may cause an increase in your COBRA premiums.

A child born or placed with you for adoption while you are on COBRA will have the same COBRA rights as your spouse or dependents who were covered by the Health & Welfare Fund before the event that triggered COBRA coverage. As with all COBRA-covered beneficiaries, their continued coverage depends on the timely and uninterrupted payment of premiums on their behalf.

D. Disability Extension of COBRA Continuation Coverage Period

If the Social Security Administration determines that you (or a member of your family who is also eligible for COBRA continuation coverage) were totally and permanently disabled on the day you lost eligibility for health coverage under the Health & Welfare Fund as an active employee, or within 60 days after that date, you or your disabled family member may elect to keep COBRA coverage for a maximum of 29 months instead of the usual 18 months.

You or your disabled eligible dependent must notify the Fund Office of the Social Security Administration's disability determination in writing within 60 days of the date it is issued and before the end of the initial 18-month COBRA coverage period. You or your disabled eligible dependent must also notify the Fund Office within 30 days of the date of any final determination by the Social Security Administration that you or your eligible dependent is no longer disabled. This extended period of COBRA continuation coverage will end at the earlier of the end of the 29 months from the date of the Qualifying Event or the date the disabled Qualified Beneficiary becomes entitled to Medicare. As with all COBRA coverage, a disabled person's eligibility for this extension depends on the timely and uninterrupted payment of premiums on their behalf.

E. Payment of COBRA Premium

You and/or your eligible dependents who elect to continue coverage will be solely responsible for the payment of the monthly premium for continuation coverage. If an election is made after the Qualifying Event, premium payment for continuation coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid in monthly installments within 30 days after the first of the month in which insurance is provided.

AFTER THE INITIAL PAYMENT IS MADE, YOU WILL NOT HAVE THE OPTION TO MAKE SELF-PAYMENT TO THE HEALTH & WELFARE FUND ON A RETROACTIVE BASIS. PAYMENTS MUST BE MADE CONTINUOUSLY AND WITHOUT INTERRUPTION. FAILURE TO MAKE THE MONTHLY PAYMENT, WHEN DUE, WILL RESULT IN THE IMMEDIATE TERMINATION OF YOUR COVERAGE WITHOUT NOTICE AND WITHOUT ANY PROVISION FOR RE-INSTATEMENT.

The Health & Welfare Fund intends to provide only you with notification of your loss of eligibility by first class or certified mail to your last address on file at the Fund Office. The Fund assumes no responsibility or liability if you allow your eligibility for benefits to terminate. If you have any reason to believe that your eligibility will be or has been terminated, it is your responsibility to contact the Fund Office to verify your eligibility status.

After an election is made regarding COBRA coverage, no change will be allowed in the level of coverage for the duration of the continuation period, though transfers between "single" and "family" coverage will be permitted if warranted based upon Changes in Family Status, as described at Section 3(E).

F. Benefit Options

If you choose to continue your coverage, the Health & Welfare Fund will provide you with the same benefits listed below, which are the same benefits provided to active participants:

- Medical Benefits
- Dental Benefits
- Orthodontic Benefits
- Temporomandibular Joint Dysfunction (TMJ) Benefits
- Vision Benefits

G. Termination of COBRA Coverage

Coverage under COBRA will cease on the first of the following dates:

- The date you or your eligible dependent becomes covered under another health plan;
- The date the Plan terminates;
- The date the required premium is due and unpaid;
- The date you and/or your dependents become eligible for Medicare;
- The date the applicable period of continuation coverage is exhausted (at the end of 18, 29, or 36 months); or
- The date you re-establish eligibility under the Health & Welfare Fund.
- The date the employer you worked for before the Qualifying Event stops contributing to the Plan, and the employer (a) establishes one or more group health plans covering a significant number of the employer's employees formerly covered under the Plan; or (b) starts contributing to another multi-employer group health plan.

Continued coverage will cease on the date you and/or your dependents become insured under another group insurance plan, regardless of whether the new benefits are the same as your current benefits, except where your new health plan has a pre-existing condition exclusion that applies to you. If the new plan has a pre-existing condition limitation that

applies to you, you may retain your COBRA coverage. Please contact the Fund Office for additional information when you and/or your dependents become insured under another group insurance plan.

If COBRA continuation coverage is terminated before the end of the maximum coverage period, the Plan Administrator will send a written notice as soon as practicable following the determination that continuation coverage will terminate. The notice will set out why continuation coverage terminated early, the date of termination and rights, if any, to alternative individual or group coverage.

If you retire and run out your active eligibility, you may elect, if eligible, retiree coverage or you will be permitted to make self-payments at the COBRA rate upon the expiration of your active eligibility.

H. The Cost of COBRA Coverage

The Board of Trustees will set COBRA premium payments according to federal law, which allows the monthly self-payment rate to be set at a level not to exceed 102% of the full expected average group cost of such benefit. If the cost changes, the Fund Office will revise the charge you are required to pay. In addition, if the benefits change for active Participants and those same benefits are provided to you under your specific COBRA coverage, your coverage will change as well.

Full details of COBRA continuation coverage will be furnished to you and your eligible dependents when the Fund Office receives notice that one of the Qualifying Events described above has occurred. Therefore, we urge you and your eligible dependents to contact the Fund Office as soon as possible after any of those events occurs.

I. Another Employer-Sponsored Health Plan

If you are or expect to be covered by another employer-sponsored health plan (including a plan of your spouse's employer), federal law guarantees you certain rights under that plan which you should consider when making your decision about COBRA continuation coverage.

Under the Health Insurance Portability and Accountability Act ("HIPAA"), the period during which a group health plan may exclude or limit coverage for pre-existing conditions is reduced or eliminated if the person previously had health coverage under another group health plan. However, credit is not given for earlier coverage if it was allowed to lapse, without replacement, for a period of at least 63 days. If there will be some delay before you can enroll in a new plan, you can avoid a break in health coverage by maintaining COBRA continuation coverage in the meantime.

J. Electing COBRA Instead of Retiree Coverage

If you retire and run out your active eligibility or hour bank, you may elect Retiree Coverage, if you are eligible, and self-pay at the COBRA rate when your active eligibility expires.

If you are eligible for retiree coverage from the Health & Welfare Fund and you elect COBRA continuation coverage instead, you will not be able to participate in the Retiree Coverage in the future.

If you are already continuing your coverage by making self-payments at the COBRA rate at the time you retire, you will still be given the opportunity to participate in the Retiree Coverage.

K. Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

L. Additional COBRA Election Period and Tax Credit in Cases of Eligibility for Benefits Under the Trade Act of 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp. The Fund Administrator may also be able to assist you with your questions.

M. For More Information

Questions concerning your Plan or your COBRA continuation coverage rights should be directed to Zenith American Solutions at the address and telephone number previously

indicated. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's website.)

13. CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When your medical, dental, vision, orthodontic, and/or temporomandibular joint dysfunction (TMJ) coverage ends, the Providers and/or the Plan Administrator will provide you and/or your covered dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan if and to the extent required by applicable law Such a certificate is no longer required under the Affordable Care Act, but if the law changes, any required certificate will be provided.

14. WORKERS' COMPENSATION BENEFITS

Medical expenses covered by the Health & Welfare Fund are for services and supplies received for the treatment of **non-occupational** bodily injuries and illnesses. If you incur a work-related injury or illness (one which arises out of or in connection with your employment), your claim for any charges related to that injury or illness must be submitted through your employer for workers' compensation coverage. No benefits are payable by the Health & Welfare Fund for such charges, unless the claim is denied by the Massachusetts Department of Industrial Accidents (DIA).

However, if you have been notified that your employer is contesting liability for your workers' compensation claim and the Fund has received a formal Notice to Contest Liability from the DIA, the Health & Welfare Fund will pay related hospital and medical expenses but will not pay Weekly Disability Income Benefits. Before related claims will be paid through the Health & Welfare Fund, you will be required to sign a Reimbursement Agreement and Consent to Lien.

Although charges relating to an occupational injury or illness must be submitted to Workers' Compensation, the life insurance and other health benefits will continue for yourself and your eligible dependents for charges incurred due to non-occupational accidental bodily injuries or illnesses, as long as you maintain eligibility.

Where a claim for workers' compensation is settled by stipulation or agreement, you cannot claim benefits for the same disability from the Health & Welfare Fund. If benefits are paid in error, the Health & Welfare Fund must be reimbursed for any payments to you or your dependents or providers, and all costs of collection, including attorneys' fees and court costs.

15. STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in the Health & Welfare Fund IBEW Local 96, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated PLAN DESCRIPTION. The Plan Administrator may make a reasonable charge for the copies

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this PLAN DESCRIPTION and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or

any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

16. PLAN AMENDMENT OR TERMINATION

The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits under the Plan and the eligibility rules for extended or accumulated eligibility at any time, even if extended eligibility has already been accumulated.

Plan benefits and eligibility rules for active, retired, or disabled Participants and their dependents:

- **Are not guaranteed;**
- **May be changed or discontinued by the Board of Trustees;**
- **Are subject to the Trust Agreement which establishes and governs the Plan's operations;**
- **Are subject to the provisions of the group insurance policies purchased by the Board of Trustees;**
- **Are subject to changing legislation. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.**

17. CONFIDENTIALITY AND ACCESS TO RECORDS

A. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Section 1: Purpose of this Notice and Effective Date

Effective Date. This Notice was effective as of September 23, 2013, and reflects changes in a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

This Notice is required by law. The Health and Welfare Fund IBEW Local 96 (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information or "PHI", defined in Section 2,
- Your rights to privacy with respect to your PHI,
- The Fund's duties with respect to your PHI,
- Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

A. Protected Health Information Defined

The term "Protected Health Information" or "PHI" includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

B. When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization and without providing you an opportunity to agree or object, in the following cases:

For Treatment, payment or health care operations. The Fund and its business associates may use PHI in order to carry out your treatment, the payment of your benefits, or their health care operations:

- **Treatment** is the provision, coordination, or management of health care and related services. It also includes consultations and referrals between one or more

of your providers. For example, your doctor or hospital may contact the Fund to request authorization for certain medical treatment.

- **Payment** includes actions to make coverage determinations and payment (including billing, claims management, reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund; may use or disclose your PHI to communicate through the Fund's third party administrator (Zenith American Solutions) with the insurance carrier to facilitate payment of medical claims, to communicate with a physician that reviews medical claims, or to communicate with a stop-loss insurance carrier. These third parties are known as "business associates."
- **Health Care operations** include but are not limited to quality assessment and improvement, including reviewing competence or qualifications of health care professionals, underwriting, premium rating and other activities relating to creating or renewing insurance contracts. If the Fund uses or discloses PHI for underwriting purposes, it is prohibited from using or disclosing PHI that is genetic information of an individual for such purposes. Health care operations also include disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. For example, the Fund may use information about your claims to refer you into a disease management program, a well-pregnancy program, to project future benefit costs, or audit the accuracy of its claims processing functions. While it is unlikely the Fund will possess your genetic information, in no event will the Fund use or disclose any of it.

Disclosure to the Fund's Trustees. The Fund may also disclose PHI to the Board of Trustees of the Fund for purposes related to treatment, payment, and health care operations, and the Board of Trustees has amended its plan document to permit this use and disclosure as required by federal law. For example, the Fund may disclose information to the Board of Trustees to allow them to decide a claim appeal or review a reimbursement matter.
When Required by Applicable Law. The Fund will disclose PHI when required to do so by any federal, state, or local law.
Public Health Purposes. The Fund will disclose PHI to an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law. In addition, PHI may be disclosed to an appropriate government agency authorized to receive reports of child abuse or neglect.
Domestic Violence or Abuse Situations. The Fund will disclose PHI when authorized by law to report to public authorities information about abuse, neglect, or domestic violence if a reasonable belief exists that you may be a victim of abuse, neglect, or domestic violence and the Fund believes the disclosure is necessary to prevent serious harm to you or other potential victims. In such cases, the Fund will promptly inform you that such a disclosure has been or will be made unless that disclosure would cause a risk of serious harm.

Health Oversight Activities. The Fund will disclose PHI to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Departments of Labor or Health and Human Services).

Legal Proceedings. The Fund will disclose PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order, or if the Fund receives a Qualified Medical Support Court Order in connection with covering a child of yours.

Law Enforcement Health Purposes. The Fund will disclose PHI when required for law enforcement purposes (for example, to report certain types of wounds).

Law Enforcement Emergency Purposes. The Fund will disclose PHI for certain law enforcement purposes, including:

- identifying or locating a suspect, fugitive, material witness, or missing person, and
- disclosing information about an individual who is or is suspected to be a victim of a crime.

Determining Cause of Death and Organ Donation. The Fund may give PHI to a coroner or medical examiner to identify a deceased person, determine a cause of death, or other authorized duties. The Fund may also disclose PHI for cadaveric organ, eye, or tissue donation purposes.

Funeral Purposes. The Fund may give PHI to a funeral director as necessary to carry out their duties with respect to the decedent.

Research. The Fund will disclose PHI for research, provided certain strict conditions are met.

Health or Safety Threats. The Fund will disclose PHI when, consistent with applicable law and standards of ethical conduct, the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Workers' Compensation Programs. The Fund will disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

C. When the Disclosure of Your PHI Requires Your Written Authorization

Except as otherwise indicated in this Notice, uses and disclosure of PHI will be made only with your written authorization subject to your right to revoke your authorization. You may make a written revocation of your authorization on a prospective basis at any time. Here are the relevant rules:

Disclosure to Other Benefit Funds. On certain occasions, the Pension Fund IBEW Local 96 and/or Annuity Fund IBEW Local 96 may need to receive information from this Fund. In those cases, we will request an authorization from you to release such information in order to enable the Pension Fund to process benefits.

Psychotherapy Notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information

about your mental health treatment. Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes without your authorization when the Fund needs to do so to defend itself in a legal proceeding, for a Fund supervised training program, or if the notes are used for treatment by the originator of the notes.

Marketing Purposes. The Fund will request authorization for any use or disclosure of PHI for marketing, except in situations involving a face-to-face communication or a promotional gift of nominal value. The Fund is not in the business of marketing PHI and does not expect to do so in the future.

Sale of PHI. The Fund will request authorization for any disclosure of PHI which constitutes a sale of PHI. The Fund is not in the business of selling PHI and does not expect to do so in the future.

D. Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives, and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend’s involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

You should note that under certain circumstances described earlier, federal law allows the use and disclosure of your PHI without your consent, authorization, or opportunity to object to such use or disclosure.

Section 3: Your Individual Privacy Rights

The following discussion is a description of your individual privacy rights. It is important to note that while all requests should be directed to the Fund, the Fund contracts with numerous vendors, also called “business associates”, who provide services to the Fund and services and benefits to you on the Fund’s behalf. Once the Fund is notified that you choose to invoke any of the individual rights listed below, it will respond or notify the appropriate vendor, as applicable, on your behalf. Because some of your PHI is maintained and used by these business associates to provide or process your benefits, the Fund requires that they administer certain aspects of the individual privacy rights.

To exercise any of the following rights, you must contact the Privacy Official, whose contact information is located in Section 6, to receive the appropriate form which you must complete in full and submit to the Privacy Official.

A. You May Request Restrictions on PHI Uses and Disclosures

You may request that the Fund:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or

- Restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request, unless the use or disclosure is for the purpose of carrying out treatment, payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which the Fund has been paid in full.

B. You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual. You will have to indicate the requested alternative means and/or locations on the form you request from and submit to the Privacy Official.

C. You May Inspect and Copy PHI

You have the right to inspect and obtain a copy of your PHI contained in a "designated record set" (defined below) as long as the Fund maintains the PHI. However, you do not have a right to inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action, or proceeding; or PHI that is subject to law(s) that otherwise prohibit access to PHI. The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained off-site. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged.

Under limited circumstances, access may be denied. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your view rights, and a description of how you may complain to the Fund and HHS.

The term "designated record set" includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

D. You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained by the Fund in the designated record set, subject to certain exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund

denies your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

E. You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. The Fund does not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.

The Fund has 60 days to provide the accounting. The Fund is allowed a single 30-day extension if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

F. Your Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time even if you have received the Notice previously or agreed to receive the Notice electronically. Your request to receive a paper copy of the Notice must be made in writing to the Privacy Official whose contact information is in Section 6.

G. Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed, and approved Appointment of Personal Representative form, which you may obtain from the Privacy Official.

The Fund retains the right to deny access to your PHI by a personal representative in the following situation. If the Fund has a reasonable belief that: (1) you have been or may be subjected to domestic abuse, violence, or neglect by such person or treating such person as your personal representative could endanger you, and (2) the Fund, in its exercise of professional judgment, decides that it is not in your best interest to treat the individual as your representative.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, absent notice of any restrictions to the contrary, the Fund will automatically consider a spouse to be the personal representative of an individual covered by the Fund. In addition, the Fund will consider a parent, guardian, or other person acting in *loco parentis* as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a minor's parent may act on an individual's behalf, including requesting access to his or her PHI. Spouses and unemancipated minors may, however, request that the Fund restrict access of PHI to family members as described in Section 3, A of this Notice.

If you have any questions about the circumstance under which the Fund will automatically consider an individual to be your personal representative, contact the Privacy Official.

<u>Section 4</u>: <u>The Fund's Duties</u>

A. Maintaining Your Privacy; Providing You a Notice of its Privacy Practices

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices with respect to PHI. The Fund is now required to notify you of anything that the law defines as a breach of your unsecured PHI, and you have a right to and will receive appropriate notifications in the event of any such breach. If the Fund experiences a breach of unsecured PHI, it will notify affected individuals within 60 days of discovery, and will also notify the U.S. Department of Health & Human Services and local media outlets if the breach affects more than 500 individuals.

This revised Notice was effective as of September 23, 2013. The Fund is required to comply with the terms of this Notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to the effective date of this Notice. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. Any revised Notice of Privacy Practices will be sent by U.S. Mail, and it will be distributed within 60 days of the effective date of any material change to: (1) the uses or disclosures of PHI, (2) your individual rights, (3) the duties of the Fund, or (4) other privacy practices stated in this Notice.

B. Disclosing Only the Minimum Necessary PHI

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your authorization,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- Cannot reasonably be expected to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund's Board of Trustees for purposes of obtaining cost bids or modifying, amending or terminating the Fund's group health plan. Summary information summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Fund's Board of Trustees has provided health benefits under the Fund's group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the Office of Civil Rights

If you believe that your privacy rights have been violated, you may file a written complaint with the Fund in care of the Privacy Official at the address listed in Section 6, immediately below. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, which address as of the date of this Notice, is

JFK Federal Building – Room 1875
Boston, MA 02203
Phone: (800) 368-1019 or 800 37-7697 (TDD)
Fax: (617 565-3809

The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following official at the Fund Office:

Privacy Official, Health & Welfare Fund IBEW Local 96
c/o Karen Palmeri
Zenith American Solutions
10 Technology Drive
Wallingford, CT 06492-3730
Phone: Toll Free: (800) 446–8646

Section 7: Conclusion

As outlined in Section I, PHI use and disclosure by the Fund is regulated by federal law known as HIPAA, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. You may find these rules at Title 45 of the *Code of Federal Regulations,* Parts 160 and 164. This Notice attempts to summarize those regulations and notify you of your rights. The regulations will prevail if there is any discrepancy between the information in this Notice and the regulations.

Please contact the Fund Office with any questions. All benefits are subject to amendment and/or termination as the Trustees may determine to be in the best interest of the Fund's participants and beneficiaries.

B. The Board of Trustees and Your Protected Health Information

The Fund may provide Protected Health Information to one or more members of the Board of Trustees, provided such member of the Board the Trustees has agreed to the restrictions on use and disclosure of Protected Health Information required by HIPAA. Each Trustee that receives or has access to Protected Health Information has agreed in writing to observe each of the following restrictions and provisions relating to his use or disclosure any Protected Health Information received from the Fund:

- The Trustee may not use or disclose any Protected Health Information received from the Fund, except as permitted in the Plan and consistent with the restrictions imposed by the Fund.

- The Trustee must require each of his subcontractors or agents to whom he may provide Protected Health Information to agree to written contractual provisions that impose at least the same obligations to protect your Protected Health Information as are imposed on the Trustee himself.

- The Trustee may not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other employee benefit plans also sponsored by the Trustee or the Trustee's employer.

- The Trustee must report to the Fund any impermissible or improper use or disclosure of Protected Health Information which he has obtained from the Fund and which use or disclosure is not authorized by the Fund.

- The Trustee must make Protected Health Information available to the Fund if necessary to permit individuals to inspect and copy their Protected Health Information.

- The Trustee must make an individual's Protected Health Information available to the Fund to permit such individual to amend or correct Protected Health Information that is inaccurate or incomplete and must incorporate amendments to Protected Health Information provided by the Fund.

- The Trustee must make an individual's Protected Health Information available to permit the Fund to provide an accounting of disclosures.

- The Trustee must make his own practices, books, and records relating to the use and disclosure of Protected Health Information available to the Fund and to the Department of Health and Human Services or its designee for the purpose of determining the Fund's compliance with HIPAA (and the Trustee's compliance with these provisions).

- When Protected Health Information is no longer needed for the purpose for which disclosure was made, the Trustee must, if feasible, return to the Fund or destroy all

Protected Health Information that he received from or on behalf of the Fund. This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Trustee agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

- The Trustee must use his best efforts to request only the minimum necessary type and amount of Protected Health Information to carry out the functions for which the information is requested.

- The Trustee must provide for adequate separation between his duties for the Fund and the duties he engages in for his employer so that Protected Health Information will be used only for the purpose of Fund administration.

Any Trustee who agrees to the above provisions may be given access to and use of Protected Health Information for all aspects of performance of his duties as Trustee of the Fund as described in the Agreement and Declaration of Trust and as required by federal law.

18. ADDITIONAL ITEMS OF INFORMATION

The Plan Sponsor is:

Board of Trustees
Health & Welfare Fund IBEW Local 96
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Telephone (800) 446-8646
Employer Identification No.: 04-2177839

The Board of Trustees is the Plan Administrator, the named fiduciary, and the agent for service of legal process. Legal process may be made upon a Plan Trustee or the Plan Administrator.

Board of Trustees
Health & Welfare Fund IBEW Local 96
10 Technology Drive, P.O. Box 5817
Wallingford, CT 06492
Telephone (800) 446-8646
Employer Identification No.: 04-2177839

Insured medical benefits are provided by:

The Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472
Telephone (800) 462-0224

Blue Cross Blue Shield of Massachusetts (Medicare Supplement for Retirees Only)
101 Huntington Avenue, Suite 1300
Boston, MA 02199-7611
Telephone (800) 358-2227

Insured accidental death and dismemberment and life insurance benefits are provided by:

Aetna
151 Farmington Ave.
Hartford, CT 06156
Telephone (800) 872-3862

Self-insured dental and orthodontic benefits are administered by:

Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129
Telephone (800) 872-0500The Plan Number assigned by the Trustees is 501/502.

The Plan is operated on a January 1 through December 31 calendar year.

The Plan is administered and maintained by a joint Board of Trustees consisting currently of three union representatives and three employer representatives.

You may make a written request to the Fund Office for information, as to whether a particular employer is a Contributing Employer with respect to this Plan and, if so, you may request the address of that Contributing Employer.

The Fund is maintained pursuant to collective bargaining agreements which provide for the rate of employer contributions to the Fund and areas of work for which contributions are payable and certain other terms governing contributions. Copies of collective bargaining agreements may be obtained upon written request to the Board of Trustees, and are available for examination at the Fund Office or your local union office.

This Plan provides medical, dental, orthodontic, temporomandibular joint dysfunction (TMJ), vision, hearing aid, short-term temporary disability income, term life insurance, and accidental death and dismemberment (AD&D) benefits to eligible Participants and their dependents. Medical, life insurance, and AD&D benefits are fully insured by the insurance companies identified above and at Section 9. Premiums are paid by Trust Fund assets for the provision of benefits. The vision, temporomandibular joint dysfunction (TMJ), hearing aid, and short-term temporary disability income benefits are self-insured benefits that are paid from the assets of the Trust Fund directly to Plan Participants. The Board of Trustees has contracted with Zenith American Solutions to administer the Fund and the self-insured portion of its benefits program. Dental and orthodontic benefits are self-insured but administered and provided through Delta Dental of Massachusetts.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreements, participation agreements and the Trust Agreement, and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. The Fund's assets and reserves are held in custody by Comerica Bank and invested pursuant to the Fund's investment guidelines.

Names and Addresses of the Members of the Board of Trustees:

Union

Thomas Maloney, Secretary-Treasurer
IBEW Local No. 96
242 Mill Street
Worcester, MA 01602

Employer

Matthew L. Ostrow, Board Chairman
Ostrow Electric Company, Inc.
9 Mason Street
Worcester, MA 01609-1899

George Carpenter
IBEW Local No. 96
242 Mill Street
Worcester, MA 01602

Kevin J. Menard
KM Kelly, Inc.
106 Huntoon Memorial Hwy
Rochdale, MA 01542

Brian Clarke
IBEW Local No. 96
242 Mill Street
Worcester, MA 01602

Susan C. Mailman (as of January, 2018)
Coghlin Electrical Contractors, Inc.
100 Prescott Street
Worcester, MA 01605

NOTES

This has been only a brief and very general discussion of the Health & Welfare Fund. A discussion such as this cannot adequately express all the details of the Plan. Nothing in the discussion is meant to change in any way the rules and regulations expressed in the contracts with the insurance providers and the Agreement and Declaration of Trust.

If at any time the contributions to the Health & Welfare Fund are shown by the Trustees to be insufficient to meet the premiums charged for benefits by the insurance providers, the Trustees may elect to reduce or to delete benefits within the Fund's Plan if it is deemed necessary to do so. **The right is reserved in the Plan for the Board of Trustees, as Plan Administrator, to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of any insurance policy in effect**.

If you need any forms or additional information, you should contact the office of the Plan Administrator.

A summary of the annual report of the Plan will be made available once a year at no charge.

As modifications to the Health & Welfare Fund are made, you will also be notified.