LOCAL 103, I.B.E.W.

HEALTH BENEFIT PLAN

CONSOLIDATED PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

As Restated and Amended Effective as of December 1, 2015

"OUR MISSION IS TO MAKE THE PURSUIT OF HEALTH AND WELLNESS A PRIORITY FOR EVERYONE."

IMPORTANT INFORMATION ABOUT THE PLAN

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PARTICIPATING EMPLOYERS

The Electrical Contractors Association of Greater Boston, Inc. and signatory employers

PARTICIPATING LOCAL UNION

Local Union 103, International Brotherhood of Electrical Workers (I.B.E.W.), AFL-CIO

IMPORTANT INFORMATION ABOUT THE PLAN

AS RESTATED AND AMENDED THROUGH DECEMBER 1, 2015

To: Participants in the Local 103, I.B.E.W. Health Benefit Plan

From: Board of Trustees

The Trustees are pleased to provide our Participants with this new Plan description. This *Local 103, I.B.E.W. Health Benefit Plan Document* describes the benefits available to eligible Participants and their Eligible Dependents. The word "Participant" is generally used in this document to describe an Employee of an Employer that contributes to the Fund either under a Collective Bargaining Agreement or other agreement requiring that contributions be made to the Fund. The words "Eligible Dependent" are defined herein more specifically, but in general refer to the spouse of the Participant and the dependent children of the Participant. Together or individually Participants and their Eligible Dependents may be referred to as "Covered Person(s)". When a Participant reads the words "the Plan" or "the Fund," it means the Local 103, I.B.E.W. Health Benefit Plan, unless the context makes another interpretation clear.

This document, together with any applicable insurance certificates, furnishes a description of the benefits to which Participants and their Eligible Dependents are entitled, the rules governing these benefits, and the procedures that must be followed when making a claim.

Also, included in the back of the document is certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Trustees are pleased to be able to provide these benefits to each Participant and their family through the Plan. We will continue to do everything possible to maintain the Plan on a sound financial basis, so that the level of benefits described in this Summary Plan Description (SPD) can continue to be available to each Participant.

The Plan currently uses the preferred billing rates of physicians, hospitals, and other health care facilities and providers in the *Blue Cross Blue Shield of Massachusetts* (BCBSMA) Preferred Provider Organization (PPO) network. Using providers in the PPO network can save the Participant money, because, in general, these providers agree to accept what the Plan pays for the treatment or service and will not balance bill the Participant for the difference.

This document replaces all other Plan Descriptions previously published by the Trustees.

This document contains a summary in English of your plan rights and benefits.

We suggest that each Participant read this Plan document carefully in order to fully understand the benefits to which each Participant may be entitled. If a Participant has any questions concerning the benefit coverage, eligibility rules, or other matters, please refer to this Plan document or if you have difficulty understanding any part of this document, contact the Plan at 256 Freeport Street, 2nd Floor, Boston, MA 02122, (617) 288-5999 during regular office hours Monday through Friday 8:00 am – 5:00 pm, excluding holidays or the website at www.trustfunds103.com.

Board of Trustees
Local 103, I.B.E.W. Health Benefit Plan

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INTRODUCTION

This document sets forth and describes the **Local 103, I.B.E.W. Health Benefit Plan (the "Plan") originally effective December 28, 1950 and restated effective December 1, 2015.**

Participants in the Local 103, I.B.E.W. Health Benefit Plan, are covered by a comprehensive benefits program designed to protect and provide for each and their family through a broad range of unexpected events and extraordinary expenses. This document is intended to satisfy the requirements for a Plan document and Summary Plan Description (SPD) as specified in the Employee Retirement Income Security Act (ERISA). A Participant can determine their rights under this Plan by consulting this consolidated Plan document and SPD.

The Plan has made every effort to make this Plan document and SPD as accurate as possible. This Plan document and SPD was published in December 2015 and is effective for benefits on and after December 1, 2015. It replaces all Plan documents and SPDs previously published or made available.

The Board of Trustees expects to continue this benefit Plan indefinitely, but reserves the right to change or terminate the Plan at any time. If the Plan is terminated, benefits will be settled according to provisions of the Plan and applicable Trust Agreement.

Trustees' Discretionary Authority
The Trustees have complete and exclusive discretionary authority to (i) establish, adopt, amend, or discontinue all or part of this Plan of benefits provided by this Plan; (ii) establish, adopt, and amend any instruments, forms, policies, or documents by which the Trust Agreement or Plan is administered or implemented; (iii) establish, adopt, amend, and determine eligibility rules for benefits; and (iv) construe and interpret the terms of the Trust Agreement, Plan, or any other instruments, forms, policies, or documents of the Plan, including disputed or ambiguous terms and meanings, and the interpretation of the Trustees is binding and final on all interested persons. Provisions may change after the date of this SPD document. Benefits are not vested. Contact the Plan if a Covered Person has questions regarding current benefits.

Limit on Authority of Non-Trustees
No Local Union, Local Union Officer, Business Agent, Local Union Member, Employer or Employer Representative, Plan Employee, Attorney, or Consultant is authorized to speak for or to commit the Board of Trustees of this Plan on any matter without express written authority from the Trustees.

Participant's Responsibility for Selection of Providers
The selection of medical professionals and service providers is the Participant's responsibility. If the Board has contracted with a network of providers, it has tried to find the best selection of providers available. However, the Board disclaims any responsibility for the qualification or action of any provider of goods or services.

Notify The Plan In Writing Immediately If…
- A Participant changes their home address;
- A Participant retires;
- A Participant becomes disabled;
- A Participant wants to change their Beneficiary;
- Any Covered Person has a change in status, such as:
    - From a single Participant to a Participant with Eligible Dependent(s);
    - From a Participant with Eligible Dependent(s) to a Participant with no Eligible Dependent(s) (that is, a child reaches age 26);

    - A new child is born or adopted or placed with a Participant for adoption;
    - A Covered Person becomes legally divorced, legally separated, or has their marriage annulled;
    - A Covered Person remarries or wishes to enroll additional dependent(s) as a result of remarriage;
    - A Covered Person is no longer disabled;
    - A Covered Person dies;
    - A Covered Person receives a Social Security Award;
    - A Covered Person becomes eligible for Medicare benefits;
    - A Covered Person becomes covered by another insurance plan for medical, dental, prescription drug, or vision benefits;
- A Participant becomes employed by any other employer that does not contribute to the Plan.
- A Covered Person seeks medical attention for an illness or injury that is work-related, or the result of a motor vehicle accident, or the result of an act or omission of another party.

If a Covered Person does not notify the Plan promptly about any of these changes, it could result in loss of eligibility for benefits, delay in payment of benefits, or recovery of benefits paid in error.

A Participant may not enroll, or continue to enroll, a divorced former spouse or a "common law" spouse in this Plan. Section I of this Plan description has additional details. The Plan will hold a Participant financially responsible for all overpayments the Plan makes if a Participant improperly enrolls any person in the Plan, or if a Participant fails to immediately notify the Plan (in writing) when a Participant becomes legally divorced or legally separated from a Participant's Spouse.

Important Notice
The medical, dental, prescription drug, and vision benefits provided under this Plan are provided on a "self-funded" basis. This means that these benefits are not necessarily subject to the insurance laws of any state, including laws regarding mandated benefit insurance laws.

As a result, unless coverage for a benefit is set forth in the Plan, no coverage is provided, even if Massachusetts' or some other state's insurance laws require insurers or insured plans to provide coverage.

Fraud Notice
Benefits under this Plan are for the exclusive use of Participants and their Eligible Dependents. If a Participant does not follow the rules described in this Plan Description, or a Participant intentionally defrauds the Plan regarding eligibility for benefits, use of medical services, or other related matters, the Trustees retain the right to prosecute a Participant for these violations.

SECTION I: ELIGIBILITY, ENROLLMENT AND PREMIUM CONTRIBUTIONS

General Eligibility Rules for Participants

The Plan consists of several different component plans for which the Participant (and the Participant's Eligible Dependents) may be eligible depending on the Participant's employment status, for example, whether the Participant is employed with a Contributing Employer or is retired. The following is a list of the component plans:

- ***The Master Plan***
- ***The Normal Retiree Plan***
- ***The Supplemental Plan***

A Participant's eligibility for coverage under one or more of the above listed component plans depends upon whether the eligibility rules described in this section are satisfied for the particular component plan. Each component plan has its own eligibility rules that a Participant must satisfy in order to be eligible for coverage under that component plan. Eligibility for coverage means that the Participant (or Eligible Dependent[s]) is eligible for those benefits set forth for that particular component plan, subject to all exclusions and limitations.

Participant is…	***Not Retired***	***Retired, NOT Eligible for Medicare***	***Retired and Eligible for Medicare***
The Plan Participant may qualify for is …	Master Plan	Normal Retiree Plan	Supplemental Plan
Eligibility Rules Participant Dependent(s)	 See pages 5-16 See pages 21-25	 See pages 17-18 See pages 21-25	 See pages 19-20 See pages 21-25
Medical	Covered	Covered	As per Medicare Covered
Prescription Drugs	Covered	Covered	Covered
Mental Health/ Substance Abuse	Covered	Covered	As per Medicare Covered
Dental	Full Dental Benefits	Full Dental Benefits	Full Dental Benefits
Vision	Full Vision Benefits	Full Vision Benefits	Full Vision Benefits
Life Insurance	Yes	None	None
Accidental Death & Dismemberment (AD&D)	Yes	None	None
Death Benefit	None	Yes	Yes

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

Timing of Enrollment and Enrollment Changes

Participants and their Eligible Dependent(s) may enroll change, or cancel enrollment at any time once minimum eligibility requirements have been satisfied.

Annual Enrollment Requirement

In order to be eligible for coverage under the Plan, each Participant must re-enroll annually. Each year, the Plan will mail an Annual Enrollment Form to each Participant, at each Participant's last address of record with the Plan. The Annual Enrollment Form must be fully completed where applicable, signed by the Participant, and returned to the Plan within 1 month.

Participants and their Eligible Dependent(s) who have not returned the Annual Enrollment Form within the 1-month period will have their health care benefits suspended. Any Covered Person not properly enrolled will not receive coverage under the Plan until the Participants properly enroll. Anyone not enrolled will be deleted from the list of Covered Persons.

Annual Enrollment Form

All Participants are required to enroll by completing an Annual Enrollment Form and returning it within 20 days of receipt. This Form will be sent to each Participant annually and must be returned to be considered enrolled in the Supplemental Plan. Failure to return the completed form will result in a suspension benefits or termination of each Participant's coverage.

Why Is Annual Enrollment Being Required by the Trustees?

To ensure that the Plan covers only the Participant and Eligible Dependent(s) of the Participant, and to obtain updated address and other information, annual enrollment is required. The Trustees also hope that annual enrollment will discourage fraud or inadvertence on the part of the Participant that leads to overpayment of claims for ineligible persons. Examples of inadvertence are the failure of a Participant to promptly notify the Plan when they become divorced or when a dependent ceases to be an Eligible Dependent, which are some of the requirements of the Plan.

In the event that an Employer engages in any fraud with respect to its participation or the participation of its employees or others in the Plan, or otherwise submits any false or misleading reports, representations, information, or other statements to the Plan, the Trustees shall have the right to take such action as they deem appropriate. Such action may include, but not be limited to, retroactive termination of the Employer's participation in the Plan and retroactive termination or rescission of coverage by the Plan of any individual. If any act or omission by an Employer results in the Plan providing benefits on behalf of any individual who is not entitled to such benefits under the terms of the Plan, the Employer shall be liable to the Plan for any such overpayments plus interest, and for any costs and attorney's fees incurred by the Plan in connection with any legal proceeding undertaken by the Plan or the Trustees to recover such overpayments.

In the event that any Participant, dependent, or other individual engages in or participates in any fraud with respect to the Participant's participation in or coverage by the Plan, or with respect to the participation or coverage by the Plan of any other individual, or with respect to an Employer's participation in the Plan, or otherwise submits any false or misleading reports, representations, information, or other statements to the Plan, or fails to submit any information that the Participant is required to submit to the Plan, the Trustees shall have the right to take such action as they deem appropriate. Such action may include, but not be limited to, recoupment of any overpayments by reducing the amount of future benefits until the overpayment is recovered and retroactive termination or rescission of the coverage of the Participant or dependent. If any act or omission by a Participant, dependent, or other individual results in the Plan providing benefits on behalf of any individual who is not entitled to such benefits under the terms of the Plan, such Participant, dependent, or other individual shall be liable to the Plan for any overpayments plus interest, and for any

costs and attorney's fees incurred by the Plan in connection with any legal proceeding undertaken by the Plan or the Trustees to recover such overpayments.

It is a Federal crime under 18 U.S.C. §1027, punishable by up to 5 years in prison or a $5,000 fine, or both, for a person to file an enrollment form with the Plan which the Participant knows is false or that knowingly misrepresents the status of any dependent.

Example of moving from one component plan to another

Frank, a 25-year-old male, starts working for a Contributing Employer. He has a wife and 2 children, ages 3 and 5. After 30 days have passed and working 144 hours in a 1-month (30 day) calendar period, Frank becomes eligible under the Master Plan, and becomes a Participant in the Plan as of the first of the subsequent month. His spouse and 2 children, as Eligible Dependents, become eligible for coverage under the Master Plan.

Frank works continuously until age 58, when he retires and stops working. Because Frank is no longer working for a Contributing Employer, his eligibility for the Master Plan terminates. But because he had been continuously eligible under the Master Plan for 15 consecutive years immediately preceding retirement, with a total of 15,000 hours worked for a Contributing Employer during those years, Frank becomes eligible for the Normal Retiree Plan. The Normal Retiree Plan still covers Frank and his Eligible Dependents for medical, dental, prescription drug, or vision benefits. But, the Normal Retiree Plan does not cover Life Insurance and AD&D Insurance Benefits. Instead, a Death Benefit is provided. Frank can convert his group life insurance that was provided under the Master Plan into an individual policy by applying to the insurance company within 31 days of leaving the Master Plan.

At age 65, Frank is no longer eligible for the Normal Retiree Plan and becomes eligible for the Supplemental Plan. His Eligible Dependents will remain covered provided they continue to meet the definition of Eligible Dependents.

Master Plan Eligibility

Any Participant employed under the terms of a Collective Bargaining Agreement with Local 103, I.B.E.W. (or a Participation Agreement in the case of non-bargaining unit employees), together with Eligible Dependents, is eligible for Master Plan benefits on the first day of the month following the first calendar month in which the Participant:

1) Has worked for at least 30 days after the Participant's first day of employment with a Contributing Employer, and
2) Works a minimum of 144 hours with contributions received from the Contributing Employer.

No benefits are provided for the Participant before this eligibility date.

However, if an employee is employed under the terms of a Collective Bargaining Agreement with Local 103, I.B.E.W. and either the parties to that agreement or the Trustees independently have formulated a different plan of benefits other than this Plan for them, this Plan shall not be applicable to such employee but instead such employee will participate under the plan of benefits adopted by the Trustees or such other person and applicable to their employment.

An Eligible Dependent who becomes an Employee of a Contributing Employer will be eligible for Master Plan coverage upon commencement of employment with the Contributing Employer, provided contributions are received by the Plan on the Participant's behalf.

Any Participant whose benefits have been terminated for any reason must again satisfy the general eligibility requirements set forth above.

Example 1: *John first starts working for a Contributing Employer on July 5, and he works 144 hours during the month of July. John is not eligible for coverage on August 1. Although he had worked the necessary 144 hours in the calendar month of July, 30 days had not yet passed since his first day of employment with a Contributing Employer.*

Example 2: *Same facts as in Example 1, except that John start working on July 1. John is eligible for coverage on August 1. Prior to August 1, he had both worked the 144 hours during the month of July, and 30 days had passed since his first day of employment with a Contributing Employer.*

Example 3: *Sally first starts working for a Contributing Employer on July 1, and she works 72 hours during the month of July and 72 hours during the month of August. She is not eligible for coverage either on August 1 or on September 1, because even though she reached the 30 days by the August 1 eligibility date, she has not worked the 144 hours in a single calendar month.*

Example 4: *Same facts as in Example 3, except that instead of working only 72 hours in August, Sally works 144 hours in August. She is eligible for coverage on September 1, since she had reached the 30 days and she worked 144 hours in the month of August.*

Eligibility for Non-Collectively Bargained Employees Under Participation Agreements

Some Employees are not covered by the terms and conditions of the various Collective Bargaining Agreements. In some cases, the Contributing Employer and the Trustees have entered into a Participation Agreement by which certain specified, non-bargaining unit Employees of the Contributing Employer are permitted to participate in the Plan, subject to the terms and limitations of the Participation Agreement and the Plan. The contributions or premiums required to be paid for such Employee's participation are set forth in the Participation Agreement. Not all benefits provided to collectively bargained employees may be provided to such non-bargaining unit employees. An example of a benefit not provided to employees participating under a Participation Agreement is set forth in the following section concerning continued eligibility during temporary unemployment under the Collective Bargaining Agreement.

Eligibility for the Participant's Eligible Dependents

If a Participant is eligible for Master Plan coverage, the Participant's Eligible Dependents are also eligible for coverage. (see Section I; Dependent Eligibility for the definition of "Eligible Dependent").

Maintaining Eligibility Under the Master Plan

A Participant maintains eligibility by being employed by a Contributing Employer, provided that the Plan receives at least 144 hours of contributions for such Participant at the most recent hourly contribution rate required to be made to the Plan under the Agreement and Working Rules (for inside construction) between the Electrical Workers Union Local 103, I.B.E.W. and the Electrical Contractors Association of Greater Boston, Inc. for each calendar month. If the Participant is employed by a Contributing Employer for a calendar month but the Plan receives fewer than 144 hours of contributions for a calendar month, the Participant must pay the difference between the full premium and the amount contributed by the Contributing Employer based on hours worked.

To determine such cost for a Participant who has been credited with fewer than 144 hours, the full monthly premium is calculated based on the most recent hourly contribution rate under such Agreement and Working Rules multiplied by 144 hours (current hourly rate x 144 hours), and then reduced by any money contributed by the Contributing Employer.

A part-time employee will not be permitted to self-pay under the foregoing rule to maintain eligibility for any month in which the employee is considered a part-time employee. An employee is considered to be a part-time employee if the employee is an employee of a Contributing Employer who (i) normally works fewer than 30 hours each week for such Employer; (ii) has not been credited by the Plan with at least 600 hours in the 6-month period immediately preceding the month in which self-payment is sought; or (iii) is employed full-time in another profession or for a non-Contributing Employer.

Use of "Flex Hours" to Pay Monthly Premiums
For each calendar year, a Participant who has at least 6 consecutive months of Master Plan eligibility will accrue 200 "flex hours" (which are used only for purposes of premium payment) for the year. If a Participant has fewer than 144 hours in a month, the Participant may use flex hours to "pay" for any hours needed for the month. Once a member's flex hours are used up, any additional hours needed must be paid for by the Participant to maintain coverage.

> ***Flex Hours Example:*** *John starts working on July 1, 2013. John is eligible for coverage on August 1, 2013. Prior to August 1, he had both worked the 144 hours during the month of July, and 30 days in a calendar month had passed since his first day of employment with a Contributing Employer. John is continuously eligible for Master Plan through March 30, 2014. In April 2014, John only works 20 hours with a Contributing Employer; John is eligible to utilize 124 hours of his 200 earned flex hours.*

Eligibility During Temporary Unemployment Under the Collective Bargaining Agreement

Participants With 48 Months or More of Master Plan Coverage
Any Participant who becomes unemployed while working under a Collective Bargaining Agreement with a Contributing Employer, but who is willing to work, able to work, and can prove is available for work by immediately signing the Local 103 Referral List and then complying with the referral procedures (and not receiving an "R3") of Local 103, I.B.E.W., as reported by the Local Union, shall continue to be eligible for Master Plan benefits, provided the Participant has been continuously eligible for benefits in the Master Plan for the 48 months immediately preceding the first day of temporary unemployment. The unemployed Participant shall have the burden of proving the Participant has not refused employment or has been available for employment.

For purposes of determining 48 month's continuous Master Plan coverage under the above rules, the Plan will not count months of subsidized coverage using these rules or any other rules that provide coverage while an unemployed Participant has failed to satisfy the normal general eligibility requirements (that is, only months earned with Employer contributions or self-payment under the rules established will count toward the 48 months).

Participants With Fewer Than 48 Months of Master Plan Coverage
If a Participant complies with all portions of *Participants With 48 Months or More of Master Plan Coverage* (above), but has been continuously eligible for benefits under the Master Plan for more than 6 months, but fewer than 48 months as of the first day of unemployment, such unemployed Participant will be eligible for Master Plan coverage for up to 12 months. For purposes of counting the usage of the 12 months, the Plan will count all months of unemployment coverage provided by the Plan. An unemployed Participant shall

have the burden of proving that the Participant satisfies the conditions of continued eligibility during temporary unemployment (is willing to work, able to work, and who proves the Participant is available for work by immediately signing the Local 103 Referral List and then complying with the referral procedures [and not receiving an "R3"] of Local 103, I.B.E.W.). Any unused period of coverage may be carried over but, once a Participant uses up the entire 12 months of coverage, a Participant may not again use this rule unless the Participant has terminated coverage and been given a new effective date and treated like a new Employee. No Employee or Participant may obtain more than 36 months of such coverage during their lifetime no matter how many times the Participant terminates coverage under the Plan and reestablishes eligibility. A Participant who exhausts their maximum coverage period of 12 months of coverage (or 36 months of coverage lifetime) may make timely self-payment each month, without interruption in payment, of the required premium necessary to become eligible for the 48 months' rule stated in *Participants With 48 Months More of Master Plan Coverage* above and to continue the Participant's Master Plan coverage for such month of payment.

Self-payment accomplishes the following 2 things: (1) it allows for continued coverage for the month of payment and (2) it earns 1 month toward eligibility for the 48 months' eligibility rule under the section above. The required monthly premium is calculated based on the most recent hourly contribution rate under such Agreement and Working Rules multiplied by 144 hours (current rate x 144 hours), reduced by any money contributed by the employer for such month. So, the Plan will count toward the accumulation of the required 48 months only those months in which the Plan actually receives either Employer contribution for hours worked by such Participant, or self-payment under this provision by the Participant, equal to at least the most recent hourly contribution rate under such Agreement and Working Rules multiplied by 144 hours (current rate x 144 hours). The full required self-payment must be received by the Plan in advance, and by the first day of the month, for which coverage is being provided. The Plan may bill the Participant for such payment, but regardless of whether a bill is sent or not, the Participant is responsible for making the payment timely each month. Payments (reduced by Employer contributions) must be made continuously by the Participant in order for the Participant to be considered eligible for this rule. No further notice will be provided to the Participant. If the Plan fails to receive the required payment by the due date stated above, the Participant shall be considered ineligible for this rule. Self-payment under this rule may only be made to attain the 48 months of eligibility under *Participants With 48 Months More of Master Plan Coverage* as stated above, and to qualify for the continued coverage as stated under *Participants With 48 Months More of Master Plan Coverage*, and cannot be invoked to self-pay for coverage under any other provisions of the Plan.

For purposes of determining continuous Master Plan coverage under the above rule, the Plan will not count months of subsidized coverage using these rules or any other rules that provide coverage.

The Plan offered special treatment of Participants who had fewer than 48 months of continuous eligibility on January 1, 2007.

Examples: All examples assume the unemployed Participant is complying with all referral and related procedures.

Example 1: *Joe has only 8 months of Master Plan coverage at the time he becomes unemployed while working under the Collective Bargaining Agreement. Joe's Employer(s) contributed to the Plan on his behalf during those 8 months. Because Joe has only 8 months of coverage under the Plan, the maximum time the Plan will continue to cover Joe under the above rule is 12 months. Joe is still unemployed after he exhausts his 12 months of coverage. If Joe otherwise satisfies the unemployment provision (for example, he is ready, willing, and able to work), Joe has 2 options: (1) He can choose to buy in monthly to achieve his 48 months of eligibility so that he will continue to be covered while he is unemployed; or (2) He can terminate his coverage, lose his effective date, and can elect COBRA Coverage under Section II. Under Option (1) if Joe elects to "buy in," he has 8 months credited towards his 48 months, and he would need a combination of self-payment and Employer contributions equal to 40 months at the required premium.*

Example 2: *Assume the same facts as in Example 1, but that after becoming unemployed after 8 months, Joe obtains unemployed coverage for 7 months, and then works for a Contributing Employer for an additional24 months of at least 144 hours each month. Joe then becomes unemployed. How long will the Plan continue to cover Joe under the unemployment rule? Because Joe used up 7 months of unemployment coverage, he has only 5 months left (12 months of "maximum coverage" minus the 7 months that he used). After he uses up these5 months, he will either have to self-pay as described in Example 1 or his coverage will terminate.*

Example 3: *Sally had 36 months of Master Plan coverage based solely upon Employer contributions. She became unemployed and she was covered under the unemployment rule for 9 months. Sally has only 3 months left of coverage under the unemployment rule before she will have to begin self-paying each month for the remaining 12 months (she already earned 36 months and needs 12 more months to reach 48 months) or her coverage will terminate.*

Examples (continued):

Example 4: *Mary has been continuously eligible for Master Plan coverage for 27 months and her Employer contributed for each of the 27 months. At that time, she becomes unemployed and is eligible for up to 12 months of coverage during unemployment. Over the next few years, Mary then self pays or has Employer contributions as follows:*

Months	***What Mary does…***
28 to 33	*Mary uses 6 months of her unemployment coverage*
34 to 40	*Mary obtains coverage by working in covered employment, a period of 7 months*
41 to 46	*Mary is laid off and uses the remaining 6 months of her unemployment coverage*
47 to 54	*Mary timely self-pays the required premiums for each of these 8 months to maintain coverage and work toward eligibility for the 48 months*
55 to 58	*Mary obtains coverage by working in covered employment, a period of 4 months*
59 to 63	*Mary is out on disability for 5 months and is covered by the Plan for these 5 months*
64 to 65	*Mary is laid off and timely self pays the 2 required monthly premiums to maintain coverage and attains eligibility for the 48 months, and remains covered subject to the requirements of Subsection A.*

Since Mary has attained the 48 months, she no longer has to pay a monthly premium. To understand the above Example, simply add the months in which Mary was both covered by the Master Plan and either Mary or her employer made contributions and/or self-payment for coverage for each month. Mary started with 27 months. She then worked 7 months (months 34 to 40) and contributions were made to the Plan, which brought her eligibility up to 34 months. Mary then self-paid for 8 months (months 47 to 54), which brought her total up to 42 months. She then worked 4 months (months 55 to 58) and contributions were made to the Plan, which gave her 46 months. Finally, she self-paid 2 months (months 64 and 65) which brought her up to the 48 months. Because she has 48 months, Mary then shifted to the 48-month rule in Subsection A above. Note that the Plan did not count toward the 48 months' eligibility rule the 12 months of unemployed coverage that she received for having the 27 months of coverage due to payment of Employer contributions or the 5 months that Mary was out on disability. Subsidized coverage, that is, coverage provided when no contributions or payments were made to the Plan, is not counted toward the 48 months.

Example 5: *Over the years, Harry has obtained coverage under the unemployment provision several times, terminated coverage, and each time worked the required hours to reestablish his eligibility. During his first period of unemployment coverage, Harry used the full 12 months of coverage but elected not to self-pay toward attainment of his 48 months and his coverage therefore terminated. During his second period of coverage, Harry once again used the 12 months of unemployment coverage, elected not to self-pay to attain his 48 months, and had his coverage terminated. Harry subsequently reestablished coverage a third time, worked for another 3 years, and again became unemployed and used the 12 months' rule again, elected not to self-pay when his 12 months was exhausted, and again had his coverage terminated. On his fourth period, he again reestablished eligibility when the Plan received 144 hours within a 1 month (30 day) calendar period, then Harry worked 14 months thereafter. Harry is credited with 14 months of Master Plan coverage due to Employer contributions during this fourth period of eligibility, when he again is laid off. Harry signs the referral list. Because the maximum carry time is 36 months' lifetime, Harry must either immediately self-pay toward his 48 months (he only has 14 months so he needs to do so for another 34 months) or his coverage will terminate. He is no longer carried for 12 months during unemployment because he already used up his lifetime maximum of 36 months. Note also that the periods that he worked in covered employment before his coverage being terminated do not count towards his 48 months. His prior period of Master Plan coverage, once terminated, is never again counted for purposes of obtaining the 48 months of coverage under the Plan. By not self-paying then, Harry lost this prior Master Plan coverage when it was terminated. When he returns, he is treated as a new employee with respect to Master Plan coverage.*

Monies Transferred to Another Home Health Fund Under Reciprocal Agreements
The Trustees of the Plan are signatory to a Reciprocal Agreement with the Trustees of other I.B.E.W. health funds. The Reciprocal Agreement provides that if a Person is employed under the Collective Bargaining Agreement in the jurisdiction of Local 103, I.B.E.W., and the Person elects to have monies contributed to the Plan reciprocated back to the Person's "Home" Fund, pursuant to the terms of the Reciprocal Agreement, the Person will not receive coverage or benefits from this Plan that would otherwise have been provided due to hours worked for such employer during such period.

In addition, under the terms of the Reciprocal Agreement, if a Person elects to have monies transferred from this Plan to a Person's "Home" Fund, the Plan will transfer monies to the Person's "Home" Fund equal to the lesser of (1) the hours the Person works for the applicable period multiplied by the contribution rate under the Collective Bargaining Agreement, provided the monies are actually received by the Plan from the Person's Contributing Employer or (2) the hours the Person works during the applicable period multiplied by the rate applicable to employers who contribute to the Person's home plan, provided such monies are actually received by this Plan from the Person's Contributing Employer.

Eligibility While Working in Another Local's Jurisdiction
Any Participant, working in the jurisdiction of any other Local Union because of unemployment in the area of Local 103, shall remain eligible for Master Plan benefits, provided the Participant was eligible for benefits in the Master Plan for the month immediately preceding the first day of referral to work in the jurisdiction of another Local Union, satisfies the rules for unemployment (other than due to working in the jurisdiction of the other union), and elects to reciprocate hours and contributions to this Plan from the first hour onward of work in such other local jurisdiction.

If the Participant refuses employment under the Local 103, I.B.E.W. referral rules, such coverage will terminate or, if the Participant is reciprocating hours, the Participant will be required to pay the difference between the monthly contribution payable to the Plan to maintain coverage for such month and the actual monies received due to reciprocity for such month. In order to be eligible for this coverage, the Participant must report to the Plan before leaving for work in another Local. Eligibility will terminate when the Participant fails to elect to reciprocate hours and contributions to this Plan, is ineligible for coverage under the temporary unemployment rules (except as provided above), or fails to pay a monthly premium required by the Plan, whichever occurs earlier.

Continued Eligibility During Total Disability
Any Participant who, after the first 6 months of Master Plan eligibility, is continuously eligible for Master Plan benefits immediately before becoming totally disabled from engaging in employment due to an occupational or non-occupational accident, bodily injury, or illness, excluding self-inflicted injury, shall remain eligible for benefits at no additional premium to the Participant, subject to the following:

1) Eligibility will continue for the number of consecutive plan years (or months thereof) that the disabled Participant was covered immediately before the date of total and permanent disability; however, in no event will the maximum length of coverage exceed 5 years (60 months) during the Participant's lifetime.

2) Medical evidence from the Participant's qualified attending physician with a specific diagnosis, satisfactory to the Plan, must be submitted along with a letter from the Participant requesting such coverage. The letter must indicate the duration during which the Participant will be disabled and such letter may be requested or required as often as monthly by the Plan. The failure to provide such letter in advance of the month for which coverage is sought under this section will disqualify the Participant for such coverage. Total disability means a physical or mental health condition that prevents the Participant from engaging in any gainful employment or occupation, but need not be

a permanent disability. Whether a Participant is totally disabled within the meaning of these provisions will be determined in the sole discretion of the Trustees.

3) Eligibility will terminate on the earliest of the following events:
   a) When the Participant becomes eligible for Medicare, the Participant's eligibility for the Master Plan will terminate, but the Participant's Eligible Dependents (see Section I, Dependent Eligibility) may continue to remain eligible for a period not to exceed the remainder of the maximum lifetime coverage period. If an Eligible Dependent(s) remains on the Master Plan they will pay the current Normal Retiree Plan monthly premium on the first of each month. (see the Appendix, Schedule D for the current monthly premium).

      Failure to pay this premium when due will terminate the Eligible Dependent(s) from the Master Plan. The amount of the premium, and other conditions for payment of the premium, may be established by the Trustees from time to time as they determine in their sole discretion.
   b) When a Participant is no longer totally disabled; or
   c) When the maximum lifetime coverage period permitted the Participant (up to 5 years or 60 months) expires.
4) Coverage during a disability under this Section is not counted as Master Plan coverage for any other purposes under the Plan.

Participants must notify the Plan immediately upon becoming disabled.

> ***Example:*** *Joe first becomes eligible for Master Plan coverage on February 1, 2007 and is continuously eligible for such coverage until July 2013 when he hurts his back. He submits medical evidence satisfactory to the Trustees that he is totally disabled from engaging in any gainful employment or occupation. As a result, Joe is still eligible for 5 years of Master Plan coverage or until he becomes eligible for Medicare or is no longer totally and permanently disabled, if earlier. On July 15, 2018, Joe returns to work with a Contributing Employer. He cannot use this rule again, nor is the 5 years counted as Master Plan coverage for purposes of any other Plan rules.*

Election to Continue Coverage During Qualified Military Leave

Any Participant who has Master Plan benefits at the time the Participant begins to serve in Qualified Military Service may elect to continue coverage for themselves and their Covered Dependents for a period of time that is the lesser of:

1) The 24-month period beginning on the date when the military service leave commences; or
2) The period beginning on the date when the military service leave commences and ending on the date the individual fails to return to employment or to sign out of the work list and comply with the Local Union referral procedures within the timeframe provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

The Participant should contact the Plan for more details about how to continue coverage when the Participant begins a USERRA leave. In most cases, the Participant must make the Participant's election to continue coverage before the Participant's USERRA leave begins.

Participants Discharged From Qualified Military Service
Any Participant who is honorably discharged from the military service and has rights to reemployment under USERRA, as amended, including as amended by the Veterans Benefits Improvement Act of 2004 (P.L. 108 454), will be eligible for benefits on the day the Participant commences employment with a Contributing Employer or signs the Local 103 Referral List within 30 days of the discharge date on their military orders, provided that on entering military service the Participant was eligible for Master Plan coverage while working for a Contributing Employer. If the Participant does not commence reemployment with a Contributing Employer or sign the Local 103 Referral List they will be billed for the first month premium (at the then applicable rate) and if not paid within 30 days they will be ineligible for coverage.

Rules for Working Medicare Eligible Participants Whose Medicare Eligibility is Based Solely Upon Age
When a Participant (or Participant's Eligible Dependent spouse) attains age 65, the Participant may be eligible to participate in Parts A and B of Medicare. If the Participant continues to work for a Contributing Employer after age 65 and is covered under the Master Plan, the Participant and the Participant's Eligible Dependent spouse may retain Master Plan coverage or elect coverage under Medicare.

1) If coverage under the Master Plan is elected, benefits will be paid the same as any other covered Participant, except that if the Participant's (or the Participant's Eligible Dependent spouse's) Medicare eligibility is based upon age, and the Participant's current employment status is with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and preceding calendar year, then Medicare coverage will be Primary and the Plan will pay Secondary to Medicare. (see Section XIII, Coordination of Benefits Rules).
2) If the Participant elects coverage under Medicare, the Participant will be rejecting coverage under this Plan with respect to items and services covered by Medicare. The Plan will not provide any supplemental coverage with respect to Medicare covered services, except as described in the preceding paragraph for Employees whose Medicare coverage is based upon age and who are working for small employers with fewer than 20 employees.

Termination of Master Plan Coverage
Master Plan coverage terminates for a Participant after the earliest of the following events:

Events Relating to the Participant
- The date the Participant no longer satisfies the eligibility rules for Master Plan coverage;
- The date the Participant dies;
- The date a Participant, who is no longer employed by a Contributing Employer, attains normal retirement age and retires (at this point, the Participant may be eligible for coverage under the Normal Retiree Plan);
- The date a Participant who is not employed by a Contributing Employer becomes eligible for Medicare;
- The Participant becomes totally and permanently disabled; or
- The date the Participant becomes eligible for coverage under another Plan while working under a Local 103 or Building Trades Collective Bargaining Agreement for an employer that does not contribute to the Plan, for example, Massport, the MBTA, the Turnpike Authority, etc., even if the Participant does not elect that coverage.

Events Relating to the Plan

- The date the Plan terminates;
- In the case of Life Insurance Benefits or AD&D Benefits, the date any group policy of insurance terminates and is not replaced by a successor policy.

The Trustees have the right to change, limit, or discontinue Plan benefits at any time. If the Trustees abolish Master Plan benefits, in whole or in part, the effective date of such amendment is the date on which a Participant's Master Plan coverage will terminate (if such benefits are abolished in whole), or will be modified (if such benefits are only reduced).

The Trustees may, in their sole discretion, change from time to time, or discontinue, all or any part of Master Plan benefits for Participants and Eligible Dependents. This right to change, modify, or discontinue Master Plan benefits includes, but is not limited to, the right to change eligibility requirements or benefits for Participants and Eligible Dependents. The Trustees also may, in their sole discretion, adopt and amend from time to time any rules, policies or regulations they may deem appropriate. The Trustees may, in their sole discretion, change from time to time the premiums that shall be paid to maintain coverage under the Plan.

When coverage ends for the Participant, coverage ceases for the Participant's Eligible Dependents, unless a specific and express provision of the Plan provides for continued eligibility for the Eligible Dependent after the Participant's eligibility has terminated. If an Eligible Dependent spouse is divorced from the Participant, any coverage that the spouse had terminates on the date of the divorce. An Eligible Dependent child's coverage terminates on the date the child ceases to be an Eligible Dependent as defined in Section I, Dependent Eligibility. The Participant or Eligible Dependent may, however, be able to continue coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA), as described in Section II.

Frequently Asked Questions About Master Plan Eligibility

Q1: A Participant's Master Plan coverage is terminating, what happens to the Participant's benefits?

A1: The Participant will lose all benefit coverage (Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Care Benefits, Life Insurance Benefits, and AD&D Benefits).

The Participant and Participant's Eligible Dependent(s) may have the opportunity to continue some of the Participant's benefits under COBRA. (see Section II of the Plan).

Terminating can also have an adverse effect on the Participant's eligibility date. When the Participant first becomes eligible for the Master Plan, the Participant is given an "eligibility date". This date is important to the Participant for several reasons.

- To be eligible for the Normal Retiree Plan, the Participant currently needs 15 consecutive years of Master Plan coverage immediately preceding the Participant's retirement and to have worked a minimum of 15,000 hours in employment requiring contributions to the Plan during those 15 years. If the Participant had 15 consecutive years of Master Plan coverage and met the 15,000 hours' requirement but then was terminated from the Master Plan before the Participant's normal retirement date, the Participant will lose credit for those 15 years and will not be eligible for the Normal Retiree Plan (unless the Participant again become eligible for the Master Plan and remain so continuously for 15 more years and meet the 15,000 hours' requirement).
- The Participant loses the eligibility date for the Participant's life insurance. For example, let's say the Participant had 5 years continuous Master Plan coverage. This currently provides for $50,000 worth of life insurance for the Participant's designated beneficiary if the Participant dies. (see Section IX of the Plan). If the Participant terminates Master Plan coverage, the Participant loses this coverage and if the Participant again becomes eligible for the Master Plan, the Participant would not get credit for the 5 years for which the Participant had previously been covered. But, the Participant may convert the life insurance from a group to an individual policy upon termination, but the Participant will be responsible for paying the premiums.
- It starts the 48 months of continuous coverage counting for purposes of eligibility during Temporary Unemployment under the Collective Bargaining Agreement.

Q2: A Participant's coverage is terminating under the Master Plan. Can the Participant convert to an individual plan?

A2: No, except for the Life Insurance Benefit. The Medical Benefits, Prescription Drug Benefits, Dental Benefits, and Vision Care Benefits offered under the Master Plan are self-funded, so there are no conversion privileges for those benefits. The Participant and the Participant's Eligible Dependent(s) may; however, be eligible to continue coverage under COBRA. (see Section II of the Plan).

Q3: A Participant in the Master Plan recently started working in another union's jurisdiction. If the Participant fails to reciprocate contributions back to this Plan, will the Participant's Master Plan benefits be terminated?

A3: Yes, the Participant's Master Plan benefits will be terminated if the Participant doesn't reciprocate contributions back to the Plan.

Q4: A Participant is working for an employer who is delinquent in paying contributions to the Plan. Is the Participant still credited with those hours even though the contributions have not been made?

A4: No. If the Participant's Contributing Employer fails to pay the contributions (or premium), the Participant will not receive credit for those hours. The Participant will be billed personally for the premiums necessary to maintain the Participant's coverage by the Plan and the premium is due upon receipt. If the contributions are eventually collected, the Participant will be credited retroactively with the hours, and any premiums paid by the Participant for that period will be refunded.

Q5: If an unemployed Participant in the Master Plan is totally disabled from engaging in employment, is the Participant still eligible for Master Plan benefits?

A5: Assuming that the Trustees, in their sole discretion, determine that the Participant is totally disabled from engaging in employment due to the Participant's disability, the Participant may be eligible for continued coverage of up to 5 years (depending on how long the Participant was continuously eligible for Master Plan coverage immediately before the Participant's disability and if the Participant has previously used coverage under the disability provision) or, if earlier, the date the Participant becomes eligible for Medicare. This coverage runs concurrently with COBRA.

Q6: If a Participant has 17 years of Master Plan coverage before becoming disabled, and the Participant used 5 years of disability coverage as discussed in Q&A 5 above, if the Participant returns to work with a Contributing Employer will the Participant again become eligible for disability coverage?

A6: No. There is a 5-year lifetime maximum for this coverage.

Q7: Is the "up to 5 years of coverage" discussed in the last 2 questions counted as Master Plan coverage for any other Plan rules? For example, if after 2 years of such coverage a Participant returns to work, and then the Participant is laid off 2 months later, will those 2 years count toward the 48 months required for continued eligibility during temporary unemployment?

A7: No.

Q8: A Participant has just been laid off. Will the Participant's Master Plan coverage terminate?

A8: Yes, unless the Participant satisfies one of the rules for continuing coverage.

- If the Participant has 48 months of continuous Master Plan coverage, and is temporarily unemployed under the Collective Bargaining Agreement but is willing to work, able to work, and can prove to be available for work by immediately signing the Local 103 Referral List and then complying with the referral procedures (and not receiving an "R3") of Local 103, I.B.E.W., as reported by the Local Union, and otherwise satisfies the temporary unemployment eligibility rules, the Participant's Master Plan coverage will continue without the need to pay a premium while the Participant continues to satisfy such rules.
- If the Participant has more than 6 months, but fewer than 48 months of continuous Master Plan coverage, the Participant may be eligible for up to 12 months of continued coverage. Additionally, the Participant may be able to self-pay to earn the 48 months. Refer to the rules stated earlier in this section.

The Participant may be eligible to continue the Participant's medical and Prescription Drug coverage under COBRA if the Participant's Master Plan coverage does terminate.

Normal Retiree Plan Eligibility

A Participant, together with Eligible Dependent(s), becomes eligible for the Normal Retiree Plan provided that:

1) The Participant retires from employment with a Contributing Employer on or after attaining age 58 but before attaining age 65, and on the day before such retirement was both eligible for Master Plan coverage and had been continuously eligible for Master Plan coverage for 15 consecutive years immediately preceding the Participant's retirement and who worked a minimum of 15,000 hours in employment requiring contributions to the Plan during those 15 years; or

2) The Trustees determine, in their sole discretion, that the Participant is totally and permanently disabled and has been continuously eligible for Master Plan coverage and who has worked a minimum of 15,000 hours in employment requiring contributions to the Plan during the 15 years preceding total and permanent disability. The Participant will be covered under the Normal Retiree Plan until the Participant is Medicare eligible. At that time, the Participant may be eligible for coverage under the Supplemental Retirement Plan. (see page 19).

Coverage of a Dependent Who Is Eligible for Medicare

If a Retired Participant covered under the Normal Retiree Plan or Supplemental Plan, has an Eligible Dependent who is disabled, or otherwise eligible for Medicare, the Participant must inform the Plan immediately to ensure proper coverage.

Premiums

Coverage by the Normal Retiree Plan is subject to payment of a monthly premium (see Appendix; Schedule D for the current monthly premium) by the Participant, and coverage must be elected effective on the first month for which the Participant becomes eligible. The amount of the premium, and other conditions for payment of the premium, may be established by the Trustees from time to time as they determine in their sole discretion.

In addition, Participants and other individuals who are otherwise eligible for coverage under the Normal Retiree Plan and who are receiving a monthly Pension benefit from the I.B.E.W. Local 103 Pension Plan that is greater than or equal to their monthly retiree health premium shall be covered under the Normal Retiree Plan only if such premiums are paid by a deduction from their Pension benefit payments. Those Participants or other individuals who are not receiving a monthly I.B.E.W. Local 103 Pension benefit, or whose monthly I.B.E.W. Local 103 Pension benefit is less than their retiree health premium, will have to pay the monthly premium directly to the Plan.

Termination of Normal Retiree Plan Coverage

Normal Retiree Plan coverage terminates on the earliest of the following events:

1) The date the Participant attains age 65;

2) The date the Participant becomes eligible for Medicare;

3) The date the Participant dies;

4) The date the Participant becomes employed by a Contributing Employer or eligible for Master Plan coverage;

5) The failure of a Participant to timely pay any required premium to maintain such Normal Retiree Plan coverage. In this event, coverage ceases on the first of the month for which the premium was

not paid. If a Participant is terminated for non-payment of a monthly premium, the Participant may not be reinstated subsequently.

The Trustees have the right to change, limit, or discontinue Plan benefits at any time. If the Trustees abolish Normal Retiree Plan benefits, in whole or in part, the effective date of such amendment is the date on which a Participant's Normal Retiree Plan coverage terminates (if such benefits are abolished in whole), or are modified (if such benefits are only reduced).

Supplemental Plan Eligibility

A Participant, together with Eligible Dependents, becomes eligible for the Supplemental Plan provided that:

1) The Participant was eligible for the Normal Retiree Plan, elected and received such coverage, and was covered by the Normal Retiree Plan on the day before attaining age 65, or otherwise becoming Medicare eligible; or

2) The Participant retires from employment with a Contributing Employer at an age of 65 or older, and on the day before such retirement was both eligible for Master Plan coverage and had been continuously eligible for such coverage for 15 consecutive years immediately preceding the Participant's retirement and who worked a minimum of 15,000 hours in employment requiring contributions to the Plan during those 15 years; or

3) The Trustees determine, in their sole discretion, that the Participant is totally and permanently disabled and has been continuously eligible for Master Plan coverage and who has worked a minimum of 15,000 hours in employment requiring contributions to the Plan during the 15 years preceding total and permanent disability.

In addition to the items above, the Participant must be enrolled in both Medicare Part A (hospital) and Medicare Part B (outpatient medical services) and pay the monthly premium for Medicare Part B.

Coverage of a Dependent Who Is Eligible for Medicare

If a Retired Participant covered under the Normal Retiree Plan or Supplemental Plan, has an Eligible Dependent who is disabled, or otherwise eligible for Medicare, the Participant must inform the Plan immediately to ensure proper coverage.

Premiums

Coverage by the Supplemental Retiree Plan is subject to payment of a monthly premium (see Appendix; Schedule D for the current monthly premium) by the Participant, and coverage must be elected effective on the first month for which the Participant becomes eligible. The amount of the premium, and other conditions for payment of the premium, may be established by the Trustees from time to time as they determine in their sole discretion.

In addition, Participants and other individuals who are otherwise eligible for coverage under the Supplemental Plan and who are receiving a monthly Pension benefit from the I.B.E.W. Local 103 Pension Plan that is equal to or greater than their monthly retiree health premium shall be covered under the Supplemental Plan only if such premiums are paid by a deduction from their Pension benefit payments. Those Participants or other individuals who are not receiving a monthly I.B.E.W. Local 103 Pension benefit, or whose monthly I.B.E.W. Local 103 Pension benefit is less than their retiree health premium, will have to pay the monthly premium directly to the Plan.

A Participant will be required to pay an annual premium if the Participant has enrolled in a Medicare Part D Prescription Drug Plan. The premium level, and such other conditions for payment, will be established by the Trustees from time to time as they determine in their sole discretion. The Participant may be required to enroll in the Supplemental Plan annually or at such other times as may be determined by the Trustees in their sole discretion, as a condition of eligibility for the Supplemental Plan. Enrollment will be accomplished using such form or forms as may be adopted by the Trustees from time to time.

Termination of Supplemental Plan Coverage

A Participant's Supplemental Plan coverage terminates on the earliest of the following events:

1) The failure of a Participant to timely pay any required premium to maintain such Supplemental Plan coverage, including the premium that the Trustees may require to be paid by Participants who enroll in a Medicare Part D Prescription Drug Plan. In this event, coverage ceases on the first of the month for which the premium was not paid. If a Participant is terminated for non-payment of a monthly premium, the Participant may not be reinstated subsequently.
2) The date the Participant becomes employed by a Contributing Employer or eligible for Master Plan coverage, and elects Medicare as the Participant's Primary coverage, federal law prohibits this Plan from providing supplemental coverage. Therefore, the Participant's coverage will terminate as of the date the Participant becomes eligible for Master Plan benefits. (see Section I, Master Plan Eligibility, Rules for Working Medicare Eligible Participants Whose Medicare Eligibility Is Based Solely Upon Age).
3) The date the Participant dies.
4) The date the Plan terminates.

The Trustees have the right to change, limit, or discontinue Plan benefits at any time. If the Trustees abolish Supplemental Plan benefits, in whole or in part, the effective date of such amendment is the date on which a Participant's Supplemental Plan coverage terminates (if such benefits are abolished in whole), or are modified (if such benefits are only reduced).

Dependent Eligibility

A Dependent's eligibility for coverage under one or more of the above listed component plans depends upon whether the eligibility rules for a Participant have been satisfied; eligibility for coverage means that the Participant must be eligible for those benefits set forth under the Master, Normal Retiree, or Supplemental Plan, subject to all exclusions and limitations, in order for the Participant's Eligible Dependent(s) to be eligible for such benefits.

Eligible Dependents Defined

The term "Eligible Dependents" has a specific meaning under this Plan, and is limited solely to the following individuals:

1) The Participant's spouse, as evidenced by a marriage certificate that is recognized in the Commonwealth of Massachusetts as legal and valid, with such status determined at the date at which such determination is required by the Plan. Thus, a spouse does not include (i) a "common law" spouse, (ii) a divorced former spouse, or (iii) a domestic partner. The Participant and/or the Participant's spouse shall be required to provide the Plan with a copy of such marriage certificate, birth certificate, and Social Security card. Please note that the Participant is responsible for the tax consequences of any benefits provided to the Participant.
2) The Participant's natural or adopted children, children placed with the Participant for adoption, or foster children until the end of the calendar month in which the child turns age 26. Photocopies of adoption papers, birth certificates, and Social Security cards or other proof that may be required by the Trustees, in their sole discretion, must be provided to the Plan. Newborns are covered from the day they are born, provided the Participant notifies the Plan within 30 days of the date of birth and provides a copy of the child's birth certificate and Social Security card.
3) The natural or adopted children of the Participant's spouse, or an unmarried child who is placed with the Participant's spouse for adoption by a legally licensed adoption agency before being formally adopted by the Participant's spouse. The Participant must provide a copy of birth certificate identifying the spouse as the natural parent or adoption papers, and a copy of the Social Security card. *In addition, the following conditions must be satisfied:*
    a) The child must be under 26 years of age; coverage is extended until the end of the calendar month in which the child turns age 26.
    b) The Participant is required to notify the Plan that the Participant (a) wants to enroll such dependent child as an Eligible Dependent and (b) must complete a form supplied by the Plan, which requires the Participant to certify that the child is or will become a dependent of the Participant before the effective date of such enrollment. The Participant must request enrollment and complete and submit the enrollment form and certification within 30 days after the marriage, birth, adoption, or placement for adoption.
    c) The Participant must pay any applicable premium established from time to time by the Trustees, in their sole discretion, for purchasing such coverage. Should such premium be required, it shall be payable monthly to arrive at the Plan before the month for which coverage is purchased, except that if the child is being enrolled as a new dependent as a result of marriage, birth, adoption, or placement for adoption, the premium for the first month of coverage for such child shall not be due until after the Participant has enrolled the child as described above, provided the Participant completes enrollment and submits all required forms and certifications within 30 days after the marriage, birth, adoption, or placement for adoption.

The effective date of such child's enrollment shall be as follows:

a) If the child has become a dependent of the Participant because of birth of the child after marriage to such spouse, the effective date of such child's enrollment will be the date of such birth.

b) If the child has become a dependent of the Participant solely because of the spouse's adoption or placement for adoption, the effective date of such child's enrollment will be the date of the Participant's adoption or placement for adoption of the child.
c) If the child has become a dependent of the Participant because of marriage, the effective date of enrollment for such child will be the first day of the first calendar month beginning after the date the completed enrollment and certification form is received by the Plan.

If the Participant is declining enrollment for such child under this provision because of other health insurance coverage for such child, the Participant may in the future be able to enroll such child in this Plan, provided that the Participant requests enrollment for such child within 30 days after such other coverage ends.

4) A child, until the end of the calendar month in which the child turns age 26, during the period commencing on or after the effective date of enrollment and during which the Participant is the court appointed guardian of such child, and provided the Participant pays any applicable premium established from time to time by the Trustees, in their sole discretion, for purchasing such coverage. Any such premium shall be payable monthly to arrive at the Plan in advance of the month for which coverage is purchased. The effective date of such child's enrollment will be the first day of the first calendar month beginning after the date a certified or attested copy of the court order appointing the Participant guardian of the child has been provided to the Plan by the Participant. The court that issues the appointment must be a court of competent jurisdiction. The Participant must immediately notify the Plan in the event the Participant's appointment is no longer effective, is revoked or modified, or if the Participant is no longer the legal guardian of such child.
5) An Alternate Recipient under a Medical Child Support Order that is determined by the Trustees, in their sole discretion, to be a Qualified Medical Child Support Order (QMCSO). Such Eligible Dependent coverage under a QMCSO may be subject to payment of a premium for such coverage, as determined by the Trustees in their sole discretion after review of such Order and if consistent with the requirements of ERISA §609(a). Payment of benefits by the Plan to an official of a State or political subdivision thereof whose names and addresses have been substituted for the address of the Alternate Recipient in a QMCSO will be treated as payment of benefits to the Alternate Recipient and extinguish any Plan obligation to pay such benefits directly to the Alternate Recipient or to the Participant or any other person.
6) The spouse of a Participant shall not be an "Eligible Dependent" under the Normal Retiree Plan or the Supplemental Plan if the spouse married the Participant after the Participant's retirement.
7) Similarly, a newborn natural child, adopted child, stepchild, or foster child who become dependents of the Participant after the Participant's retirement, shall not be "Eligible Dependents" under the Normal Retiree or Supplemental Plans.

To consider a Participant's dependent as an "Eligible Dependent," the Participant must enroll that person by completing any necessary information. The information that the Participant provides to the Plan in enrolling an Eligible Dependent must be complete and truthful, and the Participant is required to notify the Plan immediately if a person that has been enrolled in the Plan as an Eligible Dependent no longer satisfies the above applicable requirements.

In enrolling an individual as an Eligible Dependent or in determining or making any payments for benefits of an individual as an Eligible Dependent, the Plan will not take into account the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act (Medicare). A Participant should not be submitting claims for an Eligible Dependent to Medicaid in the first instance if such person is covered by the Plan.

The Plan has the sole and absolute discretion and authority to verify the initial and continuing eligibility for participation and benefits under the Plan of any person, including any child, spouse, or dependent by requesting proof of such eligibility including, as applicable and without limitation, tax returns, marriage certificates, birth certificates, proof of residence, or other documentation deemed appropriate by the Plan. The Plan has the sole and absolute discretion to refuse enrollment or continuing participation in the Plan to any individual who refuses or otherwise fails to provide such proof of eligibility.

Eligible Dependents Who Become Employed Under the Collective Bargaining Agreement
An Eligible Dependent who becomes employed under the Collective Bargaining Agreement (or Participation Agreement) and has contributions paid by a Contributing Employer on the Participant's behalf shall cease to be an Eligible Dependent and will instead immediately be eligible for the Master Plan without accumulating the 144 hours in a 1 month (30 day) calendar period.

Coverage of a Dependent Who Is Eligible for Medicare
If a Retired Participant (that is, a retired Member who is covered under the Normal Retiree Plan or Supplemental Plan) has an Eligible Dependent who is disabled, or otherwise eligible for Medicare, the Participant must inform the Plan immediately to ensure proper coverage.

Example 1: *Henry retires at age 58 with 15 years of continuous Master Plan coverage and the required 15,000 work hours during his last 15 years. He has 2 children, ages 15 and 17 and a spouse age 58. Since none of them are eligible for Medicare, all remain eligible for the Normal Retiree Plan; once Henry and his spouse become eligible for Medicare, they become eligible for the Supplemental Retiree Plan and their children will remain coverage under the Normal Retiree Plan until coverage terminates as outlined in the next section.*

Example 2: *Assume the same facts above, except that Henry's spouse is age 67; since his spouse is eligible for Medicare she is no longer eligible for Normal Retiree Benefits but becomes eligible for Supplemental Plan Benefits. Henry and his children remain covered under the Normal Retiree Plan.*

Example 3: *Assume the same facts as Example 1, except that Henry's 17- year-old child is disabled and eligible for Medicare. In this scenario, Henry, his spouse and 15-year-old child are covered under the Normal Retiree Plan; his disabled child is eligible for the Supplemental Plan due to his eligibility for Medicare.*

Example 4: *Joe retires at age 66 with 15 years of continuous Master Plan coverage and the required 15,000 hours during his last 15 years. His spouse is age 62, and his children are ages 16 and 18. Joe is eligible for the Supplemental Plan due to his eligibility for Medicare; his spouse and children are eligible for the Normal Retiree Plan.*

Example 5: *Nick retires at age 66 with 15 years of continuous Master Plan coverage. His spouse is age 67 and he has a child age 18 and a disabled child age 20 who is Medicare eligible. Since Nick, his spouse and disabled child are all eligible for Medicare, they are eligible for Supplemental Plan Benefits; his remaining child is eligible for benefits under the Normal Retiree Plan.*

Continued Eligibility After the Participant's Death

Upon the death of a Participant who was, at the time of death, covered by the Master Plan, Normal Retiree Plan, or Supplemental Plan, the Participant's Eligible Dependents will remain eligible for the same benefits

for which they were eligible at the time of the Participant's death. Such eligibility shall continue for a period not to exceed the earliest of:

1) Five years from the date of the death of the Participant, except that after the expiration of such 5 years, such Eligible Dependents may elect to continue coverage for up to an additional 5-year period by paying a monthly premium established by the Trustees from time to time.
2) The date the Eligible Dependent(s) becomes eligible for benefits under any similar plan; or
3) The date the Eligible Dependent(s) becomes eligible for Medicare (the Eligible Dependent may, however, be eligible for Supplemental Plan coverage for up to the 5-year period referenced above); or
4) The date an Eligible Dependent fails to timely pay the applicable premium, the result will be both the termination of such coverage and the termination of any further ability to pay for such coverage for all Eligible Dependents. The Plan does not allow for retroactive payment of premiums.

Coverage is subject to payment of a monthly premium (see Appendix; Schedule D for the current monthly premium) by the Participant. In general, surviving participants will pay the same premium amount as the deceased. The amount of the premium, and other conditions for payment of the premium, may be established by the Trustees from time to time as they determine in their sole discretion.

Plan Continued Coverage in Lieu of COBRA

In certain circumstances, the Plan provides continued coverage of the same benefits with or without premium for an equal or greater period than is offered by COBRA. Such Plan coverage is in lieu of COBRA coverage. In other words, a Participant or Eligible Dependent(s) who elects the free continued coverage will be deemed to have rejected COBRA coverage. If the benefits provided under the terms of the Plan are less liberal than the benefits under the plan of benefits available for COBRA electing Participants, COBRA will run concurrently with the provisions providing continued coverage with premium.

The only exception to this rule is for coverage provided under the section entitled "*Eligibility During Temporary Unemployment Under the Collective Bargaining Agreement,"* which coverage shall not be in lieu of COBRA and therefore will not be taken into account to reduce the maximum period allowable for COBRA coverage under Section II of the Plan.

> ***Example:*** *A Participant dies while covered by the Master Plan. Darryl is survived by his wife and 2 children. Because this is a Qualifying Event under COBRA, normally the Participant's Eligible Dependents could elect to continue COBRA coverage for up to 36 months by paying a monthly premium. However, the Eligible Dependents may elect to continue the same coverage that was in effect on the date of the Participant's death for up to the earlier of 5 years (60 months) or until the Eligible Dependent(s) become covered by a similar plan. See Section I, Eligibility Rules for Eligible Dependents. This free Plan coverage is in lieu of COBRA coverage. At the expiration of such eligibility, the Eligible Dependents may not elect COBRA coverage for an additional 36 months, because the election to receive the free coverage was also an election to reject COBRA.*

The Eligible Dependent(s) must notify the Plan in writing with a copy of the Participant's death certificate and of their intent to continue coverage, within 30 days of the Participant's death. Failure of the Eligible Dependents to give notice of their election as provided herein shall constitute a waiver of their option to continue extended coverage.

Continued Coverage in Lieu of COBRA

The surviving Eligible Dependent spouse and/or child(ren) may be eligible to purchase continued coverage pursuant to the provisions of COBRA. An election under this section to continue participation in the Plan will constitute a rejection by the surviving Eligible Dependent spouse and/or child(ren) to purchase continued coverage pursuant to the provisions of COBRA.

Examples of Continued Eligibility After Participant Death

Example 1: *Mike is covered by the Normal Retiree Plan and dies at age 61. His Eligible Dependent spouse is age 60. Because Mike's Normal Retiree Plan coverage terminates on the date of his death, the Eligible Dependent spouse's coverage would terminate as well on that date. The Plan contains a specific provision that permits the Mike's Eligible Dependent spouse (and Eligible Dependent children) to remain eligible for benefits for up to 5 years after Mike's death (and up to an additional 5 years if elected). Mike's Eligible Dependent spouse's benefits would continue for 5 years (or 10 years if so elected) unless she becomes covered by another health plan. If she becomes entitled to Medicare, she would become eligible for Supplemental Plan coverage for the remaining portion of the 5- or 10-year period. After the 5 (or 10) years, Mike's Eligible Dependent spouse cannot elect COBRA, because the 5-year coverage also serves as COBRA continuation coverage period. The Plan, in effect, subsidizes the payment of the COBRA premium for the first 5-year period.*

Example 2: *Judy, age 40, is the Eligible Dependent surviving spouse of John, who died on July 1, 2012. She has 2 children ages 6 and 8. Judy and her Eligible Dependent children have been covered under this provision which first 5-year period is set to expire on June 30, 2017. Because Judy and her children will be covered on June 30, 2017, she may elect to pay the applicable monthly premiums to extend her coverage and that of her children for up to an additional 5-year period. She must pay the monthly premium by the first day of each month for which coverage is to be purchased (that is, by July 1, 2017 to purchase July 2017 coverage). Each monthly premium covers Judy and her children. If she fails to timely pay the monthly premium, or if she or her children become covered under another group health plan, their coverage will terminate even if the additional 5year period has not expired.*

Termination of Dependent Coverage

An Eligible Dependent's coverage terminates on the earliest of the following events:

1) When the Participant's Eligibility under a Plan ends; unless specific provisions of the Plan provide for the continued eligibility for the Eligible Dependent after the Participant's eligibility terminates.
2) The date an Eligible Dependent no longer satisfies the definition "Eligible Dependent";
3) The date that an Eligible Dependent becomes eligible for Medicare (the Eligible Dependent may then be eligible for the Supplemental Plan); or
4) The date the Trustees limit or discontinue such coverage. The Trustees retain the right to change, limit, or discontinue Plan benefits at any time. If the Trustees abolish the benefits of Eligible Dependents, in whole or in part, the effective date of such amendment is the date on which such benefits are reduced or terminated.

SECTION II: COBRA CONTINUATION COVERAGE

Introduction

Covered Persons in any group health plan subject to COBRA may be entitled to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, upon termination of employment with a Participating Employer. spouses and other qualified beneficiaries may also be entitled to COBRA continuation coverage in specified circumstances. This section generally explains COBRA continuation coverage, when it may become available to Participants and their families, and what must be done to protect the right to receive it. This section gives only an overview of Covered Person COBRA continuation coverage rights. For more information about COBRA rights and obligations under the Plan and under federal law, Covered Persons should ask the Plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to Covered Persons when they would otherwise lose group health coverage. It can also become available to other members of Covered Persons' families who are covered under the Plan when they would otherwise lose their group health coverage.

In addition to COBRA, there may be other coverage options available to Covered Persons and their families. For example, Covered Persons may be eligible to buy medical insurance coverage through the Marketplace. In the Marketplace, they may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, Covered Persons may qualify for a special enrollment opportunity through another group health plan for which they are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if enrollment is requested within 30 days.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of coverage under any group health plan subject to COBRA when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Participants, their spouses and their dependent children could become qualified beneficiaries if coverage under a group health plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

An Eligible Participant will become a qualified beneficiary if they lose coverage under the Plan because either one of the following qualifying events happens:

- Hours of employment are reduced; or
- Employment ends for any reason other than gross misconduct.

The spouse of an Eligible Participant can become a qualified beneficiary if they lose coverage under the Plan because any of the following qualifying events happens:

- The Eligible Participant dies;
- The Eligible Participant's hours of employment are reduced;
- The Eligible Participant's employment ends for any reason other than the Participant's gross misconduct;
- The Eligible Participant becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The Spouse of an Eligible Participant becomes divorced or legally separated from the Eligible Participant.

Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The Participant dies;
- The Participant's hours of employment are reduced;
- The Participant's employment ends for any reason other than the Participant's gross misconduct;
- The Participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

A child who is born or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of Federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Plan of the birth or adoption.

Plan Continued Coverage in Lieu of COBRA

In certain circumstances, the Plan provides continued coverage of the same benefits with or without premium for an equal or greater period than is offered by COBRA. Such Plan coverage is in lieu of COBRA coverage. In other words, a Covered Person who elects such continued coverage will be deemed to have rejected COBRA coverage. If the benefits provided under the terms of the Plan are less liberal than the benefits under the plan of benefits available for COBRA electing Covered Persons, COBRA will run concurrently with the provisions providing continued coverage with premium.

The only exception to this rule is for coverage provided under the section entitled "*Eligibility During Temporary Unemployment Under the Collective Bargaining Agreement,"* which coverage shall not be in lieu of COBRA and therefore will not be taken into account to reduce the maximum period allowable for COBRA coverage under the Plan.

The Eligible Dependent(s) must notify the Plan in writing with a copy of the Participant's death certificate and of their intent to continue coverage, within 30 days of the Participant's death. Failure of the Eligible Dependents to give notice of their election as provided herein shall constitute a waiver of their option to continue extended coverage.

When Is COBRA Coverage Available?

A Covered Person Must Give Notice of Some Qualifying Events

For qualifying events such as divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child, Covered Persons must notify the Plan, in writing, within 60 days after the qualifying event occurs. If the Covered Person does not provide timely notice, they may not be eligible for COBRA coverage.

COBRA Coverage and Family and Medical Leave Act (FMLA) Leave

The taking of leave under FMLA does not constitute a qualifying event under COBRA. However, a qualifying event will generally occur if an Eligible Participant's FMLA leave ends and the Eligible Participant does not return to work. Please contact the Plan for more information on COBRA eligibility during and following FMLA leave.

How Is COBRA Coverage Provided?

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Persons may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Eligible Participant, the Eligible Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Covered Person's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Eligible Participant's hours of employment, and the Eligible Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Eligible Participant lasts until 36 months after the date of Medicare entitlement. For example, if a covered Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). When the qualifying event is the end of employment or reduction of the Eligible Participant's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage
If a Covered Person or anyone in their family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and the Covered Person notifies the Plan in a timely fashion, the Covered Person and their entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To obtain the 11-month extension, notice must be sent to the Plan before the end of the first 18-month period of COBRA continuation coverage. Further, the Covered Person (or a covered family member) must make sure that the Plan is notified of the SSA's determination within 60 days of the later of: (a) the date of the SSA determination; (b) the date of the qualifying event; (c) the date the Covered Person would otherwise lose coverage under the Plan; or (d) the date on which the Covered Person is informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. Notice should be sent in writing, postmarked within the above timeframes, to the Plan.

If the SSA determines that the Covered Person (or a covered family member) is no longer qualified for Social Security disability benefits, notice must be sent to the Plan within 30 days of the later of: (a) the date of the SSA's determination or (b) the date on which the Covered Person is informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. The disability extension coverage will terminate upon such determination. Notice should be sent in writing, postmarked within the above timeframes, to the Plan.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage
If the Covered Person's family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children of the Covered Person can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Eligible Participant or former Eligible Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, the Covered Person or their spouse or dependent children must notify the Plan of the second qualifying event within 60 days of the second qualifying event. Notice should be given prior to the qualifying event, or as soon as possible thereafter (but not more than 60 days after the

qualifying event). Once the Plan receives such notice, it must in turn notify the Covered Person, their spouse, and children (individually or jointly) of their right to elect COBRA coverage.

Early Termination of COBRA Coverage

COBRA continuation coverage may terminate early if:

- The required premium payment is not paid when due;
- The Covered Person, their spouse or dependent child(ren), if any, become covered under another group health plan after the date COBRA coverage is elected that does not contain any exclusion or limitation for any preexisting conditions;
- The Covered Person, their spouse or dependent child(ren), if any, become entitled to Medicare benefits (under Part A, Part B, or both) after the date COBRA coverage is elected;
- All of the Local 103, I.B.E.W. Health Benefit Plan's group health plans are terminated; or
- If coverage is extended to 29 months due to disability, a determination that the individual is no longer disabled. NOTE: Federal law requires that the individual inform the Plan of any final determination that the Eligible Participant is no longer disabled within 30 days of such a determination.

Continuation coverage under COBRA is provided subject to eligibility. The Plan reserves the right to terminate COBRA coverage retroactively, subject to PPACA (Patient Protection and Affordable Care Act of 2010), if an Covered Person, their spouse or dependent child(ren) are determined to be ineligible for coverage.

How Can a Covered Person Elect Continuation Coverage?

Each qualified beneficiary has 60 days from either (1) the date coverage is lost under the Plan or (2) the date they are notified of their right to elect continuation coverage, whichever is later, to inform the Plan that the Covered Person wants to elect continuation coverage. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the Eligible Participant and the Eligible Participant's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election notice. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. **There is no extension of the election period**.

If the Covered Person, their spouse or dependent chooses continuation coverage and pays the applicable premium within the time period specified in the qualifying event notice, the Local 103, I.B.E.W. Health Benefit Plan is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated active Participants or their family members. If the Local 103, I.B.E.W. Health Benefit Plan changes or ends group health coverage for similarly situated active Participants, such coverage for COBRA Participants will also change or end.

In considering whether to elect continuation coverage, a Covered Person should take into account that they have special enrollment rights under federal law. Covered Persons have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by their spouse's employer) within 30 days after a Covered Person's group health coverage ends because of the qualifying event listed above. Covered Persons will also have the same special enrollment right at the end of continuation coverage if they get continuation coverage for the maximum time available to them.

Qualified beneficiaries do not have to show that they are insurable in order to choose continuation coverage. But a qualified beneficiary must have been actually covered by the Plan the day before the qualifying event in order to elect COBRA coverage.

An election by a surviving Eligible Dependent spouse and/or child(ren) to purchase continued coverage pursuant to the provisions of COBRA will constitute a rejection by the surviving Eligible Dependent spouse and/or child(ren) to purchase continued coverage pursuant to provisions of continued eligibility after a Participant's death (see Section I, Dependent Eligibility).

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%).

When and How Must Payment for Continuation Coverage Be Made?

First Payment for Continuation Coverage

If a Covered Person elects' continuation coverage, they do not have to send any payment for continuation coverage at the time of election. However, the Covered Person must make the first payment for continuation coverage within 45 days after the date of the Covered Person's election. (This is the date an election notice is postmarked, if mailed.) If a Covered Person does not make the first payment for continuation coverage within that 45 days, the Covered Person will lose all continuation coverage rights under the Plan.

The first payment must cover the cost of continuation coverage from the time the Covered Person's coverage under the Plan would have otherwise terminated up to the time first payment has been made. The Covered Person is responsible for making sure that the amount of their first payment is enough to cover this entire period. Covered Persons may contact the Plan to confirm the correct amount of their first payment.

First payment for continuation coverage should be sent to:

Local 103, I.B.E.W. Health Benefit Plan
256 Freeport Street, 2nd Floor
Boston, MA 02122
Attention: COBRA Notification

Periodic Payments for Continuation Coverage
After first payments for continuation coverage have been made, Covered Persons will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first of every month. If a periodic payment is made on or before its due date, coverage under the Plan will continue for that coverage period without any break.

Periodic payments for continuation coverage should be sent to:

Local 103, I.B.E.W. Health Benefit Plan
256 Freeport Street, 2nd Floor
Boston, MA 02122
Attention: COBRA Notification

Grace Periods for Periodic Payments
Although periodic payments are due on the first of each month, Covered Persons will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if a periodic payment is paid later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received.

This means that any claim that is submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Failure to make a periodic payment before the end of the grace period for that payment will result in loss of all rights to continuation coverage under the Plan.

Are There Other Coverage Options Besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Covered Persons and their families 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. Learn more about many of these options at www.healthcare.gov.

If Covered Persons Have Questions
Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the Plan. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans visit the US Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at (866) 444-EBSA (3272). For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep The Plan Informed of Address Changes
In order to protect the Participant's family's rights, the Participant should keep the Plan informed of any changes in the addresses of family members. The Participant should also keep a copy, for their records, of any notices the Participant sends to the Plan.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

SECTION III: MASTER PLAN AND NORMAL RETIREE PLAN MEDICAL BENEFITS

General
This section applies to both the Master Plan and Normal Retiree Plan Medical Benefits; benefits for the Supplemental Retiree Medical Plan are described in Section IV.

This health plan is a self-funded health benefits plan and is funded through contributions to the Plan by Contributing Employers at the hourly rates established by and in accordance with the Collective Bargaining Agreements between Local 103, I.B.E.W. and signatory employers, and by investment income earned on a portion of the Fund's assets. The Plan has designated 2 organizations to provide administrative services to this health plan, including individual case management, utilization review, other related services, and to arrange for a network of health care providers whose services are covered by this health plan. The name and address of these organizations are:

***Blue Cross Blue Shield of Massachusetts* (BCBSMA)**	***Modern Assistance Program* (MAP)**
101 Huntington Avenue Suite 1300 Boston, MA 02199-7611	1400 Hancock Street Quincy, MA 02169

This health plan is a Preferred Provider Organization (PPO) health plan. This means that the Covered Person determines the costs that they will pay each time they choose a health care provider to furnish covered services. The Covered Person will receive the highest level of benefits when they use health care providers who participate in the PPO health care network; these are called the "in-network benefits." If the Covered Person chooses to use covered health care providers who do not participate in the PPO health care network, they will usually receive a lower level of benefits and their out-of-pocket costs will be more. These are called the "out-of-network benefits."

Before using the health care coverage, the Covered Person should make note of the limits and exclusions described in Section III, E, Plan Exclusions and Limitations and the "Coordination of Benefits Rules" and "Assignment and Subrogation" rules described in Sections XIII and XIV. Claims filing, denial and appeal procedures are described in Section XII.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

A. Medical Benefit Covered Services

Medical Benefits provide for the Medically Necessary hospital, surgical, and other health care charges that a Covered Person receives because of a non-occupational illness or injury for which benefits are not payable under Worker's Compensation Laws.

A Covered Person has the right to the coverage described in this section, except as limited or excluded in other sections of this Plan document. Also, be sure to read the Participant's Schedule of Benefits (see Appendix, Schedule A). The Covered Person's coverage in this health plan consists of two benefit levels: one for in-network benefits and one for out-of-network benefits. This means that the Covered Person's cost share amount differs based on the benefit level of the covered services that the Covered Person receives. The highest benefit level is provided when the Covered Person receives covered services from a covered provider who participates in the PPO health care network. This is the in-network benefit level. The lowest benefit level is usually provided when the Covered Person receives covered services from a covered provider who does not participate in the PPO health care network. This is the out-of-network benefit level. The Participant's Schedule of Benefits shows the cost share amounts that the Covered Person will pay for in-network benefits and for out-of-network benefits.

Inpatient Medical and Surgical Care Benefits

Acute Care or Rehabilitative Hospital

Except for an admission for emergency medical care or for maternity care, the Covered Person and their health care provider must receive approval from *Blue Cross Blue Shield of Massachusetts* as outlined in this Plan Document before the Covered Person enters an acute care or rehabilitation hospital for inpatient care. In the case of inpatient care for mental health or substance abuse, the Covered Person and their health care provider must receive approval from *Modern Assistance Program* as outlined in this Plan Document before the Covered Person enters a general, mental health or rehabilitation hospital for inpatient care, other than an emergency. *Blue Cross Blue Shield of Massachusetts* or *Modern Assistance Program* will let the Covered Person and their health care provider know when their coverage is approved. (see Section III, D; Managed Health Care and Utilization Review). When inpatient medical and surgical care benefits have been approved, this Plan provides coverage as described in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Inpatient benefits are available only if the Covered Person spends a minimum of 24 hours in the treating facility on an inpatient basis.

Inpatient benefits are provided for a period of up to 90 days per period of illness as follows:

- 100% of the Allowed Charge up to the hospital's most common semi-private room rates if with a PPO provider and at 80% of the Allowed Charge if not a PPO provider.
- 100% of the Allowed Charge of daily hospital miscellaneous charges if with a PPO provider and at 80% of the Allowed Charge if not a PPO provider.

In the event the Covered Person's hospital confinement exceeds 90 days, the balance of the Medically Necessary room and board charges and hospital miscellaneous charges will be paid by the Plan at a rate of 80% of the Allowed Charge. If a Covered Person stays in a private room, the Plan will pay at only the rates for a semi-private room.

The Allowed Charge for the following services and supplies provided by the hospital are covered:

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Surgery;

- *Women's Health and Cancer Rights:* Coverage includes breast reconstruction in connection with a mastectomy. This health plan provides coverage for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- *Organ Transplants:* The Plan covers the costs of human organ and stem cell (bone marrow) transplants that are performed on a Covered Person, subject to Plan exclusions. For covered transplants, coverage also includes the harvesting of the donor's organ or stem cells when the recipient and the donor are Covered Persons and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells. The Plan will also pay for the costs of lab tests, x-rays and other imaging tests (of both the recipient and the donor when both are Covered Persons), including human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish stem cell (bone marrow) transplant donor suitability when the tests are furnished to a Covered Person. This includes testing for A, B or DR antigens or any combination in accordance with the guidelines of the Massachusetts Department of Public Health. If the donor is also covered by other coverage that covers the donor's harvesting as the Primary coverage, the Plan shall provide coverage only as the Secondary coverage. (see Section XIV, Coordination of Benefits Rules).

- *Oral Surgery* which must result from a non-occupational injury or illness, subject to Plan exclusions. If oral surgery is performed in a hospital rather than a surgeon's office, the Plan may deny coverage if it determines that oral surgery performed in a hospital setting was not Medically Necessary. The Plan does not cover oral surgery for any procedure or treatment specified in Section VI, the Dental Benefits portion of the Plan.

- *Voluntary Sterilization Procedures*

Maternity Services;

The Plan covers all medical care that is related to pregnancy and childbirth (or miscarriage) when it is furnished for the Covered Person by a covered provider. This coverage is provided for any female Covered Person as described in the Participant's Schedule of Benefits (see Appendix, Schedule A). This coverage includes:

- Semi-private room and board and special services when the enrolled mother is an inpatient in a general hospital. This includes nursery charges for a well newborn. These charges are included with the benefits for the mother's maternity admission. The mother's (and newborn child's) inpatient stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless the mother and her attending physician decide otherwise as provided by law. If the mother chooses to be discharged earlier, this health plan covers one home visit within 48 hours of discharge, when it is furnished by a physician; or by a registered nurse; or by a nurse practitioner. This visit may include the following: parent education; assistance and training in breast or bottle feeding; and appropriate tests. This health plan will cover more visits that are furnished by a covered provider only if *Blue Cross Blue Shield* determines the visits are clinically necessary.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

- Delivery of one or more than one baby. This includes prenatal and postnatal medical care that is furnished for the Covered Person by a physician; or by a nurse midwife. The benefits for prenatal and postnatal medical care that is furnished by a physician or by a nurse midwife are included in *Blue Cross Blue Shield's* payment for the delivery. The benefits that are provided for these services will be those that are in effect on the date of delivery. When a physician or a nurse midwife furnishes only prenatal and/or postnatal care, benefits for those services are based on the date the care is received. This health plan also covers prenatal and postnatal medical care exams and lab tests when they are furnished for the Covered Person by a general hospital; or by a community health center. The benefits for these services are based on the date the care is received. Standby attendance that is furnished for the Covered Person by a physician (who is a pediatrician), when a known or suspected complication threatening the health of the mother or the child requires that a pediatrician be present during the delivery.

No benefits are provided for home births, except for an emergency or unplanned delivery that occurs at home prior to being admitted to a hospital or for maternity services furnished outside of Massachusetts.

Well Newborn Inpatient Care;

The Plan covers well newborn care when it is furnished during the enrolled mother's inpatient maternity stay coverage as described in the Participant's Schedule of Benefits (see Appendix, Schedule A). This coverage includes:

- pediatric care that is furnished for a well newborn by a physician (who is a pediatrician); or by a nurse practitioner.
- routine circumcision that is furnished by a physician.
- newborn hearing screening tests that are performed by a covered provider before the newborn child (an infant under 3 months of age) is discharged from the hospital to the care of the parent or guardian.

- ***Anesthetics and their administration;***
- ***Chemotherapy;***
- ***Diagnostic services;***
- ***Durable medical equipment;***
- ***Hospital provided prescription drugs and medicines;***
- ***Laboratory and x-rays;***
- ***Medical and surgical dressings, supplies, casts, and splints;***
- ***Monitoring services related to dialysis intensive care services;***
- ***Operating room;***
- ***Oxygen and its administration;***
- ***Physician visits;***
- ***Second surgical opinions;***
- ***Therapeutic services.***

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Skilled Nursing Facility Benefits

If a Covered Person is confined to a Skilled Nursing Facility immediately following an Acute Care Hospital confinement of at least 3 days, the Plan provides coverage as described in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Outpatient Benefits

Acupuncture

The Plan covers acupuncture services as described in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Ambulance Services

The Plan covers ambulance services if the Covered Person is being transferred from one hospital to another hospital. Any med flight or similar transportation charges will only be paid by the Plan if the med flight is from the scene of an accident, the circumstances of which made transportation of the injured Covered Person by med flight Medically Necessary. See the Participant's Schedule of Benefits (see Appendix, Schedule A) .

Applied Behavior Analysis (ABA)

The Plan covers Medically Necessary ABA treatment of autism spectrum disorders only after services legally required to be provided by the appropriate school system have been exhausted. Such services must be provided by a covered board certified behavior analyst supervising or performing ABA. ABA services require prior authorization. See the Participant's Schedule of Benefits (see Appendix, Schedule A) .

Cardiac Rehabilitation Therapy

The Plan covers outpatient cardiac rehabilitation only if the Covered Person is directly referred by a physician for a condition being treated by such physician. The Plan must receive a copy of the physician's referral before any payment will be made. If services extend beyond 8 weeks, the Plan must be provided with an updated referral letter from the treating physician at the end of 8 weeks and in advance of any services incurred after the initial 8 weeks. The Plan will not pay for any services without pre-approval of such services every 8 weeks. See the Participant's Schedule of Benefits (see Appendix, Schedule A) .

Chiropractic Benefits

The Plan covers chiropractic services as described in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Diagnostic Imaging (MRI, CAT Scan, PET Scan)

At a hospital

The Plan covers diagnostic imaging services for non-emergency outpatient diagnostic imaging performed at a hospital as described in the Participant's Schedule of Benefits (see Appendix, Schedule A).

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Other Locations
The Plan covers diagnostic imaging services for non-emergency outpatient diagnostic imaging performed at a free standing facility (that is not associated with a hospital association), doctor's office, or if performed during an inpatient hospital stay or in conjunction with a same day surgical procedure, as described in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Durable Medical Equipment
The Plan covers durable medical equipment that the Covered Person buys or rents from a covered provider that is an appliance company or from another provider who is designated by *Blue Cross Blue Shield of Massachusetts* to furnish the specific covered appliance. This coverage is provided for equipment that: can stand repeated use, serves a medical purpose, is Medically Necessary for the Covered Person, is not useful if the Covered Person is not ill or injured, and can be used in the home. See the Participant's Schedule of Benefits (see Appendix, Schedule A) .

Emergency Room Benefits
Coverage is provided under the Plan for the Covered Person if they are treated in an emergency room for an emergency admission/medical emergency. If a Covered Person is admitted to the hospital after an emergency room visit, the Plan will waive the emergency room copayment; however, the Covered Person will be responsible for any inpatient costs. See the Participant's Schedule of Benefits (see Appendix, Schedule A) .

Exams, Physician Visits, and Immunizations
The Plan pays for outpatient physician visits, physical exams, and immunizations provided by many types of medical professionals (for example, pediatricians, family practitioners, surgeons, internists, and obstetricians/gynecologists) as described in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Fitting of Birth Control Devices
Coverage is provided under the Plan for the fitting by a physician of birth control devices, such as intrauterine devices (IUDs). See the Participant's Schedule of Benefits (see Appendix, Schedule A) .

Home Health Care Benefits (Non-Hospice)
Home health care benefits, as distinguished from Hospice benefits, allow a Covered Person to recuperate from an illness or injury at home rather than in a hospital. The Plan covers home health care benefits for a Covered Person only with approval from the Utilization Reviewer before being discharged from the hospital.

The Utilization Reviewer will review the proposed home care and hospital discharge planning to determine whether it is Medically Necessary within the meaning of the Plan. The Utilization Reviewer must be contacted in advance of such discharge to arrange what home health care will be covered. The Utilization Reviewer will contract with providers to provide any home health care services that it approves.

The Covered Person must start the pre-approval process if the preferred provider does not start this process or if the Covered Person is planning to obtain these services from a non-preferred provider. If the Utilization Reviewer has arranged and contracted for such home health care services, the Plan will provide coverage as described in the Participant's Schedule of Benefits (see Appendix, Schedule A) including the following:

- durable medical equipment;
- part time or occasional nursing care; and

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

- part time or occasional physical, occupational, speech, and respiratory therapy.

Such care must be required for the same (or related) condition that resulted in the Covered Person's hospitalization and be prescribed by a physician for care and treatment at home. Home health aides or other personal assistants are not covered by the Plan.

Example: *Jennifer, an Eligible Dependent, is going to be discharged from the hospital and will need home care. The Discharge Planner at the hospital contacts The Utilization Reviewer before the discharge. The Utilization Reviewer will review whether home health care is Medically Necessary for Jennifer. If the Utilization Reviewer determines it is Medically Necessary, it will contract with various providers for Jennifer's home health care before she is discharged.*

Hospice Benefits

When a Covered Person is terminally ill, Hospice care benefits are provided in the home or Hospice facility when, without Hospice care, the Covered Person would have been a patient in a hospital or skilled nursing facility.

To receive Hospice benefits, the Covered Person must have a life expectancy of 6 months or less, as certified by the attending physician. The Plan will provide coverage as described in the Participant's Schedule of Benefits (see Appendix, Schedule A) including the following:

- home health aide services;
- skilled nursing services;
- medical/social services;
- therapy;
- durable medical equipment; and
- patient and family counseling (including bereavement counseling not to exceed a period of 6 months from the initial date of bereavement counseling).

The Plan must approve in advance all Hospice benefits, including the purchase or rental of durable medical equipment. A letter from the Primary care physician must accompany the list of Medically Necessary home health care visits and the use of any Medically Necessary durable medical equipment.

Lab Tests and X-Rays

The Plan covers diagnostic laboratory tests and x-rays if an attending physician requires these services in order to diagnose or treat a Covered Person's non-occupational injury or illness. The Plan does not cover an x-ray examination in connection with dental work or treatment, unless incurred in connection with oral surgery (wisdom teeth #s 1, 16, 17, and 32) (see Section VI). See the Participant's Schedule of Benefits (see Appendix, Schedule A) .

Mental Health and Substance Abuse

The Plan covers Medically Necessary services to diagnose and/or treat mental health and substance abuse conditions subject to cost sharing and any benefit limit details as outlined in the Participant's Schedule of Benefits (see Appendix, Schedule A). This coverage includes:

- *Partial Hospitalization Program/Day Treatment Psychiatric Care/Substance Abuse*—The Plan provides coverage for the Medically Necessary partial hospitalization or day treatment of outpatient psychiatric and/or substance abuse care of a Covered Person; however, before a Covered Person is

partially hospitalized or enters a day treatment program, prior approval must be obtained from MAP.

- *Outpatient Psychiatric Care/Substance Abuse*—The Plan will pay the Allowed Charges for Medically Necessary outpatient psychiatric care and substance abuse of a Covered Person.

Occupational Health Exam

The Plan provides coverage for a Participant's occupational health examination as outlined in the Participant's Schedule of Benefits (see Appendix, Schedule A). This exam may serve as both a physical exam and an exam for occupational diseases, including exposure to lead, PCBs, solvents, or other hazardous materials. The Plan does not cover occupational illnesses or injuries. (see Section XIII, Coordination of Benefits Rules).

Oxygen and Respiratory Therapy

The Plan covers the following subject to cost sharing and any benefit limit details as outlined in the Participant's Schedule of Benefits (see Appendix, Schedule A):

- Oxygen and the equipment to administer it for use in the home. These items must be obtained from an oxygen supplier. This includes oxygen concentrators.
- Respiratory therapy services. These services must be furnished for the Covered Person by a covered provider. Some examples are: postural drainage and chest percussion.

Pain Management

The Plan provides pain management treatment only if the Covered Person is directly referred by a physician for a condition being treated by such physician. The Plan must receive a copy of the physician's referral before any payment will be made. If services extend beyond 8 weeks, the Plan must be provided with an updated referral letter from the treating physician at the end of 8 weeks and in advance of any services incurred after the initial 8 weeks. The Plan will not pay for any services without pre-approval of such services every 8 weeks. See the Participant's Schedule of Benefits (see Appendix, Schedule A).

Physical Therapy/Occupational Therapy

Physical Therapy/Occupational Therapy services are covered by the Plan only if the Covered Person is directly referred by a physician for a condition being treated by such physician. The Plan must receive a copy of the physician's referral before any payment will be made. If services extend beyond 8 weeks, the Plan must be provided with an updated referral letter from the treating physician at the end of 8 weeks and in advance of any services incurred after the initial 8 weeks. The Plan will not pay for any services without pre-approval of such services every 8 weeks. See the Participant's Schedule of Benefits (see Appendix, Schedule A).

Podiatry Benefits

The Plan covers outpatient podiatry medical services of a Covered Person performed by a podiatrist subject to cost sharing and any benefit limit details as outlined in the Participant's Schedule of Benefits (see Appendix, Schedule A).

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Pre-Admission Testing

The Plan provides coverage for a Covered Person's laboratory services on an outpatient basis received within 14 days of a scheduled admission to the hospital subject to cost sharing and any benefit limit details as outlined in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Radiation Therapy and Chemotherapy

The Plan covers outpatient radiation and x-ray therapy and chemotherapy when it is furnished for the Covered Person by a covered provider as outlined in the Participant's Schedule of Benefits (see Appendix, Schedule A). This may include (but is not limited to): a physician, nurse practitioner, a free-standing radiation therapy, and chemotherapy facility, a hospital, or a covered provider who has a recognized expertise in specialty pediatrics. This coverage includes:

- radiation therapy using isotopes, radium, radon, or other ionizing radiation.
- x-ray therapy for cancer or when it is used in place of surgery.
- drug therapy for cancer (chemotherapy).

Speech Therapy

The Plan covers charges for a speech therapy session for a speech loss or impairment that is due to a non-congenital, non-occupational injury or illness and required by a treating physician as a Medical Necessity. An exception is allowed if the service is for a congenital abnormality, in which case the service will be covered if surgery to correct it has been performed before the speech therapy and the therapy is required by a treating physician.

The Plan must receive a copy of the physician's referral before the Plan will pay for the covered services. The Plan will cover speech therapy only if the services are rendered by a qualified speech therapist and are not subject to a Plan exclusion (see Section III, E). Plan Exclusions and Limitations and Appendix, Schedule A. All services are subject to cost sharing and any benefit limit as detailed in the Participant's Schedule of Benefits (see Appendix, Schedule A).

Surgery (Outpatient)

The Plan covers outpatient surgical services furnished by covered providers subject to cost sharing and any benefit limit as detailed in the Participant's Schedule of Benefits (see Appendix, Schedule A). This includes doctor's offices, free-standing facilities and clinics; services are subject to cost sharing and any benefit limit as detailed in the Participant's Schedule of Benefits (see Appendix, Schedule A).

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Some Frequently Asked Questions About Medical Benefits

Q1: A Covered Person goes to a hospital or medical provider that is part of the PPO, and the Plan otherwise provides for full payment for such treatment if performed by a PPO provider, does the Covered Person have to pay a balance?

A1: No. The Covered Person should pay nothing aside from the required copayment to a physician or hospital that is in the PPO. Hospitals, physicians, and other medical providers in the PPO have agreed to accept what the Plan pays as full payment for the service or charge. The hospital, physician, or other medical provider should not bill the Covered Person for any balance, because the Plan has contracted (through *Blue Cross Blue Shield of Massachusetts*) that no amounts aside from any copayment should be charged a Covered Person. If the Covered Person is billed a balance, contact the Plan immediately, and notify the provider that it should not be billing the Covered Person for a balance.

Q2: A Covered Person is eligible for Medical Benefits but will be traveling out of the country. Will the Covered Person be covered for medical care?

A2: Yes, if the medical care is otherwise covered under the Plan, and the Covered Person provides the Plan with an itemized bill with an explanation of services. The Plan requests that any such bill be provided to the Plan in English. If a Covered Person establishes residence in a foreign country the Plan will pay out-of-network benefits at 80%.

Q3: How does a Covered Person obtain Hospice benefits?

A3: In the event a Covered Person is diagnosed as being terminally ill by their Primary attending physician, Hospice care benefits may be provided. The Primary physician should send a letter to the Plan stating that the Covered Person's condition has been found to be terminal. Upon receipt of the letter, the Plan will begin paying Hospice benefits.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Emergency Services

Emergency Medical Services

"Emergency medical services" are those medical services that are usually needed because of the sudden onset of a condition with acute symptoms, including severe pain. These conditions are severe enough that the lack of prompt medical attention could reasonably be expected (by a prudent layperson who possesses an average knowledge of health and medicine) to result in placing the Covered Person's health or the health of another (including an unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. Coverage under the plan in the case of emergency medical services performed at an emergency room is the same for both in-network and out-of-network facilities.

Possible examples of conditions requiring emergency medical care by the Plan include, but are not limited to, suspected heart attacks, strokes, poisoning, loss of consciousness, convulsions, possible broken bones, and suicide attempts.

Admission From the Emergency Room for Medical Procedures

The Covered Person's condition may require that the Covered Person be admitted directly from the emergency room for inpatient emergency medical care in that hospital. If this is the case, the Covered Person, the facility, or someone on the Covered Person's behalf must notify *Blue Cross Blue Shield of Massachusetts* within 48 hours of the admission. This notification *to Blue Cross Blue Shield of Massachusetts* must include the patient's name, the patient's identification number, the name of the facility, the date of admission, and the condition for which the patient is receiving treatment.

Blue Cross Blue Shield of Massachusetts may review whether the Plan's requirements for continued coverage are being met for inpatient care (see Concurrent Review and Discharge Planning).

Transfer to Another Inpatient Facility

The Covered Person's emergency room provider may recommend the Covered Person transfer for inpatient care to another facility. If this is the case, the Covered Person or the admitting facility must ***call*** *Blue Cross Blue Shield of Massachusetts* within 48 hours of the admission so that *Blue Cross Blue Shield of Massachusetts* can evaluate whether the Plan's requirements for continued coverage are being met for inpatient care in that facility (see Concurrent Review and Discharge Planning). An admission through the emergency room to the same hospital or to another inpatient facility will waive the emergency room cost share.

Filing an Emergency Care Claim

The Covered Person must always file a claim with the Plan to obtain benefits. Typically, a participating provider will do this for the Covered Person, but the Covered Person should confirm that this has been done, especially if the Covered Person has services done at a non-participating provider. The Covered Person should tell the provider that they are covered under the Plan and show the provider the Covered Person's Plan identification card. The Plan will pay the provider directly for covered services.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

B. Preventive Care Services

Preventive Care Services Under PPACA

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), (which many people refer to as "Health Care Reform"), health services, including certain office visits, that are considered to be "preventive" in nature require no copayment or coinsurance for in-network providers; "preventive" services furnished by out-of-network providers are subject to cost sharing. All "preventive" services are subject to any benefit limit as detailed in the Participant's Schedule of Benefits (see Appendix, Schedule A).

The term "preventive health services" refers to covered services that are performed to prevent diseases (or injuries) rather than to diagnose or treat a symptom or complaint, or to treat or cure a disease after it is present. The Plan provides coverage for preventive health services in accordance with applicable federal laws and regulations.

At the time this Plan document was drafted, the US Department of Health and Human Services (HHS) had published a list of Covered Preventive Services as summarized below. Please note that this list is subject to change. The Covered Person should discuss with their physician whether their services are considered to be "preventive" in nature, and therefore require no copayment from the Covered Person.

Contact the Plan if the Covered Person has questions about this list.

Covered Preventive Services for Adults

Routine Adult Physical Exams and Tests

The Plan covers routine physical exams, routine tests, and other preventive health services when they are furnished for the Covered Person by a covered provider. This coverage includes:

- routine medical exams and related routine lab tests and x-rays. This coverage for a routine physical exam is limited to one visit for each Covered Person in a calendar year.
- appropriate immunizations as recommended by the Advisory Committee on Immunization Practices.
- blood tests to screen for lead poisoning.
- routine mammograms. This coverage is limited to one baseline mammogram during the 5-year period a Covered Person is age 35 through 39; and one routine mammogram each calendar year for a member who is age 40 or older.
- routine prostate-specific antigen (PSA) blood tests. This coverage is limited to one test each calendar year for a Covered Person who is age 40 or older.
- routine sigmoidoscopies and barium enemas.
- routine colonoscopies.
- other routine services furnished in line with the Plan's medical policies.
- preventive health services and screenings as recommended by the US Preventive Services Task Force and the HHS. (This includes recommended preventive prescription drugs covered under the Covered Person's Prescription Drug Benefits.)
-

Women's Preventive Health Services

All female members have coverage for women's preventive health services as recommended by the HHS. These types of preventive health services include: yearly well-woman visits; domestic violence screening; human papillomavirus (HPV) DNA testing; screening for human immunodeficiency virus (HIV) infection; birth control methods and counseling (see Family Planning); screening for gestational diabetes; and

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

breastfeeding support and breast pumps (see Durable Medical Equipment). The Covered Person's coverage for these preventive health services is subject to all of the provisions and requirements of the Plan.

Routine Gynecological (GYN) Exams
The Plan covers one routine GYN exam for each member in each calendar year when it is furnished by a covered provider. This may include (but is not limited to): a physician or a nurse practitioner. This coverage also includes one routine Pap smear test for each member in each calendar year.

Family Planning
The Plan covers family planning services when they are furnished for the Covered Person by a covered provider. This may include (but is not limited to): a physician or a nurse practitioner. This coverage includes:

- Consultations, exams, procedures, and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the US Food and Drug Administration (FDA).
- Injection of birth control drugs. This includes a prescription drug when it is supplied during the visit.
- Insertion of a levonorgestrel implant system. This includes the implant system itself.
- IUDs, diaphragms, and other prescription contraceptive methods that have been approved by the FDA, when the items are supplied during the visit.
- Genetic counseling.

Covered Preventive Services for Children

Routine Pediatric Care
The Plan covers routine pediatric care for a member from birth through age 18 when the care is furnished by a covered provider and is in line with applicable medical policies (if there are any). This coverage is limited to an age-based schedule and a maximum number of visits. The Participant's Schedule of Benefits describes the age-based schedule and the visit limits that apply for these covered services. This coverage includes:

- Routine medical exams; history; measurements; sensory (vision and auditory) screening; and neuropsychiatric evaluation and development screening; and assessment. Hereditary and metabolic screening at birth.
- Appropriate immunizations as recommended by the Advisory Committee on Immunization Practices.
- Tuberculin tests; hematocrit, hemoglobin, and other appropriate blood tests; urinalysis; and blood tests to screen for lead poisoning.
- Preventive care and screenings supported by the Health Resources and Services Administration.
- Other preventive health services as required by applicable federal laws and regulations. This includes, but is not limited to, preventive health services as recommended by the US Preventive Services Task Force.
- Other related routine services that are furnished in line with *Blue Cross Blue Shield* medical policies.

For an enrolled child who receives coverage for vaccines from a federal or state agency, the Plan provides coverage only to administer the vaccine. Otherwise, the Plan also provides coverage for a covered vaccine along with the services to administer the vaccine.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

No benefits are provided for exams that are needed: to take part in school, camp, and sports activities; or by third parties. The only exception to this is when these exams are furnished as part of a covered routine exam.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

C. The Preferred Provider Organization

What Is A "PPO"?

This Plan is part of a Preferred Provider Organization, or PPO maintained by *Blue Cross Blue Shield of Massachusetts*. When the Plan states that it covers a service or charge at "100% of the Allowed Charge" (see Allowed Charge section for more information about this term), the Covered Person pays only any "copayment" (see Copayment section for more information about this term) when the Covered Person goes to a health care provider that has a payment agreement with *Blue Cross Blue Shield of Massachusetts*.

The Plan does cover physicians, providers, and facilities that are not in the PPO. But this coverage is "out-of-network," and the Covered Person will be required to pay a "coinsurance" amount (see the Coinsurance section for more information about this term). Typically, the Plan will pay up to 80% of the Reasonable and Customary Allowed Charge for such service, and the Covered Person will be responsible for the remainder.

The Participant can check if a physician or health care provider has a payment agreement with *Blue Cross Blue Shield of Massachusetts,* and is therefore in its PPO, by going to their website at www.bluecrossma.com, choosing "Member" from the first page the Participant sees, and then using the menu options to find the desired information. The Participant can also call the Plan for assistance.

Primary Care Providers

Under the PPO, the Covered Person is not required to select a "Primary care" physician. But, it is generally agreed that by having a Primary care physician, the Covered Person can most efficiently use the benefits under the Plan. Think of the Covered Person's Primary care physician as a "gatekeeper." A Primary care physician knows the Covered Person's medical history, which is an important part of any medical treatment the Covered Person receives. By using one physician as their "gatekeeper," the Covered Person can help themselves most effectively using the benefits under the Plan. A Primary care physician can also help the Covered Person when the Covered Person is considering using a specialist, and may assist the Covered Person by connecting the Covered Person through a referral.

Remember that with a PPO, the final decision of who the Covered Person would like as a medical service provider is their choice.

PPO Network

This health plan consists of two benefit levels: one for in-network benefits and one for out-of-network benefits. The costs that the Covered Person pays for covered services will differ based on the benefit level. To receive the highest benefit level (the Covered Person's in-network benefits), the Covered Person must obtain their health care services, and supplies from providers who participate in the PPO network. These health care providers are referred to as "preferred providers." If the Covered Person chooses to obtain their health care services and supplies from a covered provider who does not participate in this PPO network, the Covered Person will usually receive a lower benefit level (the Covered Person's out-of-network benefits).

When the Covered Person Needs Help to Find a Health Care Provider

There are a few ways for the Covered Person to find a health care provider who participates in the PPO network. To find out if a health care provider participates in the PPO network, the Covered Person can:

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

- Call the *Blue Cross Blue Shield of Massachusetts* customer service office. The toll-free phone number to call is shown on the Covered Person's ID card. They will tell the Covered Person if a provider is in the PPO network, or, they can help the Covered Person find a covered provider who is in their local area.
- Call the *Blue Cross Blue Shield of Massachusetts* Physician Selection Service at (800) 821-1388.
- Use the *Blue Cross Blue Shield of Massachusetts* online physician directory (Find a Doctor). To do this, log on to www.bluecrossma.com. This online provider directory will provide the Covered Person with the most current list of health care providers who participate in their health care network.

If a Covered Person or their physician cannot find a provider in their health care network who can furnish a Medically Necessary covered service for the Covered Person, the Covered Person can ask *Blue Cross Blue Shield* for help. To ask for this help, the Covered Person can call the *Blue Cross Blue Shield of Massachusetts* customer service office. They will help the Covered Person find providers in their health care network who can furnish the covered service.

When the Covered Person Is Living or Traveling Outside of Massachusetts

If the Covered Person lives or is traveling outside of Massachusetts, the Covered Person can get help to find a health care provider. Just call (800) 810-BLUE (2583). The Covered Person can call this phone number 24 hours a day for help finding a health care provider. When the Covered Person calls, the Covered Person should have their ID Card ready. The Covered Person must be sure to let the representative know that they are looking for health care providers that participate with the BlueCard PPO program. Or, the Covered Person can use the internet. To use the online "Blue National Doctor & Hospital Finder," log on to www.bcbs.com. (For some types of covered providers, a local *Blue Cross and/or Blue Shield* Plan may not have, in the opinion of *Blue Cross Blue Shield of Massachusetts* or BCBSMA, established an adequate PPO health care network. If this is the case and the Covered Person obtains covered services from this type of covered provider, the in-network benefit level will be provided for these covered services.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

D. Managed Health Care and Utilization Review

Managed Health Care

The Medical Benefits are managed under a "Benefits Management" Program to help the Covered Person to:

- Make informed decisions about the Covered Person's care;
- Find the most appropriate setting for the Covered Person's care.

These programs are also used to evaluate the necessity and appropriateness of the Covered Person's health care services and supplies. The Plan uses a set of formal techniques that are designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings, and drugs. These programs are designed to encourage appropriate care and services (not less care).

Individual Case Management

Individual Case Management is a flexible program for managing the Covered Person's benefits in some situations. Under this program, coverage may be approved for services that are in addition to those that are already covered by this health plan. For example, *Blue Cross Blue Shield of Massachusetts* may approve these services to:

- Shorten an inpatient stay (for example, send the Covered Person home or to a less intensive setting to continue treatment).
- Direct the Covered Person to a less costly setting when an inpatient stay has been proposed.
- Prevent future inpatient stays (for example, providing coverage for outpatient care instead or an alternative treatment plan that is Medically Necessary for the Covered Person).

Mental Health/Substance Abuse Treatment Management

Before the Covered Person is admitted to a facility for treatment of a mental condition, including alcohol and substance abuse, the Covered Person must call *Modern Assistance Programs* at (617) 774-0331 or toll-free number at (800) 878-2004 for pre-approval for inpatient admission.

Utilization Review

Medical Benefits are subject to the Utilization Review program requirements of *Blue Cross Blue Shield of Massachusetts*. The Covered Person's Medical Benefits may be reduced or denied if the Covered Person does not follow the requirements of this program. This section describes how the Plan's Utilization Review program works. To check on the status of a Utilization Review decision, the Covered Person may call the *Blue Cross Blue Shield of Massachusetts* customer service office at the toll-free number shown on the reverse side of the Covered Person's Plan identification card. (The requirements of this program do not apply to covered services when Medicare is the Primary coverage).

Prior Authorization Requirements

The Covered Person is always free to seek whatever medical care with whatever medical provider the Covered Person chooses, but if the Covered Person wishes to obtain any available coverage from the Plan for such services or treatment, the Covered Person needs to comply with the Plan's prior authorization requirements. These procedures do not dictate what care the Covered Person receives, but do set forth under what circumstances the Plan will pay for such service or treatment.

Pre-Admission Review

Important Note: All inpatient admissions must be approved in advance by *Blue Cross Blue Shield of Massachusetts* to receive benefits. In some situations, the Covered Person will need to start the process

described in this section for obtaining approval from *Blue Cross Blue Shield of Massachusetts*. Otherwise, their benefits may be reduced or denied.

Before the Covered Person enters a facility for inpatient care, the Covered Person must obtain approval from *Blue Cross Blue Shield of Massachusetts* in order for the care to be covered by this Plan. (This pre-approval is not required when the Covered Person's inpatient admission is for emergency medical care or maternity services). For proposed admissions in a participating facility, the facility may start this pre-admission review process for the Covered Person. A participating provider can tell the Covered Person if they must start this process.

The Covered Person must start the pre-admission review process if the participating facility does not start this process or if their proposed admission is to a non-participating facility. To start the pre-admission review process, the Covered Person must call the *Blue Cross Blue Shield of Massachusetts'* Utilization Review unit at the toll-free number shown on the Covered Person's Plan identification card.

Blue Cross Blue Shield of Massachusetts will contact the Covered Person's physician about the proposed admission if more information is needed. In some situations, *Blue Cross Blue Shield of Massachusetts* may arrange an evaluation with an assessment provider who will review whether the proposed admission satisfies the Plan's coverage provisions. Within 2-working days of receiving all necessary information, *Blue Cross Blue Shield of Massachusetts* will determine if the health care setting meets the Plan's coverage guidelines. If necessary information is missing or more information is needed, *Blue Cross Blue Shield of Massachusetts* will request the necessary information or records within 15-calendar days of receiving the pre-admission review request. The requested information or records must be provided within 45-calendar days of *Blue Cross Blue Shield of Massachusetts's* request. If the requested information or records are not provided to *Blue Cross Blue Shield of Massachusetts* within 45-calendar days of the request, the proposed inpatient coverage will be denied.

Mental Health or Substance Abuse Admissions

If the inpatient admission is for mental health or substance abuse, instead of *Blue Cross Blue Shield of Massachusetts*, the Covered Person should call *Modern Assistance Programs* (MAP) at (617) 774-0331 or toll-free at (800) 878-2004. If the Covered Person fails to call *MAP* for pre-admission review, the Plan will not pay any part of the admission and the Covered Person will be responsible for the entire amount of charges for such inpatient admission to a Mental Hospital, detoxification facility, or alcohol and drug treatment facility.

Coverage Approval

If *Blue Cross Blue Shield of Massachusetts* determines that the proposed setting for the Covered Person's care is suitable, *Blue Cross Blue Shield of Massachusetts* will call the facility within 24 hours of the determination to let the facility know the status of the pre-admission review. *Blue Cross Blue Shield of Massachusetts* will also send a written (or electronic) confirmation of the coverage approval to the Covered Person and the facility within 2-working days of the phone call to the facility.

If there is a medical necessity for a referral to inpatient mental health or substance abuse services, *Modern Assistance Programs* will make a referral to an in-network provider with a pre-approval for services. *Modern Assistance Programs* will consult with the inpatient provider and will conduct reviews to determine length of stay and aftercare referrals when indicated.

Note, however, that any coverage approval is only as to whether the treatment is Medically Necessary. Approval by *Blue Cross Blue Shield of Massachusetts* or *Modern Assistance Programs* as to whether such

treatment or facility is Medically Necessary is not approval that a claim for benefits will be paid by the Plan as such determination is made by the Plan after consideration as to whether all Plan requirements are satisfied. The Plan will determine if the eligibility and other Plan requirements for such benefits are satisfied.

Coverage Denial

If *Blue Cross Blue Shield of Massachusetts* determines that the proposed setting is not Medically Necessary for the Covered Person's condition, *Blue Cross Blue Shield of Massachusetts* will call the facility within 24 hours of the determination to let the facility know of the denial of coverage and what alternative treatments the Plan will cover. *Blue Cross Blue Shield of Massachusetts* will also send an explanation (written or electronic) of the coverage decision to the Covered Person and the facility within 1-working day of the phone call to the facility.

This explanation will describe the reasons for the denial, the applicable terms of the Plan, and any applicable *Blue Cross Blue Shield of Massachusetts* medical policy guidelines used and how to obtain a free copy of the guidelines, any additional information needed, the review process and the Covered Person's right to pursue legal action.

Modern Assistance Programs will see all Local 103 Covered Persons and their Dependents for mental health and substance abuse services free of charge and will not refuse services at the *Modern Assistance Programs* office. If *Modern Assistance Programs* determines that there is no need for inpatient services due to medical necessity, the treatment facility and member will be notified immediately. Appeals may be directed to the Plan for consideration.

Reconsideration of Adverse Determination

When *Blue Cross Blue Shield of Massachusetts* determines that inpatient coverage is not Medically Necessary for the Covered Person's condition, the Covered Person or their authorized claims representative may ask that *Blue Cross Blue Shield of Massachusetts* arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between the Covered Person's provider and the clinical peer reviewer within 1-working day of the request for reconsideration. If the initial determination is not reversed, the Covered Person (or the health care provider on the Covered Person's behalf) may request a formal review as described in Section XII of the Plan. The Covered Person may request a formal review even though their health care provider has not followed this reconsideration process.

Reconsideration of mental health or substance abuse adverse decisions by *Modern Assistance Programs* may be requested of the Plan. This reconsideration will be conducted between the Covered Person's provider and the Plan's reviewer within 1-working day of the request for reconsideration. If the initial determination is not reversed, the Covered Person (or the health care provider on the Covered Person's behalf) may request a formal review as described in Section XII of the Plan. The Covered Person may request a formal review even though their health care provider has not followed this reconsideration process.

Concurrent Review and Discharge Planning

Concurrent Review and Discharge Planning means that while the Covered Person is an inpatient, *Blue Cross Blue Shield of Massachusetts* will monitor and evaluate the Medical Necessity and appropriateness of the health care services for purposes of Plan requirements to evaluate whether the Covered Person's continued care is still approved for inpatient coverage in that facility. *Blue Cross Blue Shield of Massachusetts* will make this determination within 1-working day of receiving all necessary information.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

When this is the case, *Blue Cross Blue Shield of Massachusetts* will call the facility within 1-working day of the coverage determination to let the facility know the approval status of the review.

Blue Cross Blue Shield of Massachusetts will also send a written (or electronic) explanation of the decision to the Covered Person and the facility within 1-working day of the phone call to the facility. This explanation (written or electronic) will include the number of additional days that are being approved for coverage (or the next review date), the new total number of approved days or services, and the date the approved services will begin.

In other cases, based on Medical Necessity determination, *Blue Cross Blue Shield of Massachusetts* may determine that the Covered Person no longer qualifies for inpatient Plan coverage in that facility or qualifies for inpatient Plan coverage at all. *Blue Cross Blue Shield of Massachusetts* will make this coverage determination within 1-working day of receiving all necessary information. When this is the case, *Blue Cross Blue Shield of Massachusetts* will call the facility within 24 hours of the coverage determination to let the facility know of the decision and to discuss a plan for continued coverage in a health care setting that better meets their needs.

For example, the Covered Person's condition may not qualify for inpatient Plan coverage in a hospital, but still may qualify for skilled nursing coverage. If this is the case, the Covered Person's physician may decide to transfer the Covered Person to an appropriate Skilled Nursing Facility. The Covered Person's physician will discuss any proposed plans with the Covered Person. All arrangements for discharge planning will be confirmed in writing with the Covered Person.

If the Covered Person chooses to stay in a facility after coverage is no longer Medically Necessary or after the Covered Person has been notified by their provider or *Blue Cross Blue Shield of Massachusetts* that inpatient coverage is no longer Medically Necessary, the Plan will pay no further benefits. The Covered Person will be responsible for the payment of all charges for the rest of that inpatient stay, starting from the date after it has been determined that coverage is no longer Medically Necessary, or the date the written notification is sent to the Covered Person, whichever is earlier.

Modern Assistance Programs will monitor and evaluate the Medical Necessity and appropriateness of the inpatient mental health and substance abuse services for purposes of Plan requirements to evaluate whether the Covered Person's continued care is still approved for inpatient coverage in that facility. If *Modern Assistance Programs* determines that coverage is no longer needed for inpatient services due to Medical Necessity, the treatment facility and member will be notified immediately. Appeals may be directed to the Plan for consideration.

Reconsideration of Adverse Determination

The Covered Person's health care provider may ask that *Blue Cross Blue Shield* reconsider its decision when *Blue Cross Blue Shield* has determined that continued inpatient coverage is not Medically Necessary for the Covered Person's condition. In this case, *Blue Cross Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between the Covered Person's health care provider and the clinical peer reviewer. And, it will be held within 1-working day of the date that the Covered Person's health care provider asks for the *Blue Cross Blue Shield* decision to be reconsidered. If the initial decision is not reversed, the Covered Person (or the health care provider on their behalf) may ask for a formal review. The process to ask for a formal review is described in Section XII of the Plan. The Covered Person may request a formal review even if their health care provider has not asked that the *Blue Cross Blue Shield of Massachusetts* decision be reconsidered.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

The Covered Person's health care provider may ask that *Modern Assistance Programs* reconsider their decision that continued coverage for inpatient mental health or substance abuse is no longer Medically Necessary. In this case, *Modern Assistance Programs* will arrange for the decision to be reviewed by the Plan.

This reconsideration will be conducted between the Covered Person's provider and the Plan's reviewer within 1-working day of the request for reconsideration. If the initial determination is not reversed, the Covered Person (or the health care provider on their behalf) may request a formal review as described in Section XII of the Plan. The Covered Person may request a formal review even though their health care provider has not followed this reconsideration process.

Home Health Care Prior Approval

Before the Covered Person receives home health care, the Covered Person must obtain approval from *Blue Cross Blue Shield of Massachusetts* in order for the care to be covered. If a Covered Person is planning to obtain home health care from a preferred provider, the provider may start the approval process for the Covered Person. The Covered Person must start the pre-approval process if the preferred provider does not start this process or if the Covered Person is planning to obtain these services from a non-preferred provider.

When prior approval is requested, *Blue Cross Blue Shield of Massachusetts* will determine within 2-working days of receiving all necessary information if the proposed services should be covered as Medically Necessary for the Covered Person's condition. If the necessary information is missing or more information is needed, *Blue Cross Blue Shield of Massachusetts* will request the necessary information or records within 15-calendar days of receiving the request. The requested information or records must be provided within 45-calendar days of Blue Cross Blue Shield of Massachusetts' request. If the requested information is not provided to *Blue Cross Blue Shield of Massachusetts* within 45-calendar days of the request, the proposed outpatient coverage will be denied. (If the Covered Person has been receiving inpatient care, *Blue Cross Blue Shield of Massachusetts* may approve these services through "Discharge Planning").

Coverage Approval of Home Health Care

If *Blue Cross Blue Shield of Massachusetts* determines that the proposed course of treatment should be covered as Medically Necessary for the Covered Person's condition, *Blue Cross Blue Shield of Massachusetts* will call the health care provider within 24 hours of the determination to let the provider know the approval status of the review. *Blue Cross Blue Shield of Massachusetts* will also send a written (or electronic) confirmation of the approval to the Covered Person and the provider within 2-working days of the phone call to the provider. Note however that coverage approval is only as to the Medical Necessity of the home health care. The Plan will determine if the eligibility and other Plan requirements for such benefits are satisfied. Approval by *Blue Cross Blue Shield of Massachusetts* as to whether such treatment or facility is Medically Necessary is not approval that a claim for benefits will be paid by the Plan as such determination is made by the Plan after consideration as to whether all Plan requirements are satisfied.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Coverage Denial of Home Health Care

If *Blue Cross Blue Shield of Massachusetts* determines that the proposed course of treatment should not be covered as Medically Necessary for the Covered Person's condition, *Blue Cross Blue Shield of Massachusetts* will call the health care provider within 24 hours of the determination to let the provider know of the denial of coverage. *Blue Cross Blue Shield of Massachusetts* will also send a written (or electronic) explanation of the decision to the Covered Person and the provider within 1-working day of the phone call to the provider. This explanation will describe the reasons for the denial, the applicable terms of the benefits as described in the Plan, any applicable *Blue Cross Blue Shield of Massachusetts* medical policy guidelines used and how to obtain a free copy, any additional information needed, the review process and the Covered Person's right to pursue legal action.

Reconsideration of Adverse Determination

When *Blue Cross Blue Shield of Massachusetts* determines that the proposed course of treatment is not Medically Necessary as defined by the Plan given the Covered Person's condition, the Covered Person or their authorized claims representative may ask *Blue Cross Blue Shield of Massachusetts* to arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between the Covered Person's provider and the clinical peer reviewer within 1-working day of the request for reconsideration.

If the initial determination is not reversed, the Covered Person (or the health care provider on their behalf) may request a formal review as described in Section XII. The Covered Person may request a formal review even though their health care provider has not followed this reconsideration process. Note however that any coverage approval is only as to whether the treatment is Medically Necessary.

The Plan will determine if the eligibility and other Plan requirements for such benefits are satisfied. Approval by *Blue Cross Blue Shield of Massachusetts* as to whether such treatment is Medically Necessary is not approval that a claim for benefits will be paid by the Plan as such determination is made by the Plan after consideration as to whether all Plan requirements are satisfied.

Appeal Process

If the Covered Person is not satisfied with *Blue Cross Blue Shield of Massachusetts* Utilization Reviewer's or *Modern Assistance Programs'* ultimate decision, the Covered Person can appeal further to the Trustees, who reserve the right to make the final decision. (See Section XII, Medical Claims Submission and Appeals Process.)

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Some Frequently Asked Questions About Utilization Review and Hospital Admission Medical Benefits

Q1: What procedure must the Covered Person follow before admission to a Hospital?

A1: If the Covered Person is planning to be admitted to a hospital on a non-emergency basis, the Covered Person or their Physician must notify the Utilization Reviewer and receive prior approval for the Covered Person's admission. In the event the Covered Person is admitted on an emergency basis, the Utilization Reviewer should be notified within 48 hours.

Q2: The Covered Person is planning to have surgery. Does the Covered Person need to contact the Utilization Reviewer?

A2: Yes. If the Covered Person is planning to have an elective, non-emergency surgery, the Covered Person should contact the Utilization Reviewer at least 3 weeks ahead of time. The Covered Person may be required to obtain a Second Surgical Opinion. The Allowed Charges the Covered Person incurs as the result of the second opinion will be covered.

Q3: Does the Plan provide benefits for inpatient psychiatric care or substance abuse?

A3: Yes. To make sure the benefits that the Covered Person is entitled to under the Plan are not reduced or denied, *Modern Assistance Programs* must be contacted before any admission for inpatient psychiatric care or substance abuse. If MAP determines such inpatient care to be Medically Necessary, *Modern Assistance Programs* will negotiate a discounted rate with the facility to provide the care required.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

E. Plan Exclusions and Limitations

In addition to, or supplemental to any Plan exclusions stated elsewhere in this Plan, the coverage, benefits, and rights stated in the component Master Plan, Normal Retiree Plan, and Supplemental Plan are subject to and limited by the following exclusions, and such component Plans do not cover the following:

Exclusion #1: Benefits Available From Governmental Programs

The Plan does not pay if benefits are available through a governmental program (local, state, national, or foreign) that provides or pays for health services. It does not include Medicaid or Medicare.

Exclusion #2: Treatment While Incarcerated

The Plan does not pay for treatment while the Covered Person is incarcerated in a state or federal jail or prison.

Exclusion #3: Charges That the Covered Person Is Not Required to Pay

The Plan does not pay for charges that that Covered Person is not legally obligated to pay. For example, if that Covered Person is billed for a service that did not take place, that Covered Person should notify the Plan immediately.

Exclusion #4: Charges That Are Not Medically Necessary

The Plan does not cover services that are not Medically Necessary, as determined by the Authorized Claims Reviewer, to diagnose or treat an illness, injury, or disease, except that this exclusion will not apply to the harvesting of the donor's human organ or stem cells when the donor is a Covered Person and when Medically Necessary to the Covered Person receiving such organ or stem cells. (see Organ Transplants in Section III, Master Plan and Normal Retiree Plan Medical Benefits.)

Exclusion #5: Charges Incurred for Custodial Care

The Plan does not pay for charges incurred because of Custodial Care. This is care that is furnished mainly to help a person in the activities of daily living. It does not require day-to-day attention by medically trained persons. For example, it may consist, of: room and board, routine nursing, services to help in personal hygiene, and self-care for a Covered Person who is mentally and/or physically disabled but who does not require the regular attention of medically licensed staff, or services to a Covered Person whose condition is not likely to improve, even if the Covered Person receives the regular attention of medically licensed staff. Also, no benefits are provided for services to observe or reassure a Covered Person.

Exclusion #6: Cosmetic Surgery, Procedures, or Services

The Plan does not cover cosmetic services that are performed solely for the purpose of making a Covered Person look better or different, whether or not these services are meant to make the Covered Person feel better about the Covered Person, or treat a mental condition, except as required because of an accidental injury or under the *Women's Health and Cancer Rights* section of the Plan.

For example, no benefits are provided for: acne scars or lesions, cosmetic surgery, and dermabrasion, or other procedures to plane the skin, stretch mark surgery, electrolysis, hair removal or restoration, treatment or removal of tattoos, plastic revisions (such as face lifting, forehead/brow lift,), Botox® treatment, collagen and other injectables, rhinoplasty, augmentation (including breast implants or removal, lip augmentation), mastoplasty, panniculectomy. abdominoplasty lipoplasty, liposuction, and similar cosmetic procedures.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Exclusion #7: Hearing Aids, Acupuncture, and Chiropractic Care Over Plan Limits
The Plan does not pay for charges related to (1) hearing aids or exams to prescribe, fit, or change them, (2) acupuncture and (3) chiropractic care, that are in excess of the limits provided in the Plan.

Exclusion #8: War or Armed Aggression
No coverage is provided for injury because of war, declared or undeclared, including armed aggression.

Exclusion #9: Employment or Work Related Injury or Disease
The Plan does not pay for charges for bodily injury or disease arising out of or in the course of the Covered Person's employment, subject to the Coordination of Benefits rules found in Section XIII.

Exclusion #10: Travel Expenses
The Plan does not pay for transportation or travel expenses, other than emergency local use of an ambulance service to or between hospitals. Transportation by ambulance, chair care services, or other means to a doctor's appointment and treatment are also not covered.

Exclusion #11: Other Primary Coverage
This Plan does not cover charges for which the Covered Person is entitled to benefits under any other group medical plan that is required to make payment under Coordination of Benefits rules of this Plan.

Exclusion #12: Abortion
The plan does not provide coverage for abortion (the voluntary termination of pregnancy), unless the mother's life is threatened.

Exclusion #13: Court Ordered Confinement for Substance Abuse
The Plan does not pay for charges incurred for services furnished by a legally licensed hospital when the Covered Person has been confined as the result of a court order stemming from a violation of an alcohol or controlled substance statute.

Exclusion #14: Services Incurred While Not a Covered Person
No coverage is provided for services or charges incurred while the person was not a Covered Person under this Plan.

Exclusion #15: Midwives
The Plan does not pay for charges for midwives.

Exclusion #16: Educational Testing and Evaluations; Independent Occupational or Speech Therapy
No coverage is provided for exams, evaluations, or services that are performed solely for educational or developmental purposes. For example, the Plan does not cover education tutoring, therapy, schooling, or counseling, including any speech or motor therapy, pre-school therapy or treatment, schooling, or counseling. In addition, the Plan does not cover:

- Independent occupational or speech therapy services.
- Services normally within the authority of a state's school system even if the education plan or program is not approved by such school system or any federal agency. For example, early intervention and early childhood programs are not covered, whether services are performed by or for the school or at the parents' request.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

- The Plan does not pay for federal or state education testing or programs or for outside or independent testing related to such programs. For example, such programs include Massachusetts "Chapter 766" core evaluation or intelligence testing and other comparable governmental programs.

Exclusion #17: Breast Reduction; Implant Surgeries
The Plan does not cover or pay for any breast reduction, or breast implants, except as medically necessary or if a Covered Person is receiving benefits under the Plan in conjunction with a mastectomy and elects breast reconstruction, this Exclusion shall not apply to the Allowed Charges for (1) reconstruction on the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Exclusion #18: Penile Implants
The Plan does not cover charges for penile implants.

Exclusion #19: Experimental and Investigational Treatments and Procedures
The Plan does not cover tests, drugs, procedures, medical treatment, therapy or any other charge that is Experimental or Investigational.

Exclusion #20: Benefit Maximums
The Plan does not cover or pay for any benefit that would otherwise be payable by the Plan but is subject to a benefit maximum. For example, the Plan does not pay for any chiropractic services in an amount greater than a maximum benefit in a plan year. (see Appendices A and C for current maximum.)

Exclusion #21: Infertility Services, Diagnosis and Treatment
The Plan does not pay for any diagnosis, testing, treatment, or other expense or charges related to infertility. No coverage is provided for services related to achieving pregnancy through a surrogate (gestational carrier) or serving as a surrogate.

Exclusion #22: Exercise, Diet, and Nutritional Programs
The Plan does not pay for exercise, aerobic, or biofeedback programs (including related medication). The Plan does not cover or pay for dietary programs, dietary meals or dietary or nutritional supplements. The Plan does not cover or pay for nutritional consultations or visits, except that one nutritional visit per calendar year will be covered if Medically Necessary and a newly diagnosed diabetic will be permitted 6 nutritional visits for the first calendar year.

Exclusion #23: Psychological Testing
The Plan does not cover or pay for psychological testing or neuropsychological tests or evaluations. Examples of such tests may include comprehensive assessments of cognitive functions such as learning and memory or problem solving. Other examples may include tests to assess the various abilities that relate to learning and using knowledge and skills. Examples may also include attention evaluations or functional behavioral assessments.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Exclusion #24: Personal Comfort Items
The Plan does not cover or pay expenses for personal comfort items, such as a telephone, radio, television, air conditioner, saunas, or personal care services. The Plan does not cover or pay for remodeling or alteration of home or living facilities.

Exclusion #25: Alopecia
The Plan does not cover or pay for the treatment of alopecia, the medical term for baldness.

Exclusion #26: Elective Surgery
The Plan does not cover or pay for elective surgery. For example, the Plan does not pay for surgery which is defined as being performed for the satisfaction of the individual and not Medically Necessary.

Exclusion #27: Felonious Acts
The Plan does not cover or pay for any charges incurred as the result of committing or attempting to commit a felony or felonious act.

Exclusion #28: Unreasonable and Non-Customary Charges
The Plan does not cover or pay for any portion of the charges or expenses incurred for medical services, prescriptions and supplies which exceed (i) the Allowed Charge, or (ii) the fair and reasonable value of such services and supplies as determined by the Trustees, by comparing the charges incurred with the charges made to other individuals of similar age and sex for the same type of illness, disease, or injury in the locality where furnished.

Exclusion #29: Non-PPO Providers
If a Covered Person uses any services and supplies furnished by health care providers that are not considered participating providers in the PPO provided by *Blue Cross Blue Shield of Massachusetts*, the Plan will not pay more than the *Blue Cross Blue Shield* Allowed Amount for such services or supplies.

Exclusion #30: Non-Covered Providers
No coverage is provided for any services and supplies furnished by categories or types of health care providers that are not covered by this health plan.

Exclusion #31: Dental Services
Dental services, surgery, and treatment are solely covered by the Dental Benefits portion of the Plan, Section VI, and are not eligible for coverage under Medical Benefits. The only Dental service covered by Medical Benefits, Section III, is the removal of wisdom teeth #1, 16, 17, and 32. For example, dental implants would be paid solely under the Dental Benefits portion of the Plan, Section VI, and not under the Medical Benefits, Section III.

Dental services (including oral surgery) performed in a hospital are not covered or paid for by the Plan unless the Covered Person has a medical condition that precludes a visit to a dentist or an oral surgeon's office, documented by a physician and approved by the Plan.

Exclusion #32: Unlicensed Services
The Plan does not cover services beyond the scope of the license of the person performing them.

Exclusion #33: Repetitive Surgical Procedures
The Plan does not cover or pay for charges for surgical procedures by a physician of a type that lend themselves to frequent repetition.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Exclusion #34: $8,000 Motor Vehicle Accident Exclusion
The Plan excludes from coverage the first $8,000 of claims it otherwise would pay that relate to a motor vehicle accident. This exclusion applies regardless of whether or the extent to which the Covered Person may be covered or eligible for benefits or payments under any automobile or motor vehicle insurance, underinsurance, Personal Injury Protection (PIP), Med-pay, or similar type of motor vehicle insurance, regardless of the method of funding (for example, self-funded). A Covered Person is required to notify the Plan of any claim that may be related to a motor vehicle accident immediately, and before seeking payment of such claim by the Plan. The Plan will retract any payments it makes, even if inadvertently or otherwise in error, that are subject to this exclusion. See also Section XIII, "Coordination of Benefits Rules," for information regarding claims in excess of the $8,000 exclusion and the requirement that the Covered Person must exhaust all other insurance.

Exclusion #35: No Oral Plan Modifications
No coverage is provided for any claim that is not based upon the written terms of the Plan. No coverage is provided for a service or supply that is not described in this Plan as a covered service or supply.

Exclusion #36: Drugs and Chemicals Unrelated to Medical Condition or Disability
The Plan does not cover or pay for any claims arising from the Covered Person's taking, inhaling, or absorption of any gas, poison, non-prescribed drug, or medicine other than because of an accident. This exclusion will not apply if such action was the result of a medical condition or disability of the Covered Person.

Exclusion #37: Failure to Follow Plan Rules
The Plan will not cover or pay for any claims which otherwise would be covered, where the Covered Person has not complied with the procedures or notice requirements for the benefit, or where the Covered Person has failed to comply with the Coordination of Benefit rules or the Assignment and Subrogation Rules in Section XIV.

Exclusion #38: Canceled or Missed Appointments
The Plan does not cover the charges associated with missed or canceled appointments. Physicians and other providers may charge the Covered Person for failing to keep their scheduled appointments. They may do so if the Covered Person does not give reasonable notice to their office.

Exclusion #39: Phone or Other Similar Consultations
The Plan does not cover or pay for charges related to phone, electronic, wireless, Internet, or consultations that are not in person, including but not limited to consultations of such nature between a Covered Person and the Covered Person's physician.

Exclusion #40: Charges Incurred for the Covered Person's Convenience
The Plan does not cover charges incurred for the Covered Person's own convenience, such as when the Covered Person chooses to stay in a covered facility beyond the discharge hour. Expenses that the Covered Person incurs when the Covered Person chooses to stay in a hospital or other health care facility beyond the discharge time determined by *Blue Cross Blue Shield of Massachusetts*.

Exclusion #41: Reversal of Sterilization
No benefits are provided for the reversal of sterilization.

Exclusion #42: Services Furnished to Immediate Family

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

No coverage is provided for a covered service furnished by a provider who is a member of the Covered Person's immediate family. An exception is for drugs for which this Plan provides benefits when used by a physician, dentist, or podiatrist while furnishing a covered service. "Immediate family" means any of the following members of a provider's family:

- legal spouse;
- parent, child, brother, or sister (by birth or adoption);
- stepparent, stepchild, stepbrother, or stepsister.
- father-in-law, mother-in-law, son–in-law, daughter-in-law, brother-in-law, or sister-in-law. (for purposes of providing covered services, an in-law relationship does not exist between the Covered Person and the spouse of the Covered Person's spouse's brother or sister); and
- grandparent or grandchild.

NOTE: For the purposes of this exclusion, the immediate family members listed above will still be considered immediate family after the marriage which created the relationship is ended (by divorce or death).

There is another exception to this exclusion for the services of a private duty nurse who is a member of the Covered Person's immediate family. However, these benefits are provided only when the Covered Person proves to *Blue Cross Blue Shield of Massachusetts* that the private duty nurse could otherwise have been gainfully employed to perform those services.

Exclusion #43: Drug/Alcohol Testing and Screening
The Plan does not cover or pay for drug, alcohol, or controlled substance testing or screening unless performed under the supervision *of Modern Assistance Program.*

Exclusion #44: Child Birth Classes
The Plan does not cover or pay for childbirth classes.

Exclusion #45: Holistic Medicine
The Plan does not cover or pay for services and supplies that are considered "Holistic medicine." Please contact the Plan for additional services and supplies that are information about what is considered "Holistic medicine."

Exclusion #46: Other Services and Supplies That Are Not Covered
No coverage is provided for:

- A service or supply that is not described as a covered service in this Plan. An example is baby formula specifically excluded under the Prescription Drug Plan.
- Services that do not conform to *Blue Cross Blue Shield of Massachusetts* medical policy guidelines.
- Services or supplies that the Covered Person received when the Covered Person was not enrolled in this Plan. There is one exception to this exclusion. This Plan does provide benefits for routine nursery charges and may provide benefits for other newborn care. But, to ensure benefits for all covered services (including circumcision) for the newborn child, the Participant must remember to enroll the newborn in the Plan within 30 days of the child's birth.
- Any service or supply furnished along with a non-covered service.
- Services that are furnished to someone other than the patient, except as described in this Plan for: Hospice services; and harvesting of a donor's organ or stem cells (which includes the surgical removal of the donor's organ or stem cells and related Medically Necessary services and/or tests that are required to perform the transplant itself) when the recipient is a Covered Person.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

- Services that are furnished to all patients due to a facility's routine admission requirements.
- A provider's charge for shipping and handling, taxes or interest (finance charges).
- A provider's charge to file a claim. Also, a provider's charge to transcribe or copy the Covered Person's medical records.
- A separate fee for services by interns, residents, fellows, or other physicians who are salaried employees of the hospital or other facility.

Exclusion #47: Intoxication
The Plan does not cover or pay for any claims arising out of injuries incurred while the Covered Person was driving a motor vehicle while intoxicated (for example, if at the time of an accident there was alcohol in the blood in excess of the intoxication level of the State in which the accident occurred).

Exclusion #48: Methadone and Naltrexone Treatment
The Plan does not cover charges for methadone and naltrexone treatment. The Plan only covers Suboxone® for Plan Covered Person enrolled in a *Modern Assistance Program* with a lifetime maximum of up to a consecutive 2-month prescription.

Exclusion #49: Medical Marijuana
The Plan does not cover charges for medical marijuana.

Exclusion #50: Private Room Charges
While the Covered Person is an inpatient, the Plan covers charges for room and board based on the semi-private room rate. If a private room is used, the Covered Person must pay all costs that are more than the semi-private room rate.

Exclusion #51: Where Someone Else is at Fault
The Plan does not cover treatment of injuries, illnesses, or other losses that occur due to an accident or other event or occurrence that are or may be the result of an act or omission by another person or entity, unless the Covered Person complies with the Assignment and Subrogation Rules in Section XIV.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Plan Definitions

Allowed Charge

The "Allowed Charge" is the charge that is used to calculate payment of the Covered Person's health care benefits. It has different meanings, depending on the provider that furnishes the service or supply.

- Preferred Providers in Massachusetts (in-network); For health care providers that have a preferred provider arrangement (a "PPO negotiated payment arrangement") with *Blue Cross Blue Shield of Massachusetts*, the allowed charge is based on the provisions of that health care provider's PPO payment agreement. For covered services furnished by these health care providers the Covered Person pays only the applicable copayment.

- For Health Care Providers Outside of Massachusetts with a Local *Blue Cross Blue Shield* Payment Agreement (in-network); For health care providers outside of Massachusetts who have a payment agreement with the local *Blue Cross Blue Shield Plan*, the allowed charge is the "negotiated price" that the local *Blue Cross Blue Shield Plan* passes on *to Blue Cross Blue Shield of Massachusetts*. For covered services furnished by these health care providers, the Covered Person pays only the applicable copayment.

- For Other Health Care Providers (out-of-network); For health care providers in Massachusetts who do not have a PPO payment agreement with *Blue Cross Blue Shield of Massachusetts* or for health care providers outside of Massachusetts who do not have a payment agreement with the local *Blue Cross Blue Shield Plan*, the allowed charge is set by *Blue Cross Blue Shield of Massachusetts*. This allowed charge is based upon the "usual and customary" fees most often charged by similar providers for a similar health care service or supply (but in no case more than the actual provider's charge). The Plan will typically pay 80% of the allowed charge. The Covered Person is responsible for the remaining balance of the provider's charges.

For this reason, it is imperative for the Covered Person to discuss charges with their health care providers before receiving covered services and to contact the Plan to receive an estimate of what the "Allowed Charge" will be as determined by *Blue Cross Blue Shield of Massachusetts.*

Alternate Recipient

Any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Master Plan with respect to such Participant. Solely for purposes of this definition, the term "child" includes any child adopted by, or placed for adoption with, a Participant, provided the child has not attained age 26 as of the date of adoption or placement for adoption. Placement for adoption or being placed for adoption shall mean, in connection with adoption proceedings, the assumption and retention by a Participant or beneficiary of the legal duty for the total or partial support of a child to be adopted. The child's placement with such person terminates whenever the legal duty likewise terminates.

Authorized Representative

The individual who has been designated by a Claimant to act on the Claimant's behalf and 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 XII. An Authorized Representative will be named by the Claimant by filing a written designation to that effect with the Plan, 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 will be recognized as the Claimant's Authorized Representative.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Claimant
Any Covered Person who has filed a claim for benefits under the Plan. A Claimant also includes a beneficiary of a Participant for any Life Insurance Benefits.

Claims Reviewer
The person or entity designated to review claims under Section III, E. The Claims Reviewer for claims is presently the Plan.

Coinsurance
The percentage of charges for which a Covered Person is responsible, excluding any "copayment." For example, a Covered Person who visits an out-of-network physician will be responsible for the 20% coinsurance payment that the Plan will impose (the Plan pays the other 80%). The percentage of Coinsurance for which a Covered Person is responsible is described in other sections of this SPD.

Copayment
The flat dollar portion of a medical bill for which the patient will be responsible for paying. For example, for in-network services, the copayment is a dollar amount, such as $20 for certain physician visits or $200 for an inpatient hospital treatment. Note that "copayment" is not the same as "coinsurance" and that a Covered Person could be responsible for payment of each.

Covered Charges or Covered Expenses
Any Medically Necessary, reasonable and customary item or expense covered in full or part by the terms of the Plan. The Trustees will determine which items or expenses are Covered Charges. A Covered Charge is incurred on the date that the service, supply, or treatment is furnished or rendered.

Covered Person
Any individual covered under the Plan; this includes Participants and/or Eligible Dependents as defined in Section I.

Custodial Care
Any service or supply, including room and board, which (a) is furnished mainly to help a Covered Person meet his/her daily needs; and (b) can be furnished by someone who has no professional health care training or skills. Custodial care is excluded from coverage even if a Covered Person is confined to a hospital or other recognized facility.

Diagnostic Lab Tests
These covered services include the examination or analysis of tissues, liquids, or wastes from the body. These covered tests also include (but are not limited to): the taking and interpretation of 12-lead electrocardiograms; all standard electroencephalograms; and glycosylated hemoglobin (HgbA1C) tests, urinary protein/microalbumin tests, and lipid profiles to diagnose and treat diabetes.

Diagnostic X-Ray and Other Imaging Tests
These covered services include: fluoroscopic tests and their interpretation; and the taking and interpretation of roentgenograms and other imaging studies that are recorded as a permanent picture, such as film. Some examples of imaging tests are: magnetic resonance imaging (MRI); and computerized tomography (CT scans). These types of tests also include diagnostic tests that require the use of radioactive drugs.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Durable Medical Equipment
Equipment that has been prescribed by a physician and that: (1) can withstand repeated use; (2) serve a medical purpose; (3) is not useful to the patient in the absence of illness or injury; (4) can be used in the home. Note that the Plan will not pay for the rental or purchase of any such equipment that has not had prior approval by the Utilization Reviewer, even though prescribed by a physician. Durable medical equipment does not include air conditioners, exercise equipment, saunas, air purifiers, arch supports, and articles of special clothing, bedpans, corrective shoes, dehumidifiers, humidifiers, elevators, wheel chair ramps, heating pads, hot water bottles, and similar items.

Effective Date
This term is used to mean the date on which the Covered Person's coverage in a component health plan starts.

Eligible Dependent
Has the meaning set forth in Section I of the Plan.

Emergency Admission/Medical Emergency
The immediate admission of a Covered Person to a hospital for treatment of the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could endanger health and result in permanent disability. Examples include, but are not limited to, heart attack, stroke, and serious burns and poisoning. A hospital admission or surgery made or performed for the convenience of the physician or patient is not a medical emergency.

Experimental or Investigational
Any drug, device, therapy, or medical treatment or procedure if it falls within any of the following categories:

1) It is considered by any governmental agency or subdivision, including but not limited to the FDA, the Office of Health Technology Assessment or the Health Care Financing Administration Coverage Issues Manual to be:
    1) experimental or investigational;
    2) not reasonable and necessary; or
    3) any similar finding;
2) It is not covered under Medicare reimbursement laws, regulations, or interpretations;
3) It is not commonly and customarily recognized by the medical profession as appropriate for the condition being treated;
4) It is furnished in connection with medical or other research;
5) Reliable Evidence indicates that the drug, device, therapy, medical treatment or procedure is the subject of ongoing phase 1, 2, or 3 clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or
6) Reliable Evidence indicates that the consensus among experts regarding the drug, device, therapy, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Health Care Professional
A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Hospice
An organization that provides palliative and supportive care for a terminally ill Covered Person under a Hospice care program. The term "palliative and supportive care" means care and support provided mainly for the purpose of lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness.

Hospital
An institution that meets each of the following requirements:

1) Holds a license as a hospital if a license is required by the state in which it is domiciled;
2) Is operated primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients;
3) Provides 24 hour a day nursing service by registered or graduate nurses;
4) Has a staff of one or more licensed physicians available at all times;
5) Provides organized facilities for diagnosis and major surgical procedures;
6) Is not primarily a clinic, nursing or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics, or drug addicts or the mentally ill; and
7) Is operated for compensation from its patients, provided however, if a unit or area of a hospital is primarily operated for care of convalescent or ambulatory patients or for rehabilitation purposes, confinement in such unit or area shall not be considered hospital confinement unless such confinement is for purposes other than convalescence and rehabilitation, and the Covered Person is not ambulatory during such confinement.

Illness or Sickness
Any bodily disorder or disease that manifests treatable symptoms and requires treatment by a physician. All such conditions existing concurrently or successively which are due to the same or related causes shall be considered as one illness or sickness.

Injury
All damage to a person's body due to an accident or accidental means and all complications arising from that damage. For purposes of AD&D benefits, the definition of injury contained in Section IX shall apply instead of this definition.

Inpatient
The term "inpatient" refers to a patient who is a registered bed patient in a hospital or other covered health care facility and the Plan has determined that inpatient care is Medically Necessary. This also includes a patient who is receiving Plan approved intensive services such as: partial hospital programs; or covered residential care. A patient who is kept overnight in a hospital solely for observation is not considered an inpatient even though the patient uses a bed. In this case, the patient is considered an outpatient.

Medicare
Unless clearly discussed elsewhere, this term refers to both Medicare Part A (hospital benefits) and Medicare Part B (physician's benefits) of the federal government's health care program for those individuals totally disabled before age 65 and those retired individuals age 65 and over, provided by Title XVII of the Social Security Act, as amended from time to time. Medicare Part D, discussed in more detail in Section IV, is part of the overall Medicare program.

Medical Child Support Order (MCSO)
Any judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) that (1) provides for child support related to health benefits with respect to the child of a Participant, or

requires health benefit coverage of such child in the Plan, and is ordered under State domestic relations law, or (2) is made pursuant to a law relating to medical child support described in §1396g of Title 42 with respect to health benefits under the Plan. Such judgment, decree or order must be issued by a court of competent jurisdiction or issued through an administrative process established under State law and has the force and effect of law under applicable State law. See also, Qualified Medical Child Support Order.

Medical Out-of-Pocket Maximum
Under the Plan there is a maximum cost share amount the Participant has to pay for certain covered services obtained in a Plan year, this is the Participant's out-of-pocket maximum. The Schedule of Benefits details the amount of the Participant's out-of-pocket maximum and what cost share amounts the Participant pays that count towards that out-of-pocket maximum (see Appendix, Schedule A).

Medically Necessary
This term means that a specific surgical procedure, medical care, treatment, service, or supply incurred upon the advice and approval of a physician is reasonably consistent, commonly, and customarily recognized by physicians as appropriate, essential, and medically required for the treatment or management of a diagnosed medical condition, illness, or injury. Medically Necessary does not include a procedure, care, treatment, or service for educational purposes, which is experimental or cosmetic in nature or purpose.

Medically Necessary shall not include a procedure, care, treatment, or service that is solely for the Covered Person's convenience or that of the Covered Person's family or the medical provider.

To be Medically Necessary, a procedure, care, treatment, or service must be furnished in the least intensive type of medical care setting or facility required by the Covered Person's condition. The fact that the Covered Person's physician, or some other provider, has furnished, prescribed, ordered, recommended, or approved a service, treatment, surgical procedure or prescription does not of itself make the aforementioned service, treatment, etc. Medically Necessary.

The determination "Medically Necessary" will be solely made by the Trustees based on a review of the Covered Person's medical records and in conjunction with the finding by the Utilization Reviewer (presently *Blue Cross Blue Shield of Massachusetts*). *Blue Cross Blue Shield of Massachusetts* makes its determination as to which covered services are Medically Necessary and appropriate for the Covered Person by using the following guidelines. All health services must be required to diagnose or treat the Covered Person's illness, injury, symptom, complaint, or condition and they must be:

- Consistent with the diagnosis and treatment of the Covered Person's condition and in accordance with *Blue Cross Blue Shield of Massachusetts' Medical Policy* and *Medical Technology Assessment Guidelines*.
- Essential to improve the Covered Person's net health outcome and as beneficial as any established alternatives covered by the Plan. (This means that if *Blue Cross Blue Shield of Massachusetts* determines that the Covered Person's treatment is more costly than an alternative treatment, benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets the Covered Person's needs. In this case, the Covered Person must pay the difference between the claim payment and the actual charge).
- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished.
- Furnished in the least intensive type of medical care setting required by the Covered Person's medical condition.

"Medically Necessary" does not mean a service that:

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

- Is furnished solely for the Covered Person's convenience or religious preference or the convenience of the Covered Person's family or health care provider;
- Promotes athletic achievements or a desired lifestyle;
- Improves the Covered Person's appearance or how the Covered Person feels about their appearance; or
- Increases or enhances the Covered Person's environmental or personal comfort.

Medical Policy

This term means that all the Medical Benefits described in this Plan will be provided only when they conform to the *Blue Cross Blue Shield of Massachusetts Medical Policy Guidelines* that are in effect at the time the services or supplies are furnished. *Blue Cross Blue Shield of Massachusetts Medical Policy* information is available at www.bluecrossblueshield.com and (888) 533-7644 [MED-POLI].

Medical Technology Assessment Guidelines

All the Medical Benefits described in the Plan will be provided only when they conform to *Blue Cross Blue Shield of Massachusetts Medical Technology Assessment Guidelines*. These are Guidelines that *Blue Cross Blue Shield of Massachusetts* uses to assess whether a technology improves health outcomes such as length of life or ability to function. These Guidelines include the following 5 criteria:

1) The technology must have final approval from the appropriate government regulatory bodies. This criterion applies to drugs, biological products, devices (such as durable medical equipment) and diagnostic services. A drug, biological product, or device must have final approval from the FDA. Any approval granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, the Plan may limit benefits for drugs, biological products and devices to those specific indications, conditions and methods of use approved by the FDA.
2) The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer reviewed English language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.
3) The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4) The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternatives that achieve a similar health outcome.
5) The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Member
A Member of a Local 103 Contributing Employer who satisfies the eligibility rules set forth in Section I of the Plan for coverage under the Master Plan, Normal Retiree Plan, or Supplemental Plan, whichever is applicable.

Mental Hospital
An institution (other than a hospital or separate part of a hospital as defined by this Plan) that specializes in the diagnosis and treatment of mental illness or functional nervous disorders and that is operated pursuant to the law of the state in which it is domiciled and meets all of the following requirements:

1) It is approved by Medicare to give medical treatment;
2) It is operated under the supervision of a physician;
3) It provides nursing services by Registered Graduate Nurses or Licensed Practical Nurses;
4) It provides, on the premises, all necessary facilities for medical treatment;
5) It is not, other than incidentally, a place of rest, a place for the aged, a place for convalescent, Custodial, or educational care.

Non-Preferred Provider
Providers, services, or facilities that do not have payment contracts with the PPO.

Nurse
A registered nurse or licensed practical nurse, including a nursing specialist or practitioner such as a nurse anesthetist or nurse midwife, who (a) is properly licensed or certified under the laws of the state where he or she practices, and (b) provides services which are within the scope of their license. Note that the Plan excludes services of a "midwife," but not of a "nurse midwife."

Outpatient
The term "outpatient" refers to a patient who is not a registered bed patient in a hospital or other health care facility. For example, a patient who is at a health center, at a health care provider's office, at a surgical day care unit, or at an ambulatory surgical facility is considered an outpatient. A patient who is kept overnight in a hospital solely for observation is also considered an outpatient even though the patient uses a bed.

Participant
An individual who satisfies the eligibility rules set forth in Section I of the Plan for coverage under the Master Plan, Normal Retiree Plan, or Supplemental Plan, whichever is applicable. No reference in this Plan to the term Participant shall entitle such person to coverage based upon such reference if the person does not, in fact, satisfy the eligibility rules for such coverage.

Physician
A doctor of medicine (MD), a doctor of osteopathy (DO), a doctor of dental surgery (DDS), a doctor of dental medicine (DMD) a doctor of podiatric medicine (DPM) and an optometrist (OD), as the context requires for the particular procedure and good medical practice.

Preferred Provider
Those providers, services, or facilities that have payment fee schedules that have been negotiated on behalf of the Plan.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Prescription Drug Out-of-Pocket Maximum
Under the Plan there is a maximum cost share amount the Covered Person has to pay for certain covered services obtained in a Plan year, this is the Out-of-Pocket Maximum. The Schedule of Benefits details the amount of the Out-of-Pocket Maximum and what cost share amounts the Covered Person pays that count toward that Out-of-Pocket Maximum (see Appendix, Schedule A).

Preventive Care
This term shall have the meaning given to it by the Affordable Care Act.

Primary
When used in the context of coordination of benefits between this Plan and another group health plan, Medicare, or some other insurance plan, coverage or system, this term shall mean the plan or insurance that pays first.

Qualified Medical Child Support Order (QMCSO)
A Medical Child Support Order that:

- creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive Medical Benefits for which a Participant or other beneficiary is eligible under the Plan, and
- clearly specifies (a) the name and last known mailing address (if any) of the Participant and the name and address of each Alternate Recipient covered by the Medical Child Support Order, (b) a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined, (c) the period to which such Medical Child Support Order applies, and (d) that such order applies to the Plan, and
- does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under Master Plan Medical, Vision, Dental, or Prescription Drugs, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by §13822 of the Omnibus Budget Reconciliation Act of 1993).

A QMCSO shall include an appropriately completed National Medical Support Notice promulgated pursuant to §401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, provided such notice meets the requirements of paragraphs (2) and (3) above. However, nothing in a National Medical Support Notice may require the Plan to provide benefits under Master Plan Medical, Vision, Dental, or Prescription Drugs (or eligibility for such benefits) in addition to such benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt by the Plan of such National Medical Support Notice.

Qualified Military Leave
Service for which a Participant is entitled to reemployment rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, including as amended by the Veterans Benefits Improvement Act of 2004 (P.L. 108 454).

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

"Reasonable and Customary" or "Usual and Customary"
The amount that the Plan determines to be in the range of fees most often made by similar providers for the same service or supply (but no more than the provider's actual charge) in the same area. Such determination will be made by the Trustees in their sole discretion.

Reliable Evidence
Means only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, therapy or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, therapy or medical treatment or procedure.

Room and Board
For an approved inpatient admission, covered services include room and board. This means the Covered Person's room, meals, and general nursing services while the Covered Person is an inpatient. This includes hospital services that are furnished in an intensive care or similar unit.

Schedule of Benefits
This Plan Document includes a Schedule of Benefits that describes the cost share amount that the Covered Person must pay for each covered service (such as a copayment, or a coinsurance). It also describes benefit limits that apply for certain covered services. The Covered Person should be sure to read all parts of this benefit document and the Participant's Schedule of Benefits to understand all of the Covered Person's health care benefits.

Secondary
When used in the context of coordination of benefits between this Plan and another group health plan, Medicare, or some other insurance plan, coverage or system, this term shall denote the plan or insurance that pays after all Primary plans or insurance.

Second Surgical Opinion
An opinion of a qualified independent physician as determined by the Utilization Reviewer based on that qualified independent physician's examination of a Covered Person for the purpose of evaluating the medical advisability and Medical Necessity of that Covered Person undergoing a specified surgical procedure proposed by a Primary physician. The Secondary examination must be performed after the Primary qualified physician licensed to practice medicine and surgery has proposed to perform such surgical procedure. Each physician must be an independent practitioner and "board certified," not associated with each other in the practice of medicine or surgery or as a member of the same medical professional corporation.

Surgical Procedure
The incision, excision or electro cauterization of an organ or part of the body, the manipulative reduction of a fracture or dislocation, the suturing of a wound, the removal of a stone or other foreign body by endoscopic means. When an assistant surgeon is necessary for major surgery, this term shall also include the services of any such assistant surgeon.

Urgent Care Claim
Any claim for medical care or treatment 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 Covered Person or the ability of the Covered Person to regain maximum function, or (ii) in the opinion of a physician with

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule A for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

knowledge of the Covered Person's medical condition would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Utilization Reviewer

The person or entity retained by the Plan to provide Pre-Certification and Concurrent Care Review. The present entity retained by the Trustees to perform these services is *Blue Cross Blue Shield of Massachusetts, Inc.*, except for substance abuse or inpatient and outpatient mental health benefit, in which case the present entity is *Modern Assistance Programs, Inc.* However, the Trustees may retain other outside entities to provide these services from time to time.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule C for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

SECTION IV: SUPPLEMENTAL RETIREE PLAN MEDICAL BENEFITS

General

This health plan supplements Medicare approved and paid benefits as detailed; Eligible Participants or Eligible Dependents, 65 years of age or otherwise eligible for Medicare (that is, due to disability) and not actively working under the Collective Bargaining Agreement, must timely enroll in both Medicare Part A and Part B, otherwise the Plan will not supplement any coverage and will reverse any benefits paid from the Medicare eligibility date.

Medicare Part A Supplemental Benefits

The Plan supplements benefits the Covered Person receives from Medicare Part A. The Supplemental Plan provides benefits for:

- The Medicare Part A deductible minus a copay, as the deductible is assessed, from the first day thru the 60th day of each Benefit Period; (see Appendix, Schedule C)
- The full cost of the remaining coinsurance hospital charges from the 61st to the 90th day of the Benefit Period of hospital care;
- The full semi private room charges from the 91st through the 365th day per hospitalization or stay;
- The full cost of a Mental Hospital confinement for up to 120 days; and
- The full cost of the remaining Skilled Nursing Facility charges from the 21st to the 100th day of care. After the 100th day, the Plan pays $10 per day from the 101st through the 365th day of Skilled Nursing Facility charges.

Medicare Part B Supplemental Benefits

The Plan supplements benefits the Covered Person receives from Medicare Part B. The Supplemental Plan will provide benefits for the 20% coinsurance associated with the Medicare Part B covered expenses after the Part B annual deductible is paid by the Covered Person (see Appendix, Schedule C), including physician's expenses for services rendered during a hospital confinement for up to 365 days in an Acute Care Hospital and 120 days in a Mental Hospital.

It should be noted that the Covered Person will be responsible for the Medicare late enrollee penalty charge. (For details access www.medicare.gov or call (800) 633-4227 [MEDICARE]).

Outpatient Psychiatric Care

The Plan pays for the Covered Person's 50% balance of coinsurance associated with the Medicare Outpatient Psychiatric allowed expenses up to a dollar maximum in a calendar year. (see Appendix, Schedule C).

Other Outpatient Care

The Plan provides the following benefits per Covered Person up to a maximum dollar amount. (see Appendix, Schedule C).

- Acupuncture services in a calendar year;
- Chiropractic services in a calendar year;
- Hearing aids for 1 or 2 ears in any 4 consecutive year period. The 4 consecutive year period runs from the first date of service. The Plan will pay the Allowed Charges for service, maintenance or batteries per calendar year;
- One physical exam in a calendar year;
- Vision benefits every 2 years for an eye exam and eyeglasses or contacts (see Section VII);
- Podiatry benefits per calendar year;
- Dental Benefits per calendar year (see Section VI);
- Shingle shot benefit, one per lifetime.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule C for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Medicare Part D

Medicare Prescription Drug coverage is available to everyone enrolled in Medicare. This coverage is also available through private Medicare Prescription Drug Plans. All Medicare Prescription Drug Plans must provide at least a standard level of coverage established by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Plan has determined that the Prescription Drug coverage provided by the Plan is, on average for all Covered Persons, expected to pay out at least as much as the standard Medicare Prescription Drug coverage will pay. In other words, the "actuarial value" of the Plan's drug coverage is at least as good as (if not better than) the "actuarial value" of the standard Prescription Drug coverage under Medicare Part D. ***Thus, the Plan's Prescription Drug coverage is considered "creditable" coverage.*** This is an important fact, because it means that the Covered Person does not have to enroll in Medicare Part D at this time. The Covered Person will not have to pay a late enrollment penalty as long as the Covered Person joins a Medicare drug plan within 63 days after the Covered Person's "creditable" coverage with the Plan ends. Please do not sign up for Medicare Part D coverage. Doing so will cause the Covered Person to pay an additional premium to the Plan. (see Appendix, Schedule C). Call the Plan if the Covered Person has any questions about the Prescription Drug coverage available under the Plan.

Why Is an Additional Premium Charged If I Enroll in Medicare Part D?

Each year, the Plan mails to the Covered Person a notice that explains whether their Supplemental Plan Prescription Drug Benefit coverage under the Plan is, on average, at least as good as that provided by the Medicare Part D Prescription Drug Benefit. If this should change, the Plan will notify the Covered Person when it sends out its annual notice. While the Covered Person has the right to enroll in Medicare Part D, ***the Plan already provides equal or greater coverage on average than that provided by Medicare Part D, which makes the Plan's Prescription Drug coverage "creditable" coverage***.

Because the Plan provides such "Creditable Coverage" for Retiree Prescription Benefits, the Plan is allowed under Federal law to obtain an annual subsidy or payment from the government for each "qualifying covered retiree." However, ***when the Covered Person enrolls in a Medicare Part D covered plan, while also covered by this Plan, the Covered Person is no longer considered a "qualifying covered retiree" under the federal law and the Plan loses its subsidy for the credible coverage that it provides to the Covered Person.***

To offset this lost subsidy revenue to the Plan the Trustees have established an annual premium, calculated to approximate the average of the lost subsidy for each year. The amount of the premium may change each year. As long as a Covered Person continues to be enrolled in Medicare Part D, that person will have to pay this premium if the Covered Person also wants to have Supplemental Plan coverage under this Plan.

What Happens If the Covered Person Fails to Timely Pay the Premium?

An invoice will be generated based upon the Participant's Supplemental Plan Annual Enrollment Form, and Notification from Medicare.

The same premium amount is charged for any portion of the Plan year. If a Covered Person fails to pay the premium in a single payment, within 30 days of the date of the invoice, the Covered Person's Supplemental Plan coverage will terminate.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule C for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

A Covered Person will not be allowed to retroactively make payment of the premium if the Covered Person fails to make timely payment of the premium.

If a Covered Person un-enrolls in Medicare Part D and the Plan again becomes eligible for the subsidy, the Covered Person will again become eligible for Supplemental Plan coverage. The Covered Person may still have to pay the premium for 1 year if for any year the Plan loses its subsidy. The Covered Person should notify the Plan in writing if the Covered Person is no longer enrolled in Medicare Part D along with written proof.

If a Covered Person's Coverage With the Plan Ends

If a Covered Person's coverage with the Plan ends and the Covered Person does not enroll in Medicare Prescription Drug coverage within the first 63 days the Covered Person no longer has coverage under the Supplemental Plan, the Covered Person may have to pay more to enroll in Medicare Prescription Drug coverage later. After the Covered Person's initial Medicare enrollment period, if a Covered Person waits 63 or more days to enroll in Medicare Part D after the Covered Person's coverage under this Plan ceases, the Covered Person's monthly Part D premium will go up at least 1% per month for every month that the Covered Person delays enrollment. For example, if a Covered Person waits 19 months to enroll in Part D, the Covered Person's premium will always be 19% higher than the standard rate. The Covered Person will have to pay this higher premium as long as the Covered Person has the Medicare drug coverage. In addition, the Covered Person may have to wait until the next Medicare annual enrollment period for coverage to begin.

More Information About the Medicare Prescription Drug Program

More information about the Covered Person's options under Medicare Prescription Drug coverage can be found in the *Medicare & You Handbook*, which explains in detail what Prescription Drug coverage means to the Covered Person and which plans are available in their area. The Covered Person can also get more information about Medicare Prescription Drug Plans from these sources:

- Visit www.medicare.gov for personalized help
- Call the Covered Person's State Health Insurance Assistance Program (see the *Medicare & You Handbook* for their telephone number)
- Call (800) MEDICARE ([800] 633-4227). TTY users should call (877) 486-2048.
- For people with limited income and resources, extra help paying for a Medicare Prescription Drug Plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY [800] 325-0778).

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule B for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

SECTION V: PRESCRIPTION DRUG BENEFITS

General
This health plan covers certain drugs that are furnished by retail pharmacies and covered mail order pharmacies; coverage is provided **only** when all of the following criteria are met.

- The drug is listed on the Local 103, I.B.E.W. Health Plan Drug Formulary as a covered drug.
- The drug is prescribed for the Covered Person's uses while the Covered Person is an outpatient. The drug is purchased from a retail pharmacy or approved mail order pharmacy for the specific covered drug. This means that for most covered drugs and supplies, the Covered Person may buy the drug or supply from any covered retail pharmacy. However, for some specialty drugs and supplies, the Covered Person must buy the drug from a covered mail order pharmacy.
- The drugs for Covered Person can be obtained at pharmacies under the Retail Plan or through the mail using the mandatory Mail Order Plan, described below.

The Plan utilizes a Pharmacy Benefit Manager (PBM) to process prescription benefits through Retail Pharmacies and the Mail Order Program.

A Prescription Drug Card is issued to all Covered Persons to access the Plan's Prescription Drug Benefits. The Covered Person should present this Card when seeking these services from Providers.

While the Covered Person is in a hospital, any prescription drugs the Covered Person receives are covered under Medical Benefits as part of the inpatient services the Plan provides.

Formulary
A "Formulary" is a list of prescriptions that the Plan covers. The Plan's formulary list can change over time and at the Trustees' discretion.

Covered Persons will have to pay 100% of the cost for medications not covered under the Plan's "Formulary".

It is important that the Covered Person pay attention to the amount of medication the Covered Person has remaining from the Covered Person's prescription. It is the Covered Person's responsibility to order drugs on a timely basis. If a Covered Person does not order a prescription on time, the Covered Person will be responsible for the cost of express delivery and or for obtaining a new 30-day prescription from a doctor. In such cases, the Plan may not reimburse the Covered Person for the cost of this new 30-day prescription.

An advantage of the mail order program is it allows every prescription to be automatically refilled 1 month before the current prescription is empty.

Copayments
When the Covered Person receives a prescription from a physician, the amount of copayment that the Covered Person must pay depends upon the drug category:

- Is the drug categorized as "GENERIC" or is it a "BRAND NAME" prescription?
- Is the Covered Person picking it up at a retail pharmacy (the "Retail Plan") or is the Covered Person receiving a mail order prescription (the prescription is sent to the Covered Person in the mail)?

The current copayments for Generic/Brand Name drugs are noted in Schedule B.
The Trustees may, in their sole discretion, from time to time, change the copayment amounts.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule B for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

Retail Plan

When a Covered Person has a prescription filled at a retail pharmacy, the Covered Person should present their Prescription Drug Card to the pharmacist. All that a Covered Person will be required to pay is the copayment for a Generic drug or a higher copayment for a Brand Name drug for each prescription filled. The Covered Person can fill a prescription (for a maximum of 30-day supply, only) using the Covered Person's Prescription Drug Card only twice for the same drug. After the Covered Person's second fill, the Covered Person will be required to use the Mail Order Drug Plan to fill this prescription.

Mail Order Plan

The Covered Person's physician may prescribe a drug that the Covered Person will take over a long period of time. These are known as "maintenance drugs", such as, blood pressure medication, diabetes medication, and tetracycline for skin condition. The Covered Person can order a 90-day supply of these drugs by mail. The Covered Person will be required to pay a copayment for each prescription filled. (see Appendix, Schedule B).

To start a Mail Order Plan, utilize the contact information in Appendix, Schedule H "Current Vendors Used by the Plan. "

If the Covered Person is prescribed any medication that requires more than one refill, the Covered Person must obtain that prescription through the Mail Order Plan.

Order envelopes are also available from the Plan and from the current "PBM".

There are certain controlled substances which cannot be obtained through the mail order plan.

Exclusions on Prescription Drugs

In addition to the general Plan exclusions (see Section III, Schedule E), the Plan does not cover the following prescription drugs:

- Infertility medications or treatment;
- Retin A, even when used to treat acne or acne related cysts;
- Support garments or other non-medical substances;
- Prescriptions related to Worker's Compensations cases;
- Experimental drugs;
- Viagra®, Cialis®, or Levitra® (or other erectile dysfunction drugs) in an amount in excess of 6 pills per month (total of all erectile dysfunction drugs) for any Covered Person;
- Non-prescription drugs or medications unless as required by the PPACA;
- Dietary supplements or weight gain/loss medications, including muscle enhancement drugs;
- Baby formula;
- Methadone treatment or maintenance related to substance abuse disorders; and Antabuse®, Campral®, Naltrexone®, Suboxone®, Subutex®, and Vivitrol® unless preapproved and monitored for the Covered Person by *Modern Assistance Program*.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule E for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

SECTION VI: DENTAL COVERAGE

General
The Dental Plan assists the Participant and their family in paying dental expenses.

Prior to December 31, 2016 Dental Benefits were payable in accordance with a schedule of Reasonable and Customary charges up to an annual maximum.

Effective January 1, 2017 The Plan has designated an organization to provide administrative services to this plan, including claims processing and managed dental related services for those who are covered by this plan.

This plan offers two managed dental networks, the Preferred Provider Organization (PPO) and the Premier Network. This means that the Covered Person can determine the costs they will pay each time they choose a dental provider to furnish covered services. The Covered Person will receive the highest level of benefits when they use dental providers participating in the Preferred Provider Organization and a slightly lesser level under the Premier Network; these are called "in-network benefits". If the Covered Person chooses to use covered dental providers who do not participate in either network, they will receive a lower level of benefits and their out-of-pocket costs will be more. These are called the "out-of-network benefits". See Appendix, Schedule E for details.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule F for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

SECTION VII: VISION AND HEARING AID COVERAGE

General Vision Coverage

The Vision Plan covers certain vision care expenses for the Participant and their family, including eye examinations and eyeglasses or contact lenses. Vision Benefits are payable in accordance with the maximum benefit schedule as listed in the Appendix, Schedule F. The Plan has contracted with a preferred Vision Care provider for services that may lower costs for the Covered Person when the Vision Care Card issued by the provider is utilized.

Vision care benefits are limited to only include expenses incurred for routine eye exams, frames, prescription lenses (including, but not limited to, single vision lenses, bi-focal lenses, tri-focal lenses, sunglass lenses, etc.) and contact lenses that are prescribed to restore the visual acuity of the person's eyes.

Vision Plan Benefit Period	
Eye Examination	Once every other calendar year
Prescription eyeglasses or contact lenses	Once every other calendar year

No Carryover of Unused Benefit Amounts

If the Covered Person does not use all or any portion of the allowed payment level during a Benefit Period, the Covered Person will not be allowed to carryover the unused portion to the next Benefit Period. Also, the Covered Person will not be entitled to combine the payment levels or apply any unused portion of the eye examination to eyeglasses or vice versa.

Levels of Coverage

Within the Network

When the Covered Person receives care from a network provider the Covered Person receives services and supplies at negotiated fees. The Provider will direct bill the Plan up to a maximum benefit level per Benefit Period. The Covered Person is responsible for any balance above the maximum benefit level.

Outside the Network

When the Covered Person receives care from a non-network provider they pay more for care and services, depending upon where the Covered Person receives the care and what they purchased. With non-network providers, the Covered Person must pay the provider directly at the time of service and then submit the completed claim form to the Plan, along with the Covered Person's receipt, for reimbursement up to the Plan allowance. All invoices for routine eye exams, eyeglasses or contacts not purchased from the preferred Vision Care Provider will be reimbursed to the Covered Person by the Plan up to a maximum benefit level for the Benefit Period.

What the Vision Plan Does Not Cover

- Special procedures such as orthoptics and visual training, or medical or surgical treatment of the eye, including laser surgery or similar procedures.
- Vision lenses and contact lenses that are not prescribed by a physician, ophthalmologist, or licensed optometrist.

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule F for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

- The portion of a charge paid under another part of the Plan.
- Services or supplies received because of an accident related to employment or sickness covered under worker's compensation or similar law.
- Benefits for the medical treatment of eye disease or injury that are covered under the medical portion of the Plan, including:
    - non-routine eye examinations and non-prescription eyewear;
    - vision therapy;
    - replacement of lost eyewear;
    - non-prescription lenses;
    - services not performed by licensed personnel;
    - contact lenses and eyeglasses during a single benefit cycle; or
    - 2 pairs of eyeglasses in lieu of bifocals.

Where Should the Covered Person Send Provider Invoices?

Routine eye exams and prescription eyeglasses are paid by the Plan. All provider invoices should be mailed to the following address:

Local 103, I.B.E.W. Health Benefit Plan
Claims Department
256 Freeport Street, 2nd Floor
Boston, MA 02122

General Hearing Aid Coverage

The Plan provides coverage for hearing aids for a Covered Person up to a maximum per device for 1 ear, or for 2 ears in any consecutive 4-year period as described in the Participant's Schedule of Benefits (Appendix, Schedule F). The consecutive 4-year period runs from the date of service. Currently date of service is considered the Covered Person's appointment date, not the delivery date of the hearing aids.

The plan also covers batteries and/or service as described in the Participant's Schedule of Benefits.

Where Should the Covered Person Send Provider Invoices?

Hearing aids and batteries are paid by the Plan. All provider invoices should be mailed to the following address:

Local 103, I.B.E.W. Health Benefit Plan
Claims Department
256 Freeport Street, 2nd Floor
Boston, MA 02122

IMPORTANT: Refer to the Participant's Schedule of Benefits in the Appendix, Schedule G for the cost share amounts that the Participant must pay for covered services and for the benefit limits that may apply to specific covered services.

SECTION VIII: ADOPTION BENEFITS

General

The Plan covers adoption related expenses, including agency fees, court costs and legal fees, upon finalization/placement/as expenses are incurred for Participants in accordance with the maximum benefit schedule as detailed in the Appendix, Schedule G.

SECTION IX: LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT

Benefits Provided by Insurance Companies

Life Insurance Benefits are provided by a Life Insurance Company; the term "Life Insurance Company" refers to the insurance company whose policies are in effect at the time of the Participant's death. AD&D Insurance Benefits are provided by the "AD&D Insurance Company" whose policies are in effect at the time of any claim. (see Appendix, Schedule H for current Insurance Company information). The Trustees, in their sole discretion, retain the right to change the Life Insurance Company and/or AD&D Insurance Company that provide these benefits.

Designation of a Beneficiary

When the Participant becomes covered for life and AD&D Insurance Benefits, the Participant should name a beneficiary (or beneficiaries) to receive the benefits provided by this Section upon the Participant's death. A Participant should make sure that the beneficiary or beneficiaries he wishes to designate are properly registered with the Plan at all times.

A participant must designate a beneficiary on a form provided by the Plan, keeping in mind that only the last designated beneficiary on file with the Plan will receive benefits. Life Insurance Benefits under the Plan are non-taxable and 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 Life Insurance Company providing benefits.

Upon written request to the Plan, a Participant may change the beneficiary designation at any time and as often as desired. If a Participant has no living named beneficiary on file at the date of the Participant's death, benefits will be paid in accordance to the provisions of the Welfare Benefits Contracts.

A. LIFE INSURANCE BENEFIT

General

The Plan pays a Life Insurance Benefit to the Participant's named beneficiaries if the Participant dies while the Participant is an eligible Master Plan Participant. The amount of the Life Insurance Benefit payable depends on the number of consecutive years the Participant was covered by the Master Plan immediately preceding the date of the Participant's death. The life insurance is provided at no cost to Master Plan Participants.

Life Insurance Schedule of Benefits	
Years of Master Plan Coverage	***Benefit***
Fewer than 2 years	$10,000
2 years or more, but fewer than 3 years	$20,000
3 years or more, but fewer than 4 years	$30,000
4 years or more, but fewer than 5 years	$40,000
5 years or more (maximum benefit)	$50,000

Example: *Bob becomes eligible for Master Plan coverage on January 1, 2010 and remains continuously eligible for Master Plan coverage until December 31, 2012. On December 31, 2012, Bob's Master Plan coverage terminates. Bob resumes work for a contributing employer and becomes eligible for Master Plan coverage on January 1, 2014 and continues to be continuously covered by the Master Plan until his death on June 1, 2015. The Life Insurance Benefit payable would be $10,000. This is because the period in which Bob was continuously eligible for Master Plan coverage immediately preceding his death (January 1, 2014 through June 1, 2015) is fewer than 2 years. Because Bob's prior period of Master Plan coverage (January 1, 2010 through December 31, 2012) was terminated, this period of coverage is disregarded in calculating Bob's Life Insurance Benefit.*

Death Benefit. Upon receipt of due proof of death, the Company will pay the Life Insurance Benefit Amount(s) in force on the Participant's life at the time of the Participant's death, in accordance with the terms of the Policy. In no event will the total amount of Life Insurance in force for a Participant exceed the Life Insurance Maximum shown in the Schedule.

Physical Exam. The Company will have the right to have a physician of its choice examine the Participant to establish any disability. The Company will pay for the exam. The Participant may be examined as often as reasonably necessary during the period of disability, but not more than once a year after the Participant has been disabled for 2 years.

Conversion After Extension. When any applicable extension of benefits described in this section ends, the Participant may convert the Participant's coverage to an individual insurance policy, provided the Participant is Entitled to Convert as described in the Conversion Privilege provision.

Conversion Privilege
The Participant may convert the Participant's Life Insurance under the Policy to an individual whole life policy if such insurance, or any portion of it, ends, provided the Participant is Entitled to Convert and, within 31 days after such insurance ends the Participant:

1) applies in writing to the Company; and
2) pays the first premium.

Evidence of Insurability. No Evidence of Insurability will be required if the Participant converts to an individual policy under this Conversion Privilege.

Entitled to Convert. The Participant is Entitled to Convert the Participant's Life Insurance only if:

1) the Participant ceases to be a member of an Eligible Class as described in the Eligible Class(es) section of the Schedule;
2) the Policy terminates, provided the Participant has been covered under the Policy for at least 5 consecutive years immediately preceding such termination;
3) the Policy is amended to terminate the Eligible Class to which the Participant belongs, provided the Participant has been covered under the Policy for at least 5 consecutive years immediately preceding such termination.

In no event will the Participant be Entitled to Convert if the Participant's coverage under the Policy ceases due to non-payment of the required premium.

Amount of Converted Life Insurance. If the Participant's coverage terminates because the Participant is no longer a member of an Eligible Class, the amount of Life Insurance that the Participant will be eligible to convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Participant's Life Insurance ends because the Policy is amended to terminate the Eligible Class to which the Participant belongs, or if the Policy terminates, the amount of Life Insurance under the converted life policy will be the lesser of: (a) the amount of Life Insurance in force under the Policy at the time insurance ends, less any amount for which the Participant becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) $10,000**.**

Type of Policy. The individual policy will be the Company's current offering and will be on a form customarily issued by the Company. However, such policy may not be term insurance. No disability or other supplemental benefits will be covered under the policy. The individual policy will go into effect at the end of the period during which the Participant is eligible to convert.

If the individual policy contains a provision which restricts the time within which benefits would be payable as a result of suicide, or restricts the time within which coverage under the policy can be contested, such time periods will be deemed to have begun at the time the Participant was first covered under the Policy.

The premium will be based on the Company's rates for the individual policy form, the benefit amount, age and the class of risk to which the Participant belongs at the time insurance ends. To continue insurance under the individual policy, the premium must continue to be paid as required under the terms of the individual policy.

Death during the conversion period. If the Participant dies within the 31-day conversion period, the Company will pay a death benefit equal to the maximum amount the Participant could have otherwise converted.

Notice of Conversion Right Notice of the Participant's right to convert to an individual policy will be presented to the Participant or delivered to the Participant's last known address within 15 days from the

date the Participant's coverage ends. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the conversion period be extended for more than 60 days after the expiration date of the initial 31-day conversion period.

Accelerated Life Insurance Benefit
If elected by the Participant, and subject to approval by the Company, a portion of the Participant's Life Insurance Benefit may be paid before the Participant's death. To qualify for this benefit, the Participant must have been diagnosed as being terminally ill while under this Policy or must meet the qualifying conditions stated below. The Participant must apply for Accelerated Life Insurance Benefits in writing on a form acceptable to the Company.

Qualifying Conditions
To qualify for this benefit, the Participant must: 1) be unable to continuously perform one or more Activities of Daily Living (ADL), without stand by help; 2) have a Cognitive Impairment; or 3) have a terminal illness.

Any ADL the Participant is not able to perform, without stand by help, prior to the effective date of coverage will not be considered for qualifying for this benefit. Any Cognitive Impairments due to, caused by, or contributed by a cognitive condition that began prior to the effective date of coverage will not be considered for qualifying for this benefit.

Proof of Terminal Illness. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the Company that the Participant's life expectancy is 6 months or less from the date of application for this benefit. Proof of terminal illness must include certification from a physician. The Company reserves the right to obtain a second or third medical opinion at its own expense.

Proof of other Qualifying Conditions. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the Company that the Participant meets the qualifying conditions. Proof must be certified by a physician and in the form that is satisfactory to the Company. The Company reserves the right to obtain a second or third medical opinion at its own expense.

Benefit Amount

The maximum benefit the Participant may receive under this provision is the lesser of:

1) 75% of the Participant's Life Insurance Benefit shown in the Schedule, less the amount of any benefit already paid under this provision; or
2) $250,000.

However, if the Participant's Life Insurance is scheduled to reduce within 6 months of the date application for this benefit is received by the Company, the Accelerated Life Insurance Benefit will be limited to the amount that would be available for accelerated payment after such reduction takes place.

The minimum Accelerated Life Insurance Benefit the Participant may receive will be $1,000. Such benefit will be paid in a lump sum to the Participant unless an alternate payment arrangement is requested by the Participant in writing and is approved by the Company. However, the minimum payment under such installment payment arrangement will be $500 per payment.

The receipt of this Accelerated Life Insurance Benefit may be taxable. The Participant should seek assistance from a personal tax advisor with respect to receipt of this benefit. No representations as to any issue of taxation of this benefit are made by the Company.

Effect on Life Insurance Benefits at Participant's Death. The Participant's Life Insurance Benefit Amount(s) shown in the Schedule will be reduced by any amount paid under this provision.

Termination of Accelerated Life Insurance Benefits. This benefit will terminate on the date the Participant's insurance under the Policy terminates. However, this benefit will continue to be available while the Participant is covered under the Extension of Life Insurance provision of the Policy.

Limitations. The Company will not provide benefits under this provision if**:**

1) the Participant would be required by law to use the benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
2) the Participant is required by a government agency to use this benefit in lieu of applying for, obtaining, or otherwise keeping a government benefit or entitlement;
3) the Participant's Life Insurance under the Policy has terminated;
4) each irrevocable beneficiary, if any, has disapproved payment of this benefit; or
5) the Participant's Life Insurance Benefits under the Policy have been assigned.

Payees. Benefits will be paid in one lump sum to the Participant, if living. If not living, the Company may pay such benefits to the Participant's estate.

The Company will not be liable for such payment after it is made.

B. ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

General

Principal Sum. As applicable to each Participant, Principal Sum means the amount(s) of insurance in force under this Policy on the date of the accident, as described in the Schedule. In no event will the total amount of Accidental Death & Dismemberment Insurance in force for a Participant exceed the AD&D Insurance Maximum shown in the Schedule.

As applicable to a Participant's Dependent, Principal Sum means the amount of insurance in force under the Policy as described in the Schedule.

Accidental Death Benefit

If Injury to the Participant results in death within 365 days of the date of the Accident that caused the Injury, the Company will pay 100% of the Principal Sum.

Accidental Dismemberment Benefit

If Injury to the Participant results, within 365 days of the date of the Accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Principal Sum shown below for that Loss. If Injury to the Participant results, within 365 days of the date of the Accident that caused the Injury, in any one of the types of paralysis specified below, the Company will pay the percentage of the Principal Sum shown below for that type of paralysis.

Covered Losses

AD&D Benefit	**$50,000 Principal Sum**
For Loss of	***Percentage of Principal Sum***
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
2 or More: 1 Hand, 1 Foot, or Sight of 1 Eye	100%
Speech and Hearing in Both Ears	100%
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
Uniplegia	25%
1 Hand or 1 Foot	50%
Sight of 1 Eye	50%
Speech or Hearing in Both Ears	50%
Thumb and Index Finger of Same Hand	25%

If more than one Loss is sustained by a Participant as a result of the same accident, only one amount, the largest, will be paid.

Exposure and Disappearance

If by reason of an accident occurring while a Participant's coverage is in force under the Policy, the Participant is unavoidably exposed to the elements and as a result of such exposure suffers a Loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If the body of a Participant has not been found within 1 year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the Participant was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Participant has suffered accidental death within the meaning of the Policy.

Limitation on Multiple Benefits
If a Participant suffers one or more losses from the same accident for which amounts are payable under more than one of the following benefits provided under the Policy, the maximum amount payable under all of the benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit, or Paralysis Benefit.

Repatriation of Remains Benefit
If a Participant suffers loss of life due to Injury or Emergency Sickness while outside a 100-mile radius from the Participant's current place of Primary residence, the Company will pay for covered expenses reasonably incurred to return the Participant's body to the Participant's current place of Primary residence, up to a maximum of $5,000.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

AIG Benefits Travel Assist 5M must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact AIG Benefits Travel Assist 5M in advance.

Exclusion 2 in the Exclusions section of the Accidental Death & Dismemberment Benefit provision in this Certificate does not apply with respect to this benefit.

Seat Belt and Air Bag Benefit

Seat Belt Benefit. If the Participant suffers accidental death such that an Accidental Death Benefit is payable under the Policy and the Accident causing death occurs while the Participant is operating, or riding as a passenger in, an Automobile and wearing a properly fastened, original, factory-installed seat belt or, if the person is a dependent child, a properly installed and fastened child restraint device as defined by state law, the Company will pay this additional benefit. The amount payable for this additional benefit is $10,000.

Air Bag Benefit. If a Seat Belt Benefit is payable and if the Participant is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, the Company will pay an additional $10,000.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

Tuition Benefit
If a Participant suffers accidental death such that an Accidental Death Benefit is payable under the Policy on the date of the Accident causing death, the Company will pay the following benefit:

A. **For the Dependent Children under Age 25.** The Company will pay a benefit to or on behalf of any Dependent Child under age 25 who was under the Policy on the date of the Accident causing death and who, on the date of the Participant's death: (1) is a full-time student in any Institution of Higher Learning above grade 12; or (2) is in grade 12 and subsequently enrolls as a full-time student in an Institution of Higher Learning within 365 days after the date of the Participant's death. The benefit will be paid for each year of the Dependent Child's continuous enrollment as a full-time student in an Institution of Higher Learning, to a maximum of 4 consecutive years. The total amount of the benefit each year is equal to the least of:

1) the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for that Dependent Child;
2) 5% of the 's Participant's Principal Sum on the date of the Accident causing death; or
3) $5,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

A Dependent Child who ceases to be enrolled as a full-time student becomes permanently ineligible for the benefit, even if the Participant re-enrolls at a later date. The benefit is not payable for any term of enrollment as a full-time student that begins before the date of the Participant's death. If there is no Dependent Child under age 25 eligible for the benefit within 365 days after the date of the Participant's death, the Company will pay a one-time lump sum benefit of $1,000 to the Participant's designated beneficiary.

B. **For the Participant's Spouse.** The Company will pay a benefit to or on behalf of any spouse on the date of the Accident causing death and who, for the purpose of obtaining an independent source of support or to enrich the Participant's ability to earn a living: (1) is enrolled in any Institution of Higher Learning or professional or trade training program on the date of the Participant's death; or (2) subsequently enrolls in an Institution of Higher Learning or professional or trade training program within 30 months after the date of the Participant's death. The benefit will be paid for each year of the spouse's continuous enrollment in an Institution of Higher Learning or professional or trade training program, to a maximum of 4 consecutive years. The total amount of the benefit for all institutions and programs combined each year is equal to the least of:

1) The total actual tuition (exclusive of room and board) charged by those institutions or programs for enrollment during that year for the spouse;
2) 5% of the Participant's Principal Sum on the date of the Accident causing death; or
3) $5,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

A spouse who ceases to be enrolled as described above becomes permanently ineligible for the benefit, even if the Participant re-enrolls at a later date. The benefit is not payable for any term of enrollment that begins before the date of the Participant's death. If there is no spouse eligible for the benefit within 30 months after the date of the Participant's death, the Company will pay a one-time lump sum benefit of $1,000 to the Participant's designated beneficiary.

C. LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT DEFINITIONS

Accident means an event or occurrence that is sudden, unforeseen and unintended.

Activities of Daily Living (ADL) means the following activities:

- Bathing - the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;
- Dressing - the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting - the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- Transferring - the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment;
- Mobility - the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and
- Continence - the ability to voluntarily maintain control of bowel and/or bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Arm means the entire arm from the shoulder joint including the attached hand.

Automobile means a self-propelled private passenger motor vehicle with 4 or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van, camper, or motor home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Change in Family Status means:

- an Participant’s marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
- the death of or divorce from a Participant’s spouse;
- the death of or emancipation of a child;
- the spouse's loss of employment which results in a loss of group insurance; or
- a change in classification from part-time to full-time or from full-time to part-time.

Cognitive Impairment means that the Participant has been certified by a physician as having a deterioration or loss in intellectual capacity, resulting from injury, sickness, Alzheimer disease or similar forms of irreversible dementia, and the Participant needs another person's active help or verbal guidance for the Participant’s own protection and the protection of others.

Dependent Child(ren) means the Participant’s unmarried children, including natural, step, foster or adopted children from the moment of placement in the home of the Participant, under age 19, (19 to 25 if attending an accredited Institution of Higher Learning on a full time basis) and primarily dependent on the Participant for support and maintenance.

Any unmarried Dependent Children of the Participant covered under the Policy before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Participant for support and maintenance, may continue to be eligible under the Policy beyond that age limit for as long as the Policy is in force, but only if they remain continuously covered under the Policy. The Company may request that the Participant submit satisfactory proof of the Dependent Child(ren)'s incapacity and dependency to the Company within 60 days before the Dependent Child(ren) reach the age limit specified above. If the Participant fails to furnish the requested proof before the Dependent Child(ren) reach the age limit, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. If coverage is extended, the Company may request that the Participant submit satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency to the Company on an annual basis.

If the Participant fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child(ren) will terminate at the end of that 31-day period.

Family Coverage means coverage in force under the Policy on a Participant's Eligible Dependents: (1) whom the Participant has elected to cover under the Policy; and (2) for whom premium has been paid.

Hemiplegia means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

Immediate Family Member means a person who is related to the Participant in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted, stepchild, or foster child), aunt, uncle, niece, nephew, or grandchild.

Injury means bodily injury that is the direct result of an Accident occurring while the Policy is in force with respect to the person whose injury is the basis of claim and resulting directly and independently of all other causes in a covered loss.

Institution of Higher Learning means any accredited institution that provides education or training beyond the 12th-grade level, including, but not limited to, any state university, private college, or trade school.

Insured means a person who is a Participant of an Eligible Class for whom premium has been paid while covered under the Policy.

Insured Participant means the Insured.

Loss of Hand or Foot means complete severance through or above the wrist or ankle joint.

Loss of Sight of an Eye means total and irrecoverable loss of the entire sight in that eye.

Loss of Speech means total and irrecoverable Loss of the entire ability to speak.

Loss of Thumb and Index Finger means complete severance through or above the metacarpophalangeal joint of both digits.

Military means the armed land, sea, or air force of a nation.

Paramilitary means an organized, armed force on a Military pattern.

Paraplegia means the complete and irreversible paralysis of both lower limbs.

Physician means a licensed practitioner of the healing arts acting within the scope of their license, who is not: (a) the Participant; (b) an Immediate Family Member; (c) residing with the Participant; or (d) retained by the Policyholder.

Prior Plan means the Group Life Insurance and Accidental Death & Dismemberment Insurance carried by the Policyholder on the day before the Policy Effective Date.

Quadriplehia means the complete and irreversible paralysis of both upper and both lower limbs.

Schedule means the Schedule of Benefits section of the Policy.

Sickness means illness or disease diagnosed by a physician.

Spouse means the Participant's lawful spouse (not including a spouse who is legally separated from the Participant).

Supplemental Restraint System means an air bag which inflates for added protection to the head and chest areas.

Uniplegia means the complete and irreversible paralysis of one limb.

War or Insurrection means an armed conflict between the Military or Paramilitary forces of 2 or more political entities.

D. LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT EXCLUSIONS

The Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1) suicide or any attempt at intentionally self-inflicted injury;

2) sickness, disease or infections of any kind, except bacterial infections;

3) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation on a regular schedule between established airports, if the Participant is:

   a) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
   b) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c) riding as a passenger in an aircraft owned, leased or operated by the Policyholder or by the Participant's employer;

4) declared or undeclared War, or any act of declared or undeclared War;

5) full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Participant Person is not covered due to the Participant's active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);

6) the Participant being under the influence of drugs or under the influence of drugs or alcohol or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a physician; or

7) the insured Participant's commission of or attempt to commit a crime.

E. LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 20 days after an insured Participant's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at 3600 Route 66, Neptune, NJ 07753, with information sufficient to identify the Insured Participant, is deemed notice to the Company.

Claim Forms. The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 31 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured Participant's name, Policyholder's name and the Policy number.

Proof of Loss. Written proof of loss must be furnished to the Company within 90 days after the date of loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish such proof within the time required, will not reduce or deny any benefits if the proof is given as soon as reasonably possible. However, in no event, other than legal incapacity, will proof be given more than one year after the date of loss.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of a Participant will be made to the Participant's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Participant. If a Participant dies before all payments due have been made, the amount still payable will be paid to the Participant's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Company may make an initial payment, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage of the payee who is deemed by the Company to be equitably entitled thereto. Such payment does not discharge the Company's liability for any remaining benefits payable under the Policy.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

F. LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT GENERAL PROVISIONS

Entire Contract. Changes. The Policy, the Master Application, and any attached papers make up the entire contract between Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Participant will be considered representations and not warranties. No written statement made by a Participant will be used in any contest unless a copy of the statement is furnished to the Participant or the Participant's beneficiary or personal representative.

No change in the Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

Incontestability. The validity of the Policy will not be contested after it has been in force for 2 years from the Policy Effective Date, except for non-payment of premium, misrepresentation, or fraud.

After an insured Participant has been covered under the Policy for 2 years no statement made by the insured Participant will be used to contest a claim under the Policy. The Company can only contest coverage if the misstatement is made in a written instrument signed by the insured Participant and a copy is given to the Policyholder, the insured Participant or the insured Participant's beneficiary.

Interpretation of the Policy. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

If this policy comprises a part of an employee benefits plan, the Company is granted the sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of this policy.

The Company has no responsibility or control with respect to any other benefit which may be provided beyond this policy or any other plan of benefits.

Beneficiary Designation and Change. The Participant's designated beneficiary(ies) is(are) the person(s) so named by the Participant for the Policy as shown on the Policyholder's records kept on the Policy.

A legally competent Participant over the age of majority may change the Participant's beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Plan with a written request for change. When the request is received by the Plan whether the Participant is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment which is made prior to receipt of the request.

If there is no designated beneficiary, or if no designated beneficiary is living after the Participant's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The Participant's (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the insured Participant's 'estate.

If no beneficiary for a Participant Dependent's coverage is living on the date of the Participant Dependent's death, the beneficiary is the Participant's estate.

Honoring Beneficiary Information From a Prior Plan. The Participant's beneficiary should be named on a form acceptable to the Company. If not, the Company may make all payments to the last person named by the Participant as a beneficiary under a policy that ended before becoming under the Policy.

The Company may use information from the prior carrier's records to determine any payment made such as:

1) information about the last beneficiary named by the Participant under the Policy, or any other group policy; or
2) information that the Participant named no beneficiary under the Policy, or any other group Policy.

If information shows that no beneficiary was named, the Company may make all payment to anyone it selects under the provisions for Payment of Benefits.

Physical Examination and Autopsy. The Company at its own expense shall have the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy as often as it may reasonably require during the review of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Noncompliance With Policy Requirements. Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity With State Statutes. Any provision of the Policy which, as of its Policy Effective Date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

Workers' Compensation. The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Clerical Error. A purely clerical error, which arises from other than a failure to perform administrative duties hereunder, whether by the Policyholder or the Company, will not void the insurance of any insured Participant if that insurance would otherwise have been in effect; nor will it extend insurance of such person if that insurance would otherwise have ended or been reduced as provided in the Policy. Clerical error may be, by illustration but not limitation, errors in transcription or computation, but is not, by illustration but not limitation, a failure to advise insured Participant of procedural requirements.

Assignment. The Policy is non-assignable. A Participant may assign all of the Participant's rights, privileges and benefits under the Policy without the consent of the Participant's beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

Misstatement of Facts. If the material facts, including age, of the Participant were not accurate in the application to the Policy:

1) a fair adjustment of premium will be made; and
2) the true facts, including true age, will decide whether and in what amount of insurance is in force under the Policy.

Facility of Payment. If an individual appears to the Company to be equitably entitled to compensation because the Participant has incurred expenses on behalf of an insured Participant or for burial or funeral expenses, the Company may deduct from the amount payable under the Policy to be paid to such individual the expenses incurred, but not more than $250. Such payment will not exceed the amount due under the Policy.

Settlement Options. The Participant may elect to have all or any part of the Participant's Life Insurance Benefit Amount(s) paid to the Participant's beneficiary in installments or in any other way that may be agreed to by the Company. The Participant must give notice in writing to elect a settlement option. The Participant will have the right to change the election at any time. The terms of payment will be in accordance with those offered by the Company for the insurance at the time election is made.
After the Participant's death, the beneficiary:

1) may make such an election, if the Participant had not done so; and
2) may name a person(s) to receive any amount which would otherwise go to the beneficiary's estate; and
3) will have the right to change the person(s) named in accordance with 2 above.

Interest on Death Benefits Payable in a Lump Sum. Interest on Life Insurance Benefit Amount(s) paid in a lump sum for the loss of life of the insured Participant shall be paid to the insured Participant's beneficiary. Such interest shall be computed daily at the rate of interest currently payable by the Company on proceeds left under the interest settlement option, from the date of death of the insured Participant to the date of payment. Such amount shall be added to and be a part of the total Life Insurance Benefit Amount(s) paid for loss of life.

Agency. For the purposes of the Policy, the Policyholder acts on its own behalf or as the agent of the insured Participant. Under no circumstances will the Policyholder be deemed the agent of the Company without written authorization.

Discretionary Acts

The Trustees of the Plan have delegated to the Life Insurance Company discretionary authority to make Life Insurance Benefit and eligibility determinations under the Plan. The Life Insurance Company may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons, or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan applicable to Life Insurance Benefits. All benefit determinations made by the Life Insurance Company must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

SECTION X: DEATH BENEFIT

General

Retirees eligible for the Normal Retiree Plan and Supplemental Plan are not eligible for Life Insurance Benefits, but they are eligible for a death benefit in the amount described below.

Normal Retiree Plan and Supplemental Plan Participants

Participants eligible for either the Normal Retiree Plan or Supplemental Plan are eligible for the following death benefits that are paid directly from the Plan; because these benefits are not insured, their payment is generally taxable to the payee. Any amounts paid are reported to the appropriate tax authority.

Death Benefit	
Retirement Date	***Benefit***
On and after April 1, 1984	$7,500
On and after April 1, 1982 but before April 1, 1984	$5,000
On and after January 1, 1966 but before April 1, 1982	$2,500

Designation of a Beneficiary

When a Participant becomes covered for death benefits, the Participant should name a beneficiary (or beneficiaries) to receive the death benefit provided by this Section upon the Participant's death. All Participants should make sure that the beneficiary or beneficiaries they wish to designate are properly registered with the Plan at all times.

Death 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 Plan will receive a Participant's death benefit. Be sure that the designated beneficiary is updated at all times.

If a Participant is not survived by a designated beneficiary or if the Participant's Beneficiary cannot be located, the death benefit will be paid in the order listed below:

- To the Participant's surviving spouse; if none, then to
- To the Participant's surviving children, equally; if none, then to
- To the Participant's surviving parents, equally; if none, then to
- To the Participant's surviving sisters or brothers, equally; if none, then to
- To the Participant's estate.

If no executor or administrator of the Participant's estate is appointed and qualified within 180 days of notice of the Participant's death, the Trustees in their discretion may determine the recipient of the death benefit, for example among any person or persons found by the Trustees to be equitably entitled by reason of having paid expenses on account of the funeral or last illness of the Participant.

If the designated beneficiary dies after the Participant and before receiving benefits, similar distribution will be made to the beneficiary's beneficiary or beneficiaries using the above payment order. Upon written request to the Plan, a Participant may change the beneficiary designation at any time and as often as desired.

How to File a Claim

If a Participant eligible for the Normal Retiree Plan or Supplemental Plan dies, the Plan should be notified at once. The Participant's designated beneficiary or beneficiaries must file a claim with the Plan. The designated beneficiary or beneficiaries will be required to submit proof of death, such as a certified copy of the state death certificate.

The Plan will process the claim. If the claim is denied in whole or in part, a beneficiary may appeal to the Board of Trustees. See Section XII.

SECTION XI: IDENTIFICATION CARDS

Medical, Prescription, Dental and Vision Cards may not be transferred or assigned to anyone else, or used by anyone other than the person to whom it was issued. If the any Card is lost or stolen, contact the Plan at once. There is a $10 charge for a replacement Card.

Using the Health Identification and Prescription Drug Cards

Master Plan and Normal Retiree Plan Medical Identification Cards

A Medical Identification Card (*Blue Cross Blue Shield of Massachusetts*) and a Prescription Drug Card are issued to all Covered Persons, and are used for the following purposes:

1) **Blue Cross Blue Shield Card -** When a Covered Person seeks treatment, or care or services from a medical provider, the Identification Card should be shown to the provider. The identification number on the front side of the Card may be used by the medical provider to verify a Covered Person's eligibility status. The provider can telephone *Blue Cross Blue Shield of Massachusetts* or scan or swipe the ID Card to confirm the eligibility of the Covered Person. Such verification by the Plan does not mean that the Plan will pay for a Covered Person's treatment or care. When the Plan receives the provider bill, it will determine whether the treatment or service is covered by the terms of the Plan.

2) The reverse side of the Identification Card contains the telephone number of the Pre–Authorization Utilization Reviewer. Under the Plan's Pre-Admission Review procedures, a Covered Person is required to telephone the Utilization Reviewer 3 to 4 weeks in advance of all elective hospital admissions and within 48 hours of Emergency Admissions. The Utilization Reviewer must also be notified before selected outpatient Surgical Procedures and tests. For more information, see Section III, E.

Supplemental Plan Medical Identification Card

A Medicare Identification Card is issued by the Government for Medical service and treatments. A Medicare Supplemental Identification Card and a Prescription Drug Card are issued by the Plan to all Supplemental Plan Covered Persons that are used for the following purposes:

1) **The Medicare Supplemental Identification Card** is to be presented to all Part A and Part B providers for treatment and services to allow automated Supplemental bill payment to these providers by the Plan.
2) The reverse side of the Medicare Identification Card contains the telephone number and website for Medicare. Covered Persons should follow Medicare guidelines for any Part A and B services.

Please follow all Medicare guidelines for a lost or stolen card by contacting them at www.medicare.gov or at (800) 486-2048.

Prescription Drug Identification (ID) Card
A Prescription Drug ID Card is issued by the Plan to all Plan Covered Persons (see Schedule H for current vendor). The front of the Prescription Drug ID Card contains information necessary for the Covered Person to participate in the Plan's Prescription Drug Plan; the reverse side of the Card contains information for verification of eligibility (see Section V). The Covered Person should present this Card when seeking prescription drug services.

Dental Identification (ID) Card
Two Dental ID Cards are issued by the current vendor (see Schedule H for current vendor) to Plan Covered Persons in the Member's name. The front of the Dental ID Card includes information for verification of eligibility and Dental benefits (see Section VI and Appendix, Schedule E). The Covered Person should present this Card when seeking dental services from Providers.

Vision Care Identification (ID) Card
A Vision Care ID Card is issued to all Plan Participants by the current vendor (see Schedule H for current vendor). This Card contains identification information for the Covered Person to obtain eye exams, glasses and contacts at discount pricing from the vendor's retail providers, per Benefit Period. (see Schedule F for maximum payment level).

The Covered Person may not use any of the above Cards if the Covered Person's Plan eligibility is terminated.

SECTION XII: MEDICAL CLAIMS SUBMISSION AND APPEALS PROCESS

Claims Submission

The Plan cannot process a Covered Person's claim until it receives from the physician or provider a fully completed claim form containing information sufficient for the Plan to determine that the claim should be paid. No claim will be paid until this form is received. This form must be submitted for payment within 90 days from the date the claim was incurred, unless there exists sufficient reason for submitting the claim subsequent to the 90-day period. No claim will be considered for payment that is submitted to the Plan later than 1 year from the date the claim was incurred.

Claims are considered to be incurred on the date the service or treatment is rendered or purchased, not the date the bill or charge is invoiced or received. The Plan may require and request, as a condition of payment of any claims, such other information as it deems necessary to process and determine the claim coverage, and the Covered Person shall promptly provide the Plan with such information.

Supplemental Plan Participants and Eligible Dependents are required to supply all billing information to their doctors and hospitals indicating that Medicare is their Primary insurance carrier and the Local 103, I.B.E.W. Health Benefit Plan is their Secondary carrier. All provider forms, bills, and other information that must be submitted should be sent to the following address:

Claims Department
Local 103, I.B.E.W. Health Benefit Plan
256 Freeport Street, 2nd Floor
Boston, MA 02122

All payments made by this Plan for any benefit of a Covered Person and payable under the terms of the Master Plan (except Life Insurance Benefits, Accidental Death & Dismemberment Benefits, or other benefits for which there is no provider), the Normal Retiree Master Plan, or the Supplemental Plan will be paid to the provider and not directly to the Covered Person.

The Covered Person will have no right to direct payment of the claim under the Plan. However, if the Covered Person has paid the provider for claims covered by the Master Plan, the Normal Retiree Plan, or the Supplemental Plan, then payment will be made to the Covered Person directly for such claim upon submission of proof, found to be sufficient by the Trustees in their sole discretion, that the Covered Person has paid the provider in the first instance.

Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be paid by the Plan to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian, except as required to be paid to a State as provided in the QMCSO, the provisions of the following paragraph, or as required by ERISA.

Notwithstanding that the Plan may make payment of claims of a Covered Person to the provider directly, no provider will thereby have any right, title or interest to payment from this Plan, and no provider will have a right to any remedies or other procedures provided herein for the benefit of a Covered Person. Only the Covered Person may exercise any rights provided herein and any assignment, pledge, or other agreement

between the Covered Person and any provider shall not create any right against the Plan, and any such assignment, pledge, or other agreement will be null and void as to this Plan.

However, payment for benefits with respect to a Covered Person for Master Plan Medical, Dental, Vision, and Prescription Drug Benefits will be made in accordance with any assignment of rights made by or on behalf of such Covered Person as required by a State plan for medical assistance approved under Title XIX of the SSA pursuant to §1912(a) (1) (A) of such SSA (as in effect on August 10, 1993). To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the SSA in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person to such payment for such items or services.

Expenses not covered by this Plan because such expenses are ineligible for payment or the amount remaining as the result of any deductible, copayment, or any maximum benefit limit are the financial responsibility of the Covered Person.

Accuracy of Claim/Overpayment Recovery

All statements and information contained in claim forms and other information submitted to the Plan in support of payment of a claim are relied upon as to their truth and accuracy. All statements and other information submitted by a Covered Person must be true and complete, and every Covered Person is deemed to be certifying as to the accuracy of any information provided to a provider by the Covered Person for inclusion in such claim form. Each Covered Person must disclose accurately their status and eligibility for benefits, including their marital status.

The Trustees may recover from any Covered Person (as well as any other responsible person) any payments made in error by the Plan for any Covered Person. The Trustees may offset, recoup or deny future claims of a Covered Person which would otherwise be payable under the terms of the Plan until the Plan has been reimbursed in full by such Covered Person. In the event the Trustees are required to institute a civil action to recover any amount paid in error as a result of the Covered Person's (or any other responsible person's) failure to repay any payment made in error, the Plan will be entitled as a remedy under the Plan to interest at a rate of 12% per annum from the date of demand, plus its reasonable costs and attorneys' fees incurred in collection. In the event the error was the result of erroneous information, misrepresentation, or concealment by the Covered Person, the Trustees may recover in addition to the foregoing remedies all losses to the Plan, including interest from the date of payment. These Plan remedies are in addition to those provided by applicable law.

Coordination of Benefit Disclosures

A Covered Person must report duplicate coverage to the Plan on either the claim form submitted by the provider or in a separate statement attached thereto. No claims will be paid by the Plan until the Covered Person has certified as to the availability or non-availability of duplicate group coverage, including the availability of other insurance, including workers' compensation coverage, automobile coverage, or other Primary insurance or coverage that may be applicable.

Timeliness of Claim Payments

Within 30-calendar days after the Plan receives a completed request for coverage or payment, the Plan will make a decision. When appropriate, the Plan will make a payment to the health care provider (or to the Covered Person in certain situations) for the Covered Person's claim to the extent of the Covered Person's

coverage in this plan. Or, the Plan will send the Covered Person and/or the health care provider a notice in writing of why the claim is not being paid in full or in part.

General Claim Procedures, Denial and Appeal Procedures

The following claims procedure will apply specifically to claims made for benefits under a group health plan. For Life Insurance or AD&D, see Sections XII for claim denial and appeal procedures.

Incomplete Claims

In the event that a claim involving pre-admission review or Pre-Certification does not include substantially all of the information required to process the claim, or otherwise fails to follow the Plan's procedures for filing claims, the Utilization Reviewer will notify the Covered Person or their Authorized Representative of the informational or procedural deficiency and how it may be cured within 5 days (or within 24 hours in the case of an Urgent Care Claim).

Notifications of Decisions on Benefit Claims

Urgent Care Claims

In the case of an Urgent Care Claim, the Utilization Reviewer will notify the Covered Person of the Plan's benefit determination (regardless of whether the determination is adverse) as soon as possible, recognizing the medical exigencies particular to the Covered Person's situation, but not later than 72 hours after receipt of the claim by the Plan. However, if the Covered Person fails to provide information sufficient to determine whether, or to what extent, benefits are covered or payable under the Plan, the Utilization Reviewer will notify the Covered Person 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 Covered Person will have a reasonable amount of time, taking into account the Covered Person's circumstances, but not less than 48 hours, to provide the necessary information. The Utilization Reviewer may, as a condition to deciding a claim as an Urgent Care Claim, require the Covered Person to clarify what are the medical exigencies or medical circumstances that support the claim for expedited decision making as an Urgent Care Claim.

Utilization Reviewer will notify the Covered Person of the Plan's benefit determination as soon as possible but in no event more than 48 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 Covered Person may, at the Covered Person's option, extend the time periods specified above for action by the Plan on an Urgent Care Claim. A notice by the Utilization Reviewer of a favorable determination should contain sufficient information to apprise the Covered Person of the Plan's decision to grant full approval of the Urgent Care Claim.

In processing a claim for benefits, the Utilization Reviewer will determine whether a particular claim is an Urgent Care Claim on the basis of information furnished by or on behalf of the Covered Person, 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 Covered Person's condition.

Pre-Certification Claims

In the case of Pre-Admission review or Pre-Certification (Pre-Certification Claim), the Utilization Reviewer will notify the Covered Person of the Plan's 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 by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that Utilization Reviewer (i) determines that such an extension is necessary due to matters beyond the control

of the Plan and (ii) notifies the Covered Person or their 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 Utilization Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Covered Person to submit the information necessary to decide the claim, the notice should specifically describe the required information, and the Covered Person or their 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

Any request by a Covered Person 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 Utilization Reviewer will notify the Covered Person or their 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 Utilization Reviewer will notify the Covered Person or their Authorized Representative sufficiently before the reduction or termination to allow the Covered Person to appeal (provided such claim has not been delayed by the Covered Person such as to make such notice impossible), except that the foregoing shall not serve to extend the time in which the Covered Person has to appeal.

Post-Service Claims

In the case of a health benefit claim that is not an Urgent Care Claim, a claim involving Pre-Certification, or a Concurrent Care Review Claim (such other claims referred to as "Post-Service Claims"), the Claims Reviewer will notify the Covered Person or their 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 Plan and notifies the Covered Person or their 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 Covered Person or their Authorized Representative to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Covered Person or their Authorized Representative will have at least 45 days from receipt of the notice within which to provide the specified information.

Death Benefit Claims

If a Participant's death benefit claim is denied in whole or in part, the Claims Reviewer will notify the Participant, or their Beneficiary, 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 Participant, or their Beneficiary, will be notified of the reason for the extension and the Claims Reviewer will notify within an additional 90-day period.

Notice of Initial Internal Adverse Benefit Determination

If (1) the Covered Person's claim is wholly or partially denied, or (2) if there occurs a rescission of coverage (within the meaning of Public Health Service Act Section 2712) the Plan will furnish the Covered Person with a notice of the denial of a Urgent Care Claim, Pre-Certification Claim, Concurrent Care Review Claim,

or a Post-Service Claim will be given to the Covered Person or their Authorized Representative either in written or electronic form. The denial notice should include:

a) the specific reason or reasons for the Adverse Benefit Determination;
b) references to the specific plan provisions on which the determination is based;
c) a description of any additional material or information necessary for the Covered Person to perfect the claim and an explanation of why such material or information is necessary;
d) a description of the review procedures set out in this section and the time limits applicable to such procedures, including a statement of the Covered Person's right to bring a civil action under ERISA §502(a) following an Adverse Benefit Determination on review;
e) 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 Covered Person upon request;
f) 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 Covered Person's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
g) 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.
h) Covered Persons shall be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to their claim for benefits; and
i) in addition to the preceding:
    - any notice of Initial Internal Adverse Benefit Determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount [if applicable]).
    - Covered Persons shall be provided, upon request and free of charge, the diagnosis code, and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice shall contain a statement to such effect.
    - the reason or reasons for the Initial Internal Adverse Benefit Determination will include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.
    - a description of available internal appeals and External Review processes, including information regarding how to initiate an appeal will be provided.
    - the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and External Review processes will be disclosed.
    - notices will be provided in a culturally and linguistically appropriate manner.

Appealing an Adverse Benefit Determination

A Covered Person whose Urgent Care Claim, Pre-Certification Claim, Concurrent Care Review Claim, Post-Service Claim has been denied (in whole or in part), or their Authorized Representative, may request review by the Board of Trustees by filing a request for review with the Board of Trustees to be received by the Board of Trustees no later than 180 days after receipt by the Covered Person or their Authorized Representative of the notice of the Adverse Benefit Determination. A Participant, or their Beneficiary, whose claim for death benefits has been denied may request review by the Board of Trustees no later than 60 days after receipt by the Participant, or their Beneficiary, of the notice of the Adverse Benefit

Determination. The Covered Person or their Authorized Representative may review pertinent documents and may submit issues and comments in writing. An appeal must include any written or documentary proof that supports the claim, or any other information the Covered Person wishes to submit for consideration, whether or not such proof had previously been submitted.

Decision on Appeal
Upon its receipt of a notice by a Covered Person for a request for a review of an Adverse Benefit Determination, the Trustees will make a prompt decision on review. If the Adverse Benefit Determination is appealed on the basis of medical judgment, the Trustees will consult with an independent health care professional who is qualified in the areas of dispute who will not have been involved in the initial Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations will be decided and notice of the decision on appeal will provided to the Covered Person or their Authorized Representative, according to the following timetable:

Urgent Care Claims
An appeal of an Adverse Benefit Determination of an Urgent Care Claim by a Covered Person or their Authorized Representative will be decided and notice issued to the Covered Person or their 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.

If the Initial Internal Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an Internal Appeal would seriously jeopardize the Covered Person's life or health or would jeopardize the Covered Person's ability to regain maximum function, the Covered Person may file a request with the Plan for an "expedited External Review" within the meaning of interim final regulations under Section 2719 of the Public Health Service Act.

Pre-Certification Claims
An appeal of an Adverse Benefit Determination of Pre-Certification Claim by the Covered Person or their Authorized Representative will be decided and notice issued to the Covered Person or their Authorized Representative within a reasonable period but not more than 30 days after the Trustees have received the request for review.

If a Covered Person is not satisfied with the first level appeal decision of the Plan, the Covered Person has the right to request a second level appeal from the Plan. The Covered Person's second level appeal request must be submitted to the Plan within 60 days of the receipt of the first level appeal decision. The second level appeal will be conducted and the Covered Person will be notified by the Plan of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for review of the first level appeal decision.

Concurrent Care Review Claims
An appeal of an Adverse Benefit Determination of a Concurrent Care Review Claims by a Covered Person or their Authorized Representative will be decided and notice issued to the Covered Person or their Authorized Representative as soon as possible but in no event later than 72 hours after the Trustees have received the request for review if the claim involves an Urgent Care Claim, 30 days in the case of a Pre-Certification Claim, and within the time set forth in below if a Post-Service Claim.

Post-Service Claims
An appeal of an Adverse Benefit Determination of a Post-Service Claim or Death Benefit Claim by a Covered Person or their Authorized Representative will be decided by the Trustees no later than the second regularly scheduled meeting of the Trustees following the receipt of the request for review. If special circumstances exist, the Trustees may review the matter no later than the third regularly scheduled meeting following the receipt of the request for review. The notice of decision will be sent to the Covered Person or their Authorized Representative within 10 days of the date of such meeting.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and the Covered Person will be notified by the Plan of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days from receipt of a request for appeal of a denied claim. If a Covered Person is not satisfied with the first level appeal decision of the Plan, the Covered Person has the right to request a second level appeal from the Plan. The Covered Person's second level appeal request must be submitted to the Plan within 60 days of the receipt of the first level appeal decision. The second level appeal will be conducted and the Covered Person will be notified by the Plan of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days from receipt of a request for review of the first level appeal decision.

Contents of Notice of Decision on Final Internal Benefit Determination
In the case of an Adverse Benefit Determination on appeal, the notice shall set forth, in a manner calculated to be understood by the Covered Person:

a) the specific reason or reasons for the adverse determination;
b) references to the specific Plan provisions on which the final benefit determination is based;
c) a statement that the Covered Person 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;
d) A statement describing any voluntary appeal procedures offered by the Plan and the Covered Person's right to obtain information about such procedures;
e) 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 Covered Person's medical condition, or a statement that this will be provided without charge on request;
f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Final Internal Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;
g) The following statement: "The Covered Person and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the Covered Person's local US Department of Labor Office and the Covered Person's State insurance regulatory agency."; and
h) a statement describing the Claimant's right to bring a civil action under ERISA §502(a).

General Rules

Voluntary Extensions
As described above, the Plan must decide the Covered Person's claim and/or appeal within certain timeframes, and the Plan may extend those timeframes in its discretion in certain circumstances. In addition, the Plan may request that the Covered Person voluntarily agree to allow the Plan additional time extensions. The Covered Person may allow or deny these additional "voluntary" extensions at their discretion.

The following appeals procedure applies to claims made for benefits under a Non-Grandfathered Group Medical Coverage Feature subject to PPACA under these Default Internal Claims Procedures:

- The Plan must allow the Covered Person to review the claim file and to present evidence as part of the internal claims and appeals process.
- Any decision regarding hiring, compensation, termination, promotion, or similar matters with respect to an individual such as a claims adjudicator or a medical expert must not be based upon the likelihood that the individual will support a denial of benefits.
- The Plan must provide the Covered Person, free of charge, with any new or additional evidence considered, relied upon, or generated by the group health plan (or at the direction of the Plan) in connection with the Covered Person's claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Covered Person a reasonable opportunity to respond prior to that date.
- Before the Plan can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Covered Person must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Covered Person a reasonable opportunity to respond prior to that date.

Authorized Representatives
Any reference in these procedures to the "Covered Person" is also a reference to the Covered Person's Authorized Representative making a claim on the Covered Person's behalf. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on the Covered Person's behalf.

Default External Review Procedures

- The Covered Person may be entitled to request an External Review of a Final Internal Adverse Benefit Determination by the Plan (an "External Review"); and
- If a Covered Person's situation is urgent, the Covered Person may be entitled to an Expedited External Review of an Adverse Benefit Determination by the Plan (an "Expedited External Review").

For purposes of this Section, an "Adverse Benefit Determination" means an Adverse Benefit Determination as defined in 29 CFR 2560.503-1, as well as any rescission of coverage, as described in Sec. 54.9815-2712T(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and may be either an initial internal Adverse Benefit Determination ("Initial Internal Adverse Benefit Determination") or an internal Adverse Benefit Determination made on appeal thereof (a "Final Internal Adverse Benefit Determination").

Federal External Review Process
This Federal External Review Process follows interim guidance from the federal agencies that are responsible for PPACA, and apply until replaced by future guidance.

External Review under the Federal External Review Process is not available for all Adverse Benefit Determinations. For example, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Covered Person or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for External Review. In addition, with respect to claims for which External Review has not been initiated by September 20, 2011, the Federal External Review Process is suspended until further notice except for claims relating to rescissions (within the meaning of Public Health Service Act Section 2712) and/or medical judgment. The Plan further reserves the right to exclude from External Review additional types of Adverse Benefit Determination as may be permitted under PPACA and any related guidance issued from the federal agencies that are responsible for implementation of PPACA.
Any reference in these procedures to the "Covered Person" is also a reference to the Covered Person's Authorized Representative making a claim on their behalf. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on the Covered Person's behalf.

A. Standard External Review
Standard External Review is External Review that is not considered expedited (as described in paragraph B of this section).

1) **Request for External Review.** The Plan will allow the Covered Person to file a request for an External Review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2) **Preliminary Review.** Within 5-business days following the date of receipt of the External Review request, the Plan will complete a preliminary review of the request to determine whether the Covered Person meets all of the following requirements for Standard External Review:
   a) The Covered Person is or was covered under the Plan at the time the health care item or service 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;
   b) The Adverse Benefit Determination does not relate to the Covered Person's failure to meet the requirements for eligibility under the terms of the Plan (for example, worker classification or similar determination);
      c) The Covered Person has exhausted the Plan's internal appeal process unless the Covered Person is not required to exhaust the internal appeals process under applicable regulations; and
      d) The Covered Person has provided all the information and forms required to process an External Review.

   Within 1-business day after completion of the preliminary review, the Plan will issue to the Covered Person a notification in writing. If the request is complete but not eligible for External Review, such

notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number [866] 444-EBSA [3272]). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Plan will allow a Covered Person to perfect the request for External Review within the 4-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3) Referral to IRO. The Plan will assign an independent review organization (IRO) that is accredited by Utilization Review Accreditation Commission (URAC) or a similar nationally recognized accrediting organization to conduct the External Review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). The Plan will contract with at least 3 IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO will provide the following:

a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
b) The assigned IRO will timely notify the Covered Person in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the Covered Person may submit in writing to the assigned IRO within 10-business days following the date of receipt of the notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after 10-business days.
c) Within 5-business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the External Review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination. Within 1-business day after making the decision, the IRO must notify the Covered Person and the Plan.
d) Upon receipt of any information submitted by the Covered Person, the assigned IRO will, within 1 business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider the Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan must not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment. Within 1-business day after making such a decision, the Plan must provide written notice of its decision to the Covered Person and the assigned IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Plan.
e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    i) The Covered Person's medical records;

ii) The attending health care professional's recommendation;
iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Covered Person, or the Covered Person's treating provider;
iv) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
vii) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f) The assigned IRO must provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of final External Review decision to the Covered Person and the Plan.

g) The assigned IRO's decision notice will contain:
i) 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, the treatment code and its corresponding meaning, and the reason for the previous denial);
ii) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the Covered Person;
vi) A statement that judicial review may be available to the Covered Person; and
vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

h) After a final External Review decision, the IRO must maintain records of all claims and notices associated with the External Review process for 6 years. An IRO must make such records available for examination by the Covered Person, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

4) **Reversal of Plan's Decision.** Upon receipt of a notice of a final External Review decision reversing the Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited External Review

1) Request for Expedited External Review. The Plan must allow the Covered Person to make a request for an expedited External Review with the Plan at the time the Covered Person receives:

a) An Initial Internal Adverse Benefit Determination that involves a medical condition of the Covered Person for which the timeframe for completion of an expedited internal appeal under the interim final regulations under Section 2719 of the Public Health Service Act would seriously jeopardize the Covered Person's life or health or would jeopardize the Covered Person's ability to regain maximum function and the Covered Person has filed a request for an expedited internal appeal; or

b) A Final Internal Adverse Benefit Determination, if the Covered Person has a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize the Covered Person's life or health or would jeopardize the Covered Person's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services, but has not been discharged from a facility.

2) Preliminary Review. Immediately upon receipt of the request for expedited External Review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for Standard External Review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for Standard External Review to the Covered Person of its eligibility determination.

3) Referral to IRO. Upon a determination that a request is eligible for External Review following the preliminary review, the Company will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for Standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. 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 above under the procedures for Standard External Review. In reaching a decision, the assigned IRO must review the claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4) Notice of final External Review decision. The Plan's contract with the assigned IRO must require the IRO to provide notice of the final External Review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the Covered Person's 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 IRO's notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Covered Person and the Plan.

Exhaustion of Plan Claim Denial and Appeal Procedures

No Covered Person, or any person acting in the Covered Person's 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 Covered Person's appeal. No Covered Person 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. The Trustees may request, and the Covered Person

shall provide, such information as the Trustees may deem necessary to their full and fair review of the claim appeal.

Time Limitation on How Long the Covered Person Has to File a Court or Other Proceeding
No legal, equitable or other action may be brought by the Covered Person against the Plan or its Trustees after 2 years of the date the claim was first incurred by the Covered Person. For example, if the Covered Person went to the hospital on October 1, 2008, and incurred claims on that date that the Covered Person wanted the Plan to cover and were denied by the Plan, the Covered Person would have 2 years from October 1, 2008 in which to bring a court action. If the Covered Person fails to bring such action within such time, the Covered Person's claims will be time barred under the terms of the Plan. This holds true even if a longer statute of limitations under ERISA or applicable law would otherwise have applied. In addition, the Covered Person must also first exhaust all other Plan claim filing and appeal procedures as previously described in this Part of the Plan.

Questions About Covered Person's Claims and Appeal Rights
For questions about the Covered Person's rights, these claims procedures, or for assistance, the Covered Person can contact the Employee Benefits Security Administration at (866) 444-EBSA (3272).

SECTION XIII: COORDINATION OF BENEFITS RULES

The Plan will coordinate the benefits payable under the Master Plan, Normal Retiree Plan, and Supplemental Plan with similar benefits payable under other health plans. The term health plan refers to any other health coverage, plan, or insurance.

Note that these provisions do not apply to Life Insurance, Death Benefits and Accidental Death & Dismemberment Insurance.

How Does Coordination of Benefits Work?

The Covered Person may be covered under another health plan. For example, the Participant's Eligible Dependent spouse may be covered by a group health plan maintained by the spouse's employer. The expenses must be covered in part under at least one of the plans.

One of the plans involved will pay the benefits first (this plan is the "Primary" plan). The other plan or plans will pay benefits next (this is the "Secondary" plan). If this Plan is Primary, it will pay benefits first. Benefits under this Plan will not be reduced due to benefits payable under other plans. If this Plan is Secondary, benefits under this Plan will be reduced due to benefits payable under other plans that are Primary to this Plan.

The amount of Allowed Charges will be determined first. Then the amount of benefits paid by plans Primary to this Plan will be subtracted from this amount. This Plan will pay the difference, subject to all other Plan rules and exclusions.

Which Plan Is Primary

A. Coordination With Other Health Plans

In order to pay claims, the Plan must determine which Plan is Primary and which is Secondary. In order to determine which Plan is Primary and which is Secondary, the following criteria are used:

- A Plan with no provision for coordination with other plans will be Primary and pay benefits before a Plan that contains such a provision. A Plan that contains coordination of benefit provisions inconsistent with the provisions of this Plan will always be Primary.
- A Plan that covers the patient as an employee will pay benefits before the Plan that covers the patient as a dependent. For purposes of this rule, a spouse of an employee shall be considered a dependent, unless such spouse is also covered as an employee. If the Plan covers the patient as an employee but claims to reimburse or pay only after all other plans, the Plan that covers the person as an employee will still be Primary to the one that covers the person as a dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, 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 (for example, a retired employee), then the order of benefits between the 2 Plans is reversed so that the Plan covering the person as an employee, member, subscriber, or retiree is Secondary and the other plan is Primary.
- If both Plans cover the person as an employee, the Plan which covered the employee the longest will be Primary, except that the Plan that covers the employee as an active employee will pay before the Plan that covers the employee on an inactive basis (for example, under rules extending coverage after termination of employment). The Plan that covers a person as an employee who is neither laid off nor retired is Primary. A Plan that insures the patient against a particular injury (for example,

sports insurance) will be Primary, when treatment or coverage is sought for such injury, to a Plan that provides group health coverage.

- No coverage will be provided if the Plan that covers the patient as Primary has denied coverage because the patient has not complied with that Plan's rules. For example, if a health plan, such as a HMO, requires the patient to use its panel of physicians and the patient chooses not to do so, such that the HMO denies coverage, this Plan will not cover such claims as Primary.
- If a child is covered by more than one plan, the order of benefits is as follows:
    - the Primary plan is the Plan of the parent whose birthday is earlier in the calendar year if:
    - the parents are married;
    - the parents are not separated (whether or not they ever have married); or
    - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If both parents have the same birthday, the Plan that covered either of the parents longer is Primary.
- If none of the above rules are applicable, and if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to claim determination periods or Plan years commencing after the Plan is given notice of the court decree.
- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
    - the Plan of the custodial parent;
    - the Plan of the spouse of the custodial parent;
    - the Plan of the noncustodial parent; and then
    - the Plan of the spouse of the noncustodial parent.
- If the preceding rules do not determine the Primary plan, the allowable expenses will be equally shared between the plans. However, this Plan will never pay more than it would have paid had it been Primary.

A Covered Person must report to the medical provider and to the Plan any other health coverage when seeking any benefits from the Plan.

B. Coordination With No Fault Insurance and Other Motor Vehicle Laws

If a Covered Person is or may be covered or eligible for benefits under any automobile or motor vehicle insurance, underinsurance, Med-Pay or similar type of motor vehicle insurance, regardless of the method of funding (for example, self-funded), such other insurance is the Primary insurance. The Covered Person must respond accurately and completely in writing to all Plan requests for information and documentation about such other insurance before the Plan will provide any benefits after the $8,000 motor vehicle accident exclusion (See Exclusion # 35). The Plan may deny any benefits for which a Covered Person would otherwise be eligible after the $8,000 exclusion until such coverage has been exhausted from all sources (and used to pay the Covered Person's medical bills) and evidence and proof of same has been presented to the Trustees by the Covered Person. Such evidence or proof is to include, but not be limited to, a written statement from each insurer for which coverage may be provided that no coverage or no further coverage is or will be provided. Evidence or proof of exhaustion of insurance coverage shall be determined to the sole satisfaction of the Trustees. The Trustees may deny coverage until the Covered Person has exhausted all legal remedies against the Primary insurance. Any person who provides false, inaccurate, or misleading information in response to a request for information or documentation shall be subject to the Plan's rules concerning fraud.

C. Coordination With Other Non-Health Insurance
(Examples include, but are not limited to, Malpractice, Liability Insurance, and Homeowners Insurance)

If a Covered Person is injured and is or may be covered or eligible for coverage or payment under malpractice or liability insurance for claims covered by the Plan, the malpractice or liability insurance is the Primary insurance. The Plan may deny any benefits for which a Covered Person would otherwise be eligible until such insurance coverage has been exhausted from all sources and evidence and proof of same has been presented to the Trustees by the Covered Person.

Such evidence or proof is to include, but not be limited to, a written statement from each insurer for which coverage may be provided, or that no coverage or no further coverage is or will be provided. Evidence or proof of exhaustion of insurance coverage shall be determined to the sole satisfaction of the Trustees. The Trustees may deny coverage until the Covered Person has exhausted all legal remedies against the Primary insurance.

D. Coordination With Workers' Compensation Insurance or Benefits
If an illness or injury of a Covered Person arises out of, in the course of, or in connection with the Covered Person's employment and a workers' compensation claim is filed or may be filed, and such claim is not contested by the workers' compensation insurer, no benefits are payable by the Plan. A Covered Person must promptly notify the Plan of any claim that is workers' compensation related and must notify the Plan of the filing of a workers' compensation claim with the state agency. In order to receive benefits in the interim, a Covered Person must execute an Assignment. (see Section XIV). Where a claim for workers' compensation benefits is settled by judgment, stipulation, order, or agreement by the Covered Person or their representative, the Covered Person cannot claim benefits for the same disability, illness, or injury from the Plan.

If benefits of the Plan are paid in error or the Covered Person fails to report the workers' compensation claim to the Plan, the Plan can recover and be reimbursed by the Covered Person and/or Workers' Compensation insurer for any payments made to/or on behalf of the Covered Person.

E. Effect of Medicare on the Plan for Employed Participants
When a Participant, working for a Contributing Employer, or the Participant's Eligible Dependent spouse, reaches age 65, the Participant or Eligible Dependent may be eligible for Medicare based upon their age. The Participant or the Participant's Eligible Dependents may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease. If the Participant's employer is subject to the Medicare Secondary Payer requirements of federal law, the Plan will pay Primary.

The Plan pays health benefits after Medicare in the following situations:

- The Participant's (or the Participant's Eligible Dependent spouse's) Medicare eligibility is based upon age, and the Participant's current employment status is with a Contributing Employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year. The

combined Primary Medicare payments and Secondary Plan payments will not exceed the Allowed Charges for such treatment.

- The Participant's or Eligible Dependent's eligibility for Medicare is due to disability and the Participant or Eligible Dependent's coverage does not derive from the Participant's "current employment status with an employer" as defined by federal law. Generally, a Participant has current employment status with an employer if the Participant is an employee of a Contributing Employer by virtue of being on the employment rolls of the Contributing Employer.
- The Participant's or Eligible Dependents' eligibility for Medicare is due to end-stage renal disease, but only after the first 18 months of entitlement to Medicare benefits due to end-stage renal disease (30 months for a Participant or Eligible Dependent whose entitlement began on or after March 1, 1996), except as follows. Medicare will continue to be Primary and this Plan Secondary if:
    - The Participant or Eligible Dependent was already entitled on the basis of age or disability when Participant becomes eligible on the basis of end-stage renal disease; and
    - The age based or disability based entitlement to Medicare was not by virtue of current employment status or, if based upon current employment status in the case of age based entitlement, the Contributing Employer had fewer than 20 employees as described above.

When Medicare pays Primary, as in the above 3 situations, the Plan supplements benefits after Medicare has paid its benefits. If a person is also covered under another group plan and federal law requires that other group plan to pay Primary to Medicare, this Plan is Secondary to both that Plan and Medicare. This holds true even if this Plan is determined to be Primary to that other group plan by the rules shown in paragraph (a), entitled "Coordination With Other Health Plans." Federal law determines the order of payment between Medicare and the other plan.

If Medicare pays benefits first, then this Plan pays benefits in the following manner. If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating physicians), this Plan determines the amount of covered expenses based upon the amount of charges allowed by Medicare. If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physicians), this Plan determines the amount of covered expenses based on the lesser of the following:

- the Allowed Charges;
- the amount of the limiting charge as defined by Medicare.

The Plan determines the amount payable without regard to Medicare benefits. Then the Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference between Plan benefits and Medicare benefits.

The same expenses payable under this Plan may also be payable under another employer's plan. If the benefits under that employer's plan must be paid before Medicare because of federal law, this Plan still subtracts the amount of Medicare benefits payable determined as if benefits were not payable under that plan.

Some Frequently Asked Questions About Coordination of Benefits

Q1: An Eligible Dependent spouse is covered by their employer's HMO. Will the Plan pay their claims Primary or Secondary?

A1: The Plan will pay as Secondary. The Plan that covers the person as an employee pays first.

Q2: A spouse belongs to their employer's HMO, which requires that they use the HMOs panel of physicians. If they use a physician not on the panel and the HMO denies the medical claims, will the Plan pay?

A2: No. The Plan will coordinate benefits as if the spouse were covered by the HMO. In other words, if the HMO is Primary, the spouse cannot shift the burden of payment to the Plan by failing to follow the HMO's rules.

Q3: A Covered Person in the Master Plan was injured at work. They filed a claim in accordance with the workers' compensation laws, but the employer's workers' compensation insurance carrier has yet to pay. Will the Plan pay it?

A3: No. Work related injuries are excluded from payment. However, if the Covered Person's injuries have not yet been determined to be work related, the Plan may pay the Covered Person's claims pending the outcome of the workers' compensation proceedings under the Plan's Assignment and Subrogation Rules (see Section XIV).

Q4: If a Covered Person is eligible for Medicare as well as being covered by the Master Plan, should they submit their bills to Medicare?

A4: No. This Plan is Primary.

Q5: If a Participant has a spouse who has coverage with another health plan. The spouse also obtains discounts from their doctor by virtue of being in a preferred provider network. If the doctor sends bills to this Plan for the full amount (as if no discount applied), will this Plan pay under coordination of benefits?

A5: No. The Plan excludes from coverage any charges the Covered Person is not required to pay (see Section III, E). If a doctor or other medical provider under another health plan has agreed to accept the other health plan's coverage as full payment, the doctor cannot balance bill this Plan.

Q6: A Covered Person in the Master Plan was in a serious car accident. The Covered Person will have extensive medical bills and will likely sue the other driver. How will the Master Plan treat those claims?

A6: The Master Plan contains an excluded dollar amount. (see Section III, E for the excluded dollar amount). Claims otherwise payable under the Plan are the Covered Person's responsibility up to this dollar amount. The Covered Person should make sure that they have adequate auto insurance to cover this excluded dollar amount in potential medical claims. If the other driver was at fault, the Covered Person may be able to make a claim against the other driver's insurance company. If the other driver's insurance company admits liability for the Covered Person's medical bills, the Master Plan will not pay any claims, but the other driver's auto insurer will be Primary, and the Covered Person should submit any medical bills to the auto insurer for payment. If the auto insurer disputes liability such that litigation may be required, the Plan may pay the Covered Person's claims under the Plan's Assignment and Subrogation Rules. (see Section XIV of the Plan.). However if it was determined the Covered Person was at fault due to intoxication, abuse of drugs or committing a felonious act the Plan excludes any payments (see Section III, E Exclusions).

SECTION XIV: ASSIGNMENT AND SUBROGATION RULES

The Plan is a self-funded "Employee welfare benefit plan" as that term is defined in ERISA and, as such, it is governed by rules of ERISA. ERISA pre-empts any state law purporting to restrict the Plan's rights to reimbursement as outlined below.

Assignment Rules

If a Covered Person suffers an injury, illness or a loss in an accident or other event or occurrence as a result of an act or omission by another person (any and all of which are referred to as an "injury" for purposes of this Section), a claim may be made for damages or other recovery against the other person by the Covered Person.

The Plan has the right to obtain the proceeds of any recoveries, settlements or judgments, no matter how characterized (for example, as payments for medical bills, pain and suffering or emotional distress experienced by a Participant or a spouse, child, or other person, loss of consortium of a spouse or child or other family member, loss of income or otherwise), by the Covered Person or others to the extent of the total benefits paid, or to be paid in the future, to or on behalf of the Covered Person or others.

A Covered Person who applies, or who intends to apply, for any benefits provided by the Plan by reason of an injury is required to notify the Plan, as a condition for eligibility for benefits under the Plan. The Covered Person is required to notify the Plan within 7 days of any injuries for which the Covered Person will seek payment from the Plan.

The Covered Person is required to immediately notify the Plan of any recoveries, settlements or judgments recovered against any source (for example, the person at fault, any insurance company, etc.), and the Plan shall have a right of reimbursement and a lien and a first priority right of recovery from such recoveries, settlements or judgments. The Plan shall be reimbursed from such recoveries as stated herein. This means that if a Covered Person or other person makes any recoveries, whether by judgment, settlement or in some other manner, the Plan gets reimbursed in full first, before the Covered Person, the Covered Person's attorneys, and any other person, and for all claims the Plan has paid or will in the future pay for claims related to such injuries and without reduction for attorney's fees, costs, expenses or any other reduction.

Furthermore, this right of reimbursement and first priority right of recovery applies no matter how the recovery is characterized. For example, if a judgment or settlement agreement awards $1,000 to the Participant and $10,000 to the Participant's spouse for loss of consortium, the Plan considers the Participant's recovery to be $11,000 and will, under the Assignment rules of this Plan, have the right to be reimbursed from such proceeds. In addition, if the case is settled such that the liability or causality for certain injuries or damages is not proven, the Plan's lien and right to recovery may not be reduced based upon arguments or contentions that the settlement reflects a reduction in the amount claimed by the Covered Person due to a potential lack of success on the merits if liability for such injuries had been adjudicated.

The Plan's right of reimbursement and lien applies to the full settlement recovery without reduction or discount for likelihood of success as to one or more injuries for which the Plan has made payment, even if such discount was actually taken into account in reducing the Covered Person's claims against the defendant(s) for purposes of settlement. Finally, the Plan's right of reimbursement and first priority right of recovery applies even if the Covered Persons are not made whole by whatever recoveries, if any, are left after the Plan is paid under the Assignment. The Covered Person must complete such forms and supply such information as may be requested by the Plan, and must cooperate with and assist the Plan by whatever

means are necessary to enable the Plan to obtain reimbursement from other parties, such as, but not limited to, worker's compensation insurance companies.

The Plan will require that the Covered Person assign their rights to any recoveries, settlements, or judgments to the Plan, and that the Plan be paid from such recoveries, settlements or judgments as a first right of recovery (that is, before the Covered Person, their attorneys, and any other person, and without reduction for attorneys' fees or other costs or expenses), and regardless of whether the Covered Person is made whole by their recoveries.

Such recoveries, settlements, or judgments shall constitute Plan assets to the extent of the benefits paid or to be paid by the Plan, and shall create a lien upon such monies, and any person who handles such assets will hold them in trust for the Plan. Monies assigned to the Plan become assets of the Plan once such monies become payable to the Covered Person. These "plan assets" of the Plan must be held in trust by the Covered Person or whomever ends up holding such monies, including the Covered Person's attorneys, agents, beneficiaries, trusts, insurance companies, or any other person or entity that takes possession of such proceeds.

The Covered Person is considered a "fiduciary" of the Plan when the Covered Person holds such monies in trust or otherwise exercise discretion over such monies. The Covered Person must disclose to any other person, with whom the Covered Person makes arrangements, the terms of the Assignment and that the Plan has a first priority right of recovery, including the Covered Person's attorneys or any other person.

If, in the exercise of the Covered Person's discretion over such monies, the Covered Person violates the terms of the Plan and the Assignment by paying or converting such funds to the Covered Person or some other person, the Covered Person may be liable for breach of the Covered Person's fiduciary duties to the Plan under ERISA and personally liable to make up all losses to the Plan, including lost investment return, as well as costs and attorneys' fees incurred in the recovery of same.

The Covered Person will be required to sign an Assignment form in order to be eligible for benefits arising out of this injury. However, the failure of any Covered Person to sign an Assignment form will in no way affect the Plan's right to enforce these provisions and to obtain the proceeds of any recoveries, settlements or judgments, no matter how characterized, as described above.

Any Covered Person who has the Plan pay their claims does so with the understanding that these Assignment and Subrogation rules are binding upon the Covered Person, their attorneys, or the agents, assigns or heirs and executors of the Covered Person. The Covered Person is required to pay their own legal expenses and the Covered Person is required to notify their attorney of these provisions and assignment. Any amounts recovered by the Covered Person in excess of the full amount expended by the Plan may be retained by the Covered Person or used to pay legal or other expenses.

By accepting advance payment from the Plan, the Covered Person is consenting to the entry of a temporary, preliminary, or permanent injunction against the Covered Person to be filed in order to protect the Plan's rights under ERISA and the Assignment and to waive any defenses or objections thereto and agree that such action satisfies the "in aid of jurisdiction" to the Anti-Injunction Act, 28 U.S.C. §2283 and agree that

such injunction may be issued under the All Writs Act, 28 U.S.C. §1651 to enjoin a proceeding in state court in violation of the Plan's rights under ERISA or the Assignment.

Please note that the Plan contains time limits on the filing of claims (generally 90 days from the treatment date but in no event later than 1 year from the treatment date). If the Covered Person delays executing and returning the Assignment beyond the claims filing deadline, the Covered Person's claims may be denied as time barred even if the claims were submitted to the Plan within the 90-day or 1-year time period. This is because a claim is not considered to be filed by the Plan if an essential component required to pay the claim, namely the executed Assignment, has not been provided by the Covered Person.

> ***Example:*** *Charlie, a Covered Person, is injured in an auto accident. He sues the other driver and the other drivers' insurance company. Claims related to the accident are filed with the Plan within 90 days of Charlie's treatment date. The Plan forwards to Charlie the Assignment form for execution within the same 90-day period. Over a year passes before Charlie sends the Assignment form back to the Plan. The Plan may deny such claims as beyond the Plan's filing limitation.*

In addition, if the Covered Person fails to return the Assignment form, the Covered Person will be deemed to have elected to proceed directly against the Primary carrier or third party for payment of all of the Covered Person's medical bills and other expenses related to the accident or injury. The Covered Person will not have assigned any recoveries the Covered Person obtains to the Plan, but the Plan will not pay any claims related to the accident, occurrence, or injury.

If the Plan has already mistakenly paid claims related to the accident, occurrence or injury, as provided above, the Plan provides that it has a first priority right of recovery to any recoveries the Covered Person makes to the extent of the amounts already paid by the Plan, regardless of whether the Assignment is executed. Alternatively, the Plan may seek to recoup from the provider any such payments made in error.

In the event that the Covered Person submits additional claims for benefits following settlement of or recovery on a liability claim and reimbursement to the Plan for claims paid as of that date, the Plan will not cover such new charges and they will be the Covered Person's responsibility.

Subrogation Rules

In the event a Covered Person suffers an injury, illness, or loss because of a negligent or wrongful act or omission by a third party, the Plan has the right to pursue subrogation. The Trustees will be subrogated and may succeed to the Covered Person's right of recovery against the third party, as determined by the Trustees in their sole discretion. The Covered Person agrees to help the Trustees use this right when requested.

> ***Example:*** *Malcolm is a Covered Person who is injured and soon after the injury he recovers on a claim in the amount of $100,000. At the time of the recovery, the Plan has paid $75,000 in benefits for treatment of Malcolm's injuries, and Malcolm reimburses the Plan $75,000. If Malcolm's treatment is not finished, and continues after he reimbursed the Plan from his recovery, the Plan will deny up to the next $25,000 of all Malcolm's future claims for treatment of those injuries. Once the full amount of the settlement is exhausted in this manner, the Plan will start paying claims to Malcolm for that treatment again, provided Malcolm otherwise remains eligible for coverage.*

Enforcement Procedures and Remedies

In addition to any legal or equitable remedy that may be available under applicable law, the Trustees may exercise the following remedies if a Covered Person fails to comply with the rules of this Section:

- Refuse to pay any benefits related to the Covered Person's injuries or illness;
- Recover from the Covered Person benefits already paid through deducting any overpayments from claims otherwise payable. If the Covered Person is the Participant, the Trustees may also offset claims payable to any Eligible Dependent of the Participant. If the Covered Person is an Eligible Dependent, the Trustees may also offset claims payable to any other Eligible Dependent or the Participant;
- Assess interest on the outstanding benefits or the amount of claims paid at a rate of 12% per annum, compounded annually, until paid; or
- Recover all monies through the PPO managed by *Blue Cross Blue Shield of Massachusetts* by charging back the individual providers who in turn will bill back the Covered Person for all related expenses;
- In the event the Trustees institute litigation to enforce these provisions, the Covered Person, and any other responsible person, will be required to pay the Plan's costs and attorneys' fees, as well as any investigation fees.

The Trustees may promulgate rules and regulations to govern procedures hereunder.

SECTION XV: PLAN ADMINSTRATION

Withholding Payment

In the event any question or dispute arises as to the proper person or persons to whom any payments are to be made under the Plan or the Trust Agreement or any other instrument, the Trustees may withhold such payment until there is an adjudication or resolution of such question or dispute which, in the Trustees' sole judgment, is satisfactory to them, or until the Trustees will have been fully protected against loss by means of such indemnification agreement or bond as they, in their sole judgment, determine to be adequate.

Prohibition Against Alienation and Assignment

The Plan will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person other than the Trustees and their duly Authorized Representatives, and by such Trustees or representatives, only to the extent and for the purposes as provided in the Trust Agreement.

No Covered Person will have the right to assign, alienate, or otherwise encumber the benefits to which he may be or become entitled to by reason of the Plan or to receive cash consideration in lieu of such benefits except as may be permitted by the Trustees in their sole discretion consistent with applicable law.

Trustees' Discretionary Authority

The Trustees have complete and exclusive discretionary authority to (i) establish, adopt, amend, or discontinue all or part of this Plan of benefits provided by this Fund, (ii) establish, adopt, and amend any instruments, forms, policies or documents by which the Trust Agreement or Plan is administered or implemented, (iii) establish, adopt, amend, and determine eligibility rules for benefits, and (iv) construe and interpret the terms of the Trust Agreement, Plan, or any other instruments, forms, policies, or documents of the Plan, including disputed or ambiguous terms and meanings, and the interpretation of the Trustees is binding and final on all interested persons. Provisions may change after the date of this SPD document. Benefits are not vested. Contact the Plan if a Covered Person has questions regarding their current benefits.

Whenever a benefit under the Plan is abolished or limited with respect to a Participant, it will also be considered abolished or limited with respect to any Eligible Dependent or beneficiary of the Participant unless provided otherwise in this Plan.

Limit on Authority of Non-Trustees

No Local Union, Local Union Officer, Business Agent, Local Union Member, Employer or Employer Representative, Plan Employee, Attorney or Consultant is authorized to speak for or to commit the Board of Trustees of this Plan on any matter without express written authority from the Trustees.

Plan Controls Over Written or Oral Misstatements

In many cases, Plan employees may communicate to Covered Persons or others information about the Plan, including eligibility for benefits. The terms of the Plan control over any misstatements that may be made, even if intentionally made. No Covered Person, or other person, or any person claiming through them, may claim an estoppel against the Trustees or otherwise preclude them from enforcing the Trust Agreement, the Plan, or any other instrument or policy, as construed and interpreted by the Trustees in their sole discretion.

No oral or written representations made by any Employer, the Union, a Plan Employee, or any Trustee, that is inconsistent with the Trust Agreement or Plan as interpreted by the Trustees in their sole discretion, will be binding upon the Plan or the Trustees unless specifically authorized in writing by the Trustees or the Fund Administrator.

Examination of Records

The Plan will generally make available to each Covered Person such of their records under the Plan as pertain to the Covered Person for examination at reasonable times during normal business hours, but the Plan shall have no obligation to disclose any records or information which the Plan, in its sole discretion, determines to be of a privileged or confidential nature.

Reliance on Tables

In administering the Plan, the Plan is entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by or in accordance with the instructions or recommendations of accountants, counsel, actuaries, consultants, or other experts employed or engaged by the Plan.

HIPAA Privacy Provisions

HIPAA requires group health plans to protect the confidentiality of the Covered Person's private health information. The Plan will not use or further disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health plan operations and Plan Administration, or as otherwise permitted or required by applicable law. In particular, the Plan will not, without authorization, use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit of the Local 103, I.B.E.W. Health Benefit Plan. In addition, the Plan requires all of its business associates (that is, service providers who help us administer the Plan) to also observe HIPAA's privacy rules.

Under HIPAA, the Covered Person has certain rights with respect to their Protected Health Information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. Covered Persons also have the right to file a complaint with the Plan or with the Secretary of the HHS if they believe their rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of the Covered Person's rights under HIPAA's privacy rules. For a copy of the notice, please contact the Plan. If a Covered Person has questions about the privacy of their health information, or if the Covered Person wishes to file a complaint under HIPAA, the Participant should contact the Local 103, I.B.E.W. Health Benefit Plan's privacy officer.

SECTION XVI: PLAN INFORMATION REQUIRED BY ERISA

The Plan is established in accordance with an Agreement and Declaration of Trust which provisions are also applicable to the Plan. The following information, together with the information contained in this Summary Plan Description, is being provided in accordance with government regulations.

General Plan Information

Local 103, I.B.E.W. Health Benefit Plan
The Trust has assigned Plan Number 501 to the Plan
The provisions of the plan became effective on December 1, 2015
The Plan Year begins on December 1 and ends on November 30

Employer Identification Number

The Employer Identification Number (EIN) as assigned by the Internal Revenue Service to the Board of Trustees as Plan sponsor is 04 6063733.

Type of Administration of the Plan

Most of the benefits under this Plan, including the medical, prescription drug, dental, vision, mental health, substance abuse and death benefits are currently administered by the Plan. These benefits are "self-funded." Any appeal of the denial of these benefits is made to the Trustees.

The Life Insurance and Accidental Death & Disability benefits are through a Life Insurance Company but are administered by the Plan. Any appeal of a denial of these benefits is made to the Life Insurance Company.

The Death Benefit described in Section X is administered directly by the Plan and paid out of Fund reserves.

The Plan is administered and maintained by a joint Board of Trustees currently consisting of 3 Union Trustees and 3 Employer Trustees. The Board of Trustees is governed by the Agreement and Declaration of Trust established and maintained in accordance with the Collective Bargaining Agreements.

Name and Address of the Plan Administrator

The Board of Trustees is considered to be the "Plan Administrator." The Trustees have complete discretionary authority to determine eligibility for benefits under the Plan, except where expressly delegated, or to construe the terms of the Plan, including ambiguous or disputed terms of the Plan, the Agreement and Declaration of Trust or other Plan documents or policies.

The Plan address is

Local 103, I.B.E.W. Health Benefit Plan
256 Freeport Street, 2nd Floor
Boston, MA 02122
Phone: (617) 288-5999
Toll free: (800) 564-5999
Fax: (617) 288-6696

The Trustees retain the right to delegate their authority with respect to the denial, granting, and administration of claims to an insurance company or other appropriate named fiduciary and may enter into an agreement with such insurer for the handling and determination of claims including, but not limited to, the processing, investigation, granting, or denial of claims and claim appeals therefrom. In the event the Trustees have so delegated their authority, such insurer will be the named fiduciary for purposes of review of a Covered Person's, or beneficiary's claim and claim appeal and have discretionary authority to review such claim and claim appeal.

The Trustees have delegated such authority concerning Life Insurance and Accidental Death & Dismemberment Insurance to an insurance company. As a result of such the Life Insurance Company, and not the Trustees, is therefore the named fiduciary concerning claim processing and any appeal from an Adverse Benefit Determination concerning any claim that the Participant may have.

Name and Address of the Fund Administrator

Richard P. Gambino
Administrator
Local 103, I.B.E.W. Health Benefit Plan
256 Freeport Street, 2nd Floor
Boston, MA 02122
Phone: (617) 288-5999
Toll free: (800) 564-5999
Fax: (617) 288-6696

Contributing Employers
A Participant may make a written request to the Fund Administrator for information as to whether a particular employer or employee organization is a Contributing Employer with respect to the Fund and, if so, the Participant may request the address of the Contributing Employer.

Reference to Collective Bargaining Agreements
This Plan is maintained pursuant to the various Collective Bargaining Agreements between the Electrical Contractors Association of Greater Boston, Inc. and the Local Union No. 103, International Brotherhood of Electrical Workers, AFL-CIO. Copies of these Agreements may be obtained by Covered Persons upon written request to the Plan and are available for examination by Covered Person. Covered Persons may receive from the Plan, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan.

Type of Plan
The Plan provides medical benefits, vision care benefits, dental benefits, mental health and substance abuse benefits, prescription drug benefits, life insurance, death benefits, and accidental death and dismemberment insurance.

Funding Medium
The assets and reserves of the Plan are held in trust by the Trustees in a Trust Fund pursuant to an Agreement and Declaration of Trust. Assets for the purpose of establishing reserves and to pay benefits and expenses are accumulated in a national bank in the name of the Plan.

This Plan is funded through contributions to the Trust Fund by Contributing Employers at the hourly rates established by and in accordance with the Collective Bargaining Agreements between Local 103, I.B.E.W.

and signatory employers, and by investment income earned on a portion of the Plan's assets. Contributions are held in a Trust Fund for the purpose of providing benefits to Covered Persons and defraying reasonable administrative expenses. This Plan is subject to periodic actuarial review to assure that the relationship between income and benefit costs meet the funding needs of the Plan. Under certain circumstances, Covered Persons losing eligibility under the Plan may maintain eligibility for a limited period of time on a self-pay basis.

Eligibility

The Plan's requirements with respect to eligibility for Covered Persons, as well as the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension Benefits of any benefits, are described in Section I of this Plan Description.

Description of Benefits

The benefits provided by the Plan are set forth in Sections I through XVI of this Plan Description. The complete terms of any benefits provided through an insurance company engaged by the Plan are provided in a Certificate of Coverage or group policy contract. This Certificate or contract, if applicable, is available to Covered Persons and beneficiaries from the Plan upon written request.

Termination Provisions

The Plan will continue during the term of the Collective Bargaining Agreements referred to herein and during the term of any renewal or extension of the Agreements as long as available assets to pay benefits exist. In the event that the obligations of all of the participating employers to make contributions and negotiations therefore terminate, the Trustees will determine how any assets that may remain after expenses have been paid will be disbursed. The distribution made by the Trustees will be made only for the benefit of former eligible employees and for legitimate Plan purposes, including but not limited to the purchase of insurance benefits, the provision of benefits in any form, or the transfer to another trust fund.

Claims and Appeal Procedure

The procedure to follow for filing a claim for benefits is set forth in several Sections of this Plan Description. If an Adverse Benefit Determination is made, the Covered Person may appeal that decision. See Section XII for the Plan's general claim denial and appeal procedures.

Statement of Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a Participant eligible for coverage under the Local 103, I.B.E.W. Health Benefit Plan, the Participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (known as ERISA). ERISA provides that all Participants shall be entitled to:

Receive Information About the Participant's Plan and Benefits

- Examine without charge, at the Plan, 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 US Department of Labor.
- Obtain, upon written request to the Plan, 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 copy of the Plan. A reasonable charge may be made for the copies.
- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage for the Participant, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The Participant or the Participant's dependents may have to pay for such coverage. Review this Plan description, Section II, on the rules governing the Participant's COBRA continuation rights.
- If the Participant terminates coverage from this Plan and seek to be covered by another group health plan that excludes coverage for preexisting conditions, the Participant may be able to reduce or eliminate such exclusionary periods of coverage for preexisting conditions if the Participant has creditable coverage from this Plan. The Plan will provide the Participant with a certificate of creditable coverage, at no cost to the Participant, when the Participant loses coverage under the Plan, when the Participant becomes entitled to elect COBRA continuation coverage, when the Participant's COBRA continuation coverage ceases, if the Participant requests it before losing coverage, or if the Participant requests it up to 24 months after losing coverage. Without evidence of creditable coverage, the Participant may be subject to preexisting condition exclusion for 12 months (18 months for later enrollees) after the Participant's enrollment date in the Participant's coverage under some other group health plan.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Participants and beneficiaries.

No one, including the Participant's Employer, the Participant's Union, or any other person, may fire the Participant or otherwise discriminate against the Participant in any way to prevent the Participant from obtaining a benefit or exercising the Participant's rights under ERISA.

Enforce The Participant's Rights

If the Participant's claim for a benefit is denied in whole or in part the Participant must receive a written explanation of the reason for the denial. The Participant has the right to have the Plan review and reconsider the Participant's claim. Under ERISA, there are steps the Participant can take to enforce the above rights. For instance,

- If the Participant requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Participant may file suit in a federal court. In such a case, the court may require the Plan to provide the materials and pay the Participant up to $110 a day until the

Participant receives the materials unless the materials were not sent because of reasons beyond the control of the Plan.

- If the Participant' has a claim for benefits that is denied or ignored in whole or in part the Participant may file suit in federal court.
- If the Participant disagrees with the Plan's decision or lack of response to the Participant's request concerning the qualified status of a medical child support order, the Participant may file suit in federal court.
- If it should happen that Fund fiduciaries misuse the Fund's money, or if the Participant is discriminated against for asserting the Participant's ERISA rights, the Participant may seek assistance from the US Department of Labor, or the Participant may file suit in a federal court.
- If the Participant files suit against the Plan, the court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the entity the Participant has sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees if, for example, it finds the Participant's claim to be frivolous.

Help With Participant's Questions

If the Participant has any questions about the Plan, the Participant should contact the Plan. If the Participant has any questions about this statement or about the Participant's rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan, the Participant should contact the nearest office of the Pension Benefits and Welfare Benefits Administration, US Department of Labor, listed in the Participant's telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. The Participant may also obtain certain publications about the Participant's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration: (866) 444-EBSA (3272). The Participant may also visit their website at www.dol.gov/ebsa.

SECTION XVII: HIPAA PRIVACY AND SECURITY RULES

This section describes how medical information about the Covered Person may be used and disclosed and how the Covered Person can get access to this information. Please review it carefully.

The Federal Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended) provides privacy protection of the Covered Person's verbal, written, and electronic records under a company sponsored health care benefits plan. In compliance with HIPAA requirements, the Plan maintains privacy policies and procedures to protect the Participant and the Participant's family's health information under the various health plans maintained by the Plan. Please read the following privacy notice carefully and share the information with family members as appropriate. If the Covered Person has any questions, please call the Plan at (617) 288- 5999.

Introduction

Title II of HIPAA imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as "Protected Health Information," or "PHI," includes virtually all individually identifiable health information held by the Plan, whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the Local 103, I.B.E.W. Health Benefit Plan.

The Plan's Duties With Respect to Health Information About the Covered Person

The Plan is required by law to maintain the privacy of the Covered Person's health information and to provide the Covered Person with this notice of the Plan's legal duties and privacy practices with respect to the Covered Person's health information. It is important to note that under Title II of HIPAA, these rules apply to the Plan, not to any participating Union or any contributing sponsor to this Plan. Different policies may apply to other Plan programs or to data unrelated to this Health Plan.

How the Plan May Use or Disclose the Covered Person's Health Information

The privacy rules generally allow the use and disclosure of the Covered Person's health information without the Covered Person's permission (known as an "authorization") for purposes of health care treatment, payment activities, and health care operations. Here are some examples of these purposes:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share health information about the Covered Person with physicians who are treating the Covered Person.
- Payment activities include activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about the Covered Person's coverage or the expenses the Covered Person has incurred with another health plan in order to coordinate payment of benefits.
- Health care operations include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For

example, the Plan may use information about the Covered Person's claims to review the effectiveness of wellness programs.

- The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Plan may also contact the Covered Person to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to the Covered Person.

How the Plan May Share the Covered Person's Health Information Within the Plan

The Plan may internally use the Covered Person's health information without written authorization for Administration purposes. The Plan may need the Covered Person's health information to administer benefits under the Plan. The Plan agrees not to use or disclose the Covered Person's health information other than as permitted or required by the Plan documents and by law. Only the Plan will have access to the Covered Person's health information for Plan Administration functions.

In addition, the Covered Person should know that the Plan cannot and will not use health information for any employment related actions. However, health information received by the Plan from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, disability income programs, or Workers' Compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other Allowable Uses or Disclosures of the Covered Person's Health Information

In certain cases, the Covered Person's health information can be disclosed without authorization to a family member, close friend, or other person identified by the Covered Person who is involved in the Covered Person's care or payment for the Covered Person's care. Information describing the Covered Person's location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). The Covered Person will generally be given the opportunity to agree or object to these disclosures (although exceptions may be made, for example if the Covered Person is not present or if the Covered Person is incapacitated). In addition, the Covered Person's health information may be disclosed to the Covered Person's legal representative without authorization.

The Plan is also allowed to use or disclose the Covered Person's health information without written authorization for the following activities:

Workers' Compensation	Disclosures to Workers' Compensation or similar legal programs that provide benefits for work related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good faith belief that releasing the Covered Person's health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the FDA to collect or report adverse events or product defects.
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if the Covered Person agrees or the Plan believes that disclosure is necessary to prevent serious harm to the Covered Person or potential victims (the Covered Person will be notified of the Plan's disclosure if informing the Covered Person won't put the Covered Person at further risk).
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify the Covered Person of the request, or receive satisfactory assurance from the party seeking the Covered Person's health information that efforts were made to notify the Covered Person or to obtain a qualified protective order concerning the information).
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if the Covered Person agrees or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using the Covered Person's health information and treatment of the information during a research project.
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of the Covered Person's health information to the HHS to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with the Covered Person's written authorization. The Covered Person may revoke the authorization as allowed under the HIPAA rules. However, the Covered Person cannot revoke the authorization if the Plan has taken action relying on it. In other words, the Covered Person cannot revoke the authorization with respect to disclosures the Plan has already made.

It is the Plan's policy not to disclose any Covered Person's health information to anyone other than the Covered Person. The Plan will not disclose health information to family members, unless an authorization form is on file, or the Covered Person is a minor. To authorize an individual(s), please contact the Plan to complete the applicable authorization form(s). A Covered Person may change their authorization(s) at any time.

The Covered Person's Individual Rights

The Covered Person has the following rights with respect to the Covered Person's health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This Section of the SPD describes how the Covered Person may exercise each individual right.

Right to Request Restrictions on Certain Uses and Disclosures of the Covered Person's Health Information and the Plan's Right to Refuse

The Covered Person has the right to ask the Plan to restrict the use and disclosure of the Covered Person's health information for treatment, payment, or health care operations, except for uses or disclosures required by law. The Covered Person has the right to ask the Plan to restrict the use and disclosure of the Covered Person's health information to family members, close friends, or other persons the Covered Person identifies as being involved in the Covered Person's care or payment for the Covered Person's care. The Covered Person also has the right to ask the Plan to restrict use and disclosure of health information to notify those persons of the Covered Person's location, general condition, or death, or to coordinate those efforts with entities assisting in disaster relief efforts. If the Covered Person wants to exercise this right, the request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by the Covered Person's written request, by agreement between the Covered Person and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after the Covered Person is notified that the Plan has removed the restrictions. The Plan may also disclose health information about the Covered Person if the Covered Person needs emergency treatment, even if the Plan has agreed to a restriction.

Right to Receive Confidential Communications of the Covered Person's Health Information

If the Covered Person thinks that disclosure of the Covered Person's health information by the usual means could endanger the Covered Person in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If the Covered Person wants to exercise this right, the request to the Plan must be in writing and must include a statement that disclosure of all or part of the information could endanger the Covered Person.

Right to Inspect and Copy the Covered Person's Health Information

With certain exceptions, the Covered Person has the right to inspect or obtain a copy of their health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, the Covered Person does not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny the Covered Person's right to access, although in certain circumstances the Covered Person may request a review of the denial.

If the Covered Person wants to exercise this right, the request to the Plan must be in writing. Within 30 days of receipt of such request (60 days if the health information is not accessible onsite), the Plan will provide the Covered Person with:

- The access or copies the Covered Person requested;
- A written denial that explains why the request was denied and any rights the Covered Person may have to have the denial reviewed or file a complaint; or

- A written statement that the time period for reviewing the request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address the request.

The Plan may provide the Covered Person with a summary or explanation of the information instead of access to or copies of the Covered Person's health information, if the Covered Person agrees in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan does not maintain the health information but knows where it is maintained, the Covered Person will be informed of where to direct the request.

Right to Amend the Covered Person's Health Information That is Inaccurate or Incomplete
The Covered Person has a right to request that the Plan amend the Covered Person's health information in a Designated Record Set; however, there are certain exceptions. The Plan may deny the Covered Person's request for a number of reasons. For example, the Covered Person's request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (for example, psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If the Covered Person wants to exercise this right, the request to the Plan must be in writing, and must include a statement to support the requested amendment. Within 60 days of receipt of the request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why the request was denied and any rights the Covered Person may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing the request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address the Covered Person's request.

Right to Receive an Accounting of Disclosures of the Covered Person's Health Information
The Covered Person has the right to a list of certain disclosures the Plan has made of the Covered Person's health information. This is often referred to as an "accounting of disclosures." The Covered Person generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

The Covered Person may receive information on disclosures of the Covered Person's health information going back for 6 years from the date of the Covered Person's request. The Covered Person does have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To the Covered Person about their own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in the Covered Person's care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or

- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, the Covered Person's right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If the Covered Person wants to exercise this right, the request to the Plan must be in writing. Within 60 days of the request, the Plan will provide the Covered Person with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address the Covered Person's request. The Covered Person may make one request in any 12-month period at no cost to the Covered Person, but the Plan may charge a fee for subsequent requests. The Covered Person will be notified of the fee in advance and have the opportunity to change or revoke the request.

Changes to the Information in This Notice
The Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, the Covered Person will be provided with a revised privacy notice that will be sent to the Covered Person in the same manner as this notice was provided.

Complaints
If the Covered Person believes their privacy rights have been violated, they may file a complaint with the Secretary of Health and Human Services and or with the Plan. The Covered Person will not be retaliated against if they file a complaint. To file a complaint with respect to a violation of the Covered Person's privacy rights, please contact the Privacy Official or its designee.

Contact
For more information on the Plan's privacy policies or the Covered Person's rights under HIPAA, please call the Plan at (617) 288-5999.

The Plan's Legal Duty
The Plan is required by law to protect the privacy of the Covered Person's information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If the Covered Person wishes to inspect their records, receive a listing of disclosures, or correct or add to the information in their record, or if the Covered Person has any questions, complaints, or desire additional information, please contact the following Privacy Officer:

Richard P. Gambino, Administrator
Local 103, I.B.E.W. Health Benefit Plan
256 Freeport Street, 2nd Floor
Boston, MA 02122
(617) 288-5999

The Board of Trustees and the Covered Person's Protected Health Information
The Plan may provide Personal Health Information to members of the Board of Trustees, provided the Trustees have agreed to the restrictions on use and disclosure of Protected Health Information required by HIPAA.

The Trustees must require each of its subcontractors or agents to whom it may provide Protected Health Information to agree to written contractual provisions that impose at least the same obligations to protect the Covered Person's Protected Health Information as are imposed on the Trustee themselves.

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 their use or disclosure of any Protected Health Information received from the Plan:

- The Trustee may not use or disclose any Protected Health Information received from the Plan, except as permitted in the Plan and consistent with the restrictions imposed by the Plan.
- 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 Plan any impermissible or improper use or disclosure of Protected Health Information which they have obtained from the Plan and not authorized by the Plan.
- The Trustee must make Protected Health Information available to the Plan 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 Plan 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 Plan.
- The Trustee must make an individual's Protected Health Information available to permit the Plan 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 Plan and to the HHS or its designee for the purpose of determining the Plan'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 Plan or destroy all Protected Health Information that he received from or on behalf of the Plan. 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 Plan and the duties he engages in for his employer so that Protected Health Information will be used only for the purpose of Plan Administration.

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

SECTION XVIII: OTHER LEGAL REQUIREMENTS

Family and Medical Leave Act (FMLA)
If a Participant takes leave in certain circumstances such as serious illness, birth of a child, or caring for a seriously ill parent or spouse, the Participant's employer may be obligated to continue contributions on the Participant's behalf under the Family Medical Leave Act (FMLA). Participants should discuss with their employer for details.

Continuation of Health Coverage Upon Military Leave (USERRA)
The Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 continues the protection of civilian job rights and benefits for veterans and members of Reserve components. If a Participant is absent from employment due to service in the United States Armed Forces, the Participant may be eligible to continue medical coverage under this Plan for the Participant or the Participant's Eligible Dependents on a self-pay basis for the period of the Participant's military service (to a maximum of 24 months). Please contact the Plan for additional information.

The Newborn's and Mother's Health Protection Act (NMHPA)
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA)
If a Covered Person has had or is going to have a mastectomy, the Covered Person 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:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.
- These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan as described in the Schedule of Benefits.

Contact the Plan for further information.

Qualified Medical Child Support Order (QMCSO)
The Plan shall enroll for immediate coverage under the Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" (QMCSO) or a "National Medical Support Notice" (NMSN) if such an individual is not already covered by the Plan as an Eligible Dependent once the Plan has determined that such order meets the standards for qualification set out in the paragraph below.

The following definitions shall apply for these purposes:

- "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under The Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.
- "Medical Child Support Order" means any judgment, decree, or order (including approval of a domestic relations settlement Agreement) issued by a court of competent jurisdiction that (1) provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law), or (2) enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.
- "Qualified Medical Child Support Order" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under the Plan. In order for such an order to be a QMCSO, it must clearly specify (1) the name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order; (2) a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; (3) the period of coverage to which the order pertains; and (4) the name of this Plan. However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants and Eligible Beneficiaries without regard to this Section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).
- "National Medical Support Notice" is a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a QMCSO that directs the Plan to effectuate coverage for an Alternate Recipient as the dependent child of the noncustodial parent who is (or will become) a Participant covered by the Plan pursuant to a domestic relations order that includes a provision for health care coverage.

Upon receiving a Medical Child Support Order or National Medical Support Notice, the Plan shall as soon as administratively possible (1) notify the Participant and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO, and (2) make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

To give effect to this requirement, the Plan shall (1) establish reasonable, written procedures for determining the qualified status of a Medical Child Support order; and (2) permit any Alternate Recipient to designate

a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to the order.

Within 40-business days of the date of the notice, the Plan shall: (1) notify the state or local agency issuing the NMSN whether coverage is available to the child who is the subject of the notice and, if so, whether the child is covered under the Plan, and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by an official of the issuing agency) to effectuate coverage, and (2) provide to the custodial parent (or official of the governmental agency involved in the notice) a description of the coverage available and any forms or documents necessary to effectuate the coverage.

Contact the Plan to obtain, without charge, a copy of the Plan's QMCSO procedures and further information.

Mental Health and Substance Use Disorder Parity
If any Group Medical Coverage Feature (1) provides both medical and surgical, and mental health or substance use disorder benefits, and (2) is not subject to an Increased Cost Exemption:

- The Group Medical Coverage Feature may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Group Medical Coverage Feature may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any Group Medical Coverage Feature with respect to mental health or substance use disorder benefits shall be made available by the Plan (in accordance with the Wellstone Act) to any current or potential Participant upon request.
- The reason for any denial under the Plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or as otherwise required under the Wellstone Act, be made available by the Plan to the Participant in accordance with the claims procedures applicable to the Group Medical Coverage Feature.
- The Plan shall be operated and construed in all respects in compliance with the MHPA and the Wellstone Act.

"Mental health benefits" and "substance use disorder benefits" mean benefits with respect to items or services for mental health conditions and substance use disorders, respectively, and shall be as defined in the Welfare Benefit Contract applicable to the Group Medical Coverage Feature, pursuant to applicable state and Federal law, and consistent with generally recognized independent standards of current medical practice.

Genetic Nondiscrimination
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of individuals or their family members. "Genetic information" that should not be disclosed pursuant to GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, genetic information of a

fetus carried by an individual or an individual's family member, and genetic information of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Availability of Health Insurance Marketplace Under PPACA
As part of the implementation of the Affordable Care Act (ACA), there is a new way for some people to buy health insurance known as the "Health Insurance Marketplace" (this might have been called a "Marketplace" or "Exchange"). This new way to buy insurance began January 1, 2014 and allows health consumers the ability to find and compare insurance options that private insurance companies will provide.

Discrimination is Against the Law
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as qualified interpreters and Information written in other languages

If you need these services, contact Richard P. Gambino, Administrator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Richard P. Gambino, Administrator, 256 Freeport Street, 2nd Floor, Boston, MA 02122, phone (617) 288-5999, fax (617) 288-6696. If you need help filing a grievance, Richard P. Gambino, Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-(800) 564-5999.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

1(800) 564-5999

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1(800) 564-5999

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1(800) 564-5999

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1(800) 564-5999 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1(800) 564-5999

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1(800) 564-5999

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1(800) 564-5999

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1(800) 564-5999

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1(800) 564-5999

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguisticos, grátis. Ligue para 1(800) 564-5999

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1(800) 564-5999

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। ' 1(800) 564-5999 पर कॉल करें।

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1(800) 564-5999

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1(800) 564-5999

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1(800) 564-5999

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1(800) 564-5999

APPENDIX

LOCAL 103, I.B.E.W. HEALTH BENEFIT PLAN

Welfare Benefit Information	Eligibility Requirements	For More Information
Local 103, I.B.E.W. Health Benefit Plan	See Section I – Eligibility	(617) 288-5999 or (800) 564-5999 Local 103, I.B.E.W. Health Benefit Plan 256 Freeport Street, 2nd Floor Boston, MA 02122 www.trustfunds103.com

Please Note: Provisions may change after the date of this Summary Plan Description document. Benefits are not vested. Contact the Plan if the Covered Persons have questions regarding current benefits.

APPENDIX SCHEDULE A

MASTER PLAN AND NORMAL RETIREE PLAN MEDICAL SCHEDULE OF BENEFITS

Out-of-Pocket Maximums	In-Network	Out-of-Network
Medical Out-of-Pocket Maximum Out-of-Pocket Maximum per Plan Year *This is the total of the Covered Person's copayments and coinsurance*	**Medical** $4,600 per individual; $9,200 per family	**Medical** Unlimited
Prescription Drug Out-of-Pocket Maximum Out-of-Pocket Maximum per Plan Year *This is the total of the Covered Person's copayments and coinsurance*	**Prescription Drug** $2,000 per individual; $4,000 per family	**Prescription Drug** Unlimited

APPENDIX SCHEDULE A

MASTER PLAN AND NORMAL RETIREE PLAN MEDICAL SCHEDULE OF BENEFITS

Covered Services	Participant's Cost In-Network	Participant's Cost Out-of-Network
Emergency Room Services Emergency room Visits	$100 copayment, (waived if admitted)	$100 copayment (waived if admitted)
Ambulance Services • Hospital transfers • Med flight or other	 $0 10% coinsurance	 10% coinsurance 10% coinsurance
Inpatient Medical and Surgical Benefits per 90 Days * (including maternity care) ** Room and board beyond 90 days and miscellaneous charges beyond 90 days paid at 80%* Acute Care or Rehabilitative Hospital	$200 copayment/admission	20% coinsurance
Mental Hospital or Substance Abuse Facility	$200 copayment/admission	20% coinsurance
Skilled Nursing Facility following 3 days of hospital confinement (up to 90 days less hospital, home health care, and previously used a Skilled Nursing Facility)	$0	20% coinsurance
Short-term Rehabilitation Therapy: Cardiac, physical, and occupational therapies	$20 copayment/visit	20% coinsurance
Outpatient Benefits Clinic visits; physicians', podiatrists', acupuncturists', and chiropractors' visits *($500 podiatrist, $2,500 podiatry surgery $300 acupuncture, and $400 chiropractic benefit maximums)*	$20 copayment/visit	20% coinsurance
Speech Therapy	$20 copayment/visit	20% coinsurance
Oxygen and Respiratory Therapy	$0	20% coinsurance
Pain Management ($2,500 benefit maximum)	$20 copayment/visit	20% coinsurance
Diagnostic Lab Tests and X-Rays	$0	20% coinsurance
Diagnostic Imaging: MRIs, CAT, and PET scans • In Hospital • Other locations including free-standing facilities with no hospital affiliation or doctor's office	 $200 copayment $0	 20% coinsurance 20% coinsurance
Home Health Care and Hospice Services	$0	N/A
Prosthetic Devices	$0	20% coinsurance
Durable Medical Equipment	$0	20% coinsurance

APPENDIX SCHEDULE A

MASTER PLAN AND NORMAL RETIREE PLAN MEDICAL SCHEDULE OF BENEFITS

Covered Services	Participant's Cost In-Network	Participant's Cost Out-of-Network
Surgery and Related Anesthesia • Hospital • Day surgical center • Office and health center services	 $200 copayment $0 $20 copayment	 20% coinsurance 20% coinsurance 20% coinsurance
Preventive Care Routine Pediatric Care Exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • 3 visits during the second year of life (ages 1 to 2) • 2 visits for age 2 • 1 visit per calendar year from age 3 through age 18	$0	20% coinsurance
Routine Adult Physical Exams, including related tests, for members age 19 or older (one per calendar year)	$0	20% coinsurance
Routine GYN Exams, including related lab tests (1 per calendar year)	$0	20% coinsurance
Routine Hearing Exams, including routine tests	$20 copayment/visit	20% coinsurance
Routine Sigmoidoscopy, Colonoscopy, or Barium Enema	$0	20% coinsurance

APPENDIX SCHEDULE B

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Covered Services	Participant's Cost In-Network	Participant's Cost Out-of-Network
Retail Prescriptions 30-day supply (2 refill maximum)	$15 Generic/$25 Brand Name	N/A
Mail Order Prescriptions 90-day supply	$15 Generic/$25 Brand Name	N/A
Lost Card Replacement Fee	$10	N/A

APPENDIX **SCHEDULE C**

SUPPLEMENTAL MEDICAL PLAN

Supplemental Benefit	Participant's Cost
Part A Inpatient Hospital Copayment	$200 per Benefit Period
Part B Medical Services and Supplies	Annual Medicare Part B Deductible
Outpatient Psychiatric Care	$0, Up to a Maximum $250 per year
Other Outpatient Care • Acupuncture ($300 maximum) • Chiropractic ($400 maximum) • Physical Exam (1 per year, up to a maximum of $250) • Vision Exam, eyeglasses and contacts (see Schedule F) • Podiatry Benefits ($500 maximum) • Dental Benefits (see Schedule E) • Shingle Shot (1 per lifetime, up to a maximum of $125)	$0

APPENDIX **SCHEDULE D**

NORMAL RETIREE AND SUPPLEMENTAL PLAN PREMIUMS

Premiums; ***If the Participant is…***	***… and any Eligible Dependents are …***	***The Monthly Premium is …***
Eligible for Medicare (Supplemental Retiree Plan)	Eligible for Medicare (Supplemental Retiree Plan)	$150
Not Eligible for Medicare (Normal Retiree Plan)	Eligible for Medicare (Supplemental Retiree Plan)	$300
Not Eligible for Medicare (Normal Retiree Plan)	Not Eligible for Medicare (Normal Retiree Plan)	$300
Eligible for Medicare (Supplemental Retiree Plan)	Not Eligible for Medicare (Normal Retiree Plan)	$300
Retired before March 1, 1996 (Supplemental Retiree Plan)	---	$50

Note A: If any Participant, Spouse or Dependent is covered by the Normal Retiree Plan, the monthly premium is $300
Note B: A Spouse of a deceased Normal Retiree Participant pays $300
Note C: A Spouse of a deceased Supplemental Plan Retiree pays $150 unless retired prior to 1996
Note D: If any Participant, Spouse or Dependent is covered by Medicare Part D, the annual premium is $800

Dependent Coverage after a Participant's Death:	***Premium for First 5 Years***	***After the First 5 Years, the Monthly Premium is …***
If the Participant was covered under Master Plan	$0	The monthly premium for continued coverage after the initial 5-year period will be the then current hourly rate from the Collective Bargaining Agreement multiplied by 144 hours (currently $13 per hour x 144 hours = $1,872 per month)
If the Participant and all Eligible Dependents were covered under Normal Retiree Plan	$300	
If all Dependents are Eligible for Medicare and covered under the Supplemental Medical Plan	$150	
If the Participant retired prior to March 1, 1996	$50	

APPENDIX **SCHEDULE E**

DENTAL PLAN

Dental Category/Procedure	Qualifications	In-Network	Out-of-Network*
Deductible	None		
Maximum Benefit per Calendar Year (all covered procedures)	$1,000 per Covered Person		
Preventive		100%	100%
Teeth Cleaning	Twice per calendar year.		
Fluoride Treatments	Twice per calendar year for members under age 19.		
Space Maintainers	Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.		
Sealants	Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.		
Diagnostic		100%	100%
Comprehensive Evaluation	Once every 60 months.		
Periodic Oral Exam	Twice per calendar year.		
Panoramic or Full Mouth X-rays	Once every 60 months.		
Bitewing X-rays	Twice per calendar year.		
Single Tooth X-rays	As needed.		
Restorative		80%	80%
Silver Fillings	Once every 24 months per surface per tooth.		
White Fillings (Front Teeth)	Once every 24 months per surface per tooth.		
Inlays and White Fillings (Back Teeth)	Covered only for single surfaces. Once every 24 months per surface per tooth; multi-surfaces will be processed as a silver filing and the patient is responsible up to the submitted charge.		
Protective Restorations	Once per tooth.		
Stainless Steel Crowns	Once every 24 months per tooth (on primary teeth only).		
Oral Surgery		80%	80%
Extractions	Once per tooth.		
General Anesthesia	General Anesthesia and IV sedation allowed with covered surgical impacted wisdom teeth only (up to one hour).		
Periodontics (on natural teeth only)		80%	80%
Periodontal Surgery	One surgical procedure per quadrant in 36 months.		
Scaling and Root Planing	Once in 24 months, per quadrant. No more than 2 quadrants per date of service.		
Periodontal Cleaning		100%	100%

APPENDIX **SCHEDULE E**

DENTAL PLAN

Dental Category/Procedure	Qualifications	In-Network	Out-of-Network*
Bone Grafts/GTR	Once every 3 months following active periodontal treatment. Not to be combined with preventive cleanings. No more than 2 teeth per quadrant per 36 months on natural teeth.	80%	80%
Endodontics Root Canal Treatment Root Canal Retreatment Vital Pulpotomy	 Once per tooth. Once per tooth after 24 months have elapsed from initial treatment. Limited to deciduous teeth.	80%	80%
Prosthetic Maintenance Bridge or Denture Repair Crown or Onlay Repair Rebase or Reline of Dentures Recement of Crowns & Onlays, Bridges	 Once per bridge/denture per 12 months, after 24 months of initial insertion. Once per tooth per 12 months after 24 months of initial placement. Once per denture within 36 months. Once per crown, onlay or bridge.	80%	80%
Emergency Dental Care Palliative Treatment	 Three occurrences in 12 months.	80%	80%
Prosthodontics Dentures Fixed Bridges Implants Implant Abutments	 Once within 60 months (age 16 and older). Once within 60 months (age 16 and older). Once per 60 months per implant. (Pre-estimate recommended). Once per implant only when surgical implant is benefitted.	80%	80%
Major Restorative Crowns or Onlay Cast Posts/Buildups	 When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older). Once per tooth per 60 months only benefitted to retain a crown.	80%	80%
Orthodontia	Orthodontic services.	80%	80%

*Non-participating dentists may balance bill. Covered Persons are responsible for the difference between the non-participating maximum plan allowance and the full fee charged by the dentist.

Pre-Treatment Estimates: Ask the dentist to submit a pre-treatment estimate for any procedure that exceeds $300. This will help estimate any out-of-pocket expenses and will confirm that the services are covered under the Plan.

APPENDIX **SCHEDULE F**

VISION AND HEARING AID PLAN

Vision Service or Supply	**Dollar Maximum Payable by the Plan**
Eye Examination per Benefit Period	$60 per Covered Person, Every 2 years
Prescription Eyeglasses/Contacts per Benefit Period	$150 per Covered Person, Every 2 years
Hearing Service or Supply	**Dollar Maximum Payable by the Plan**
Hearing Aid Equipment per Benefit Period	• 1 Ear $1,600, Every 4 years • 2 Ears $3,200, Every 4 years • Batteries or Service $100, per Year, per Ear

APPENDIX **SCHEDULE G**

ADOPTION BENEFITS

Service	Dollar Maximum Payable by the Plan
Adoption Expenses	$350 per Child

APPENDIX **SCHEDULE H**

CURRENT VENDORS USED BY THE PLAN

Medical PPO Network

Blue Cross Blue Shield of Massachusetts
101 Huntington Avenue, Suite 1300
Boston, MA 02199
Phone: (617) 800 -2653
Fax: (617) 246-0193
www.bcbsma.com

Prescription Drug Coverage

CVS/Caremark Corporation
One CVS Drive
Woonsocket, RI 02895
Mail Phone: (401) 765-1500
Fax: (800) 378-0323
Prescription Help Line: (800) 966-5772
Mail Order Program: (888) 216-5022
www.cvscaremark.com

Dental Network

Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129
www.deltadentalma.com

Vision Care

Davis Vision
Capital Region Health Park, Suite 301
711 Troy-Schenectady Road
Latham, NY 12110
Phone: (800) 999-5413
www.davisvision.com

Mental Health/Substance Abuse

*Modern Assistance Program*s, *Inc. (MAP)*
1400 Hancock Street
Quincy MA 02169
Phone: (617) 774-0331
Fax: (617) 774- 0336
www.modernassistance.com

Life Insurance and AD&D Insurance

American General Life Insurance Companies
99 High Street
Boston, MA 02110
Phone: (617) 290-609
Fax: (617) 457-6868
Travel Assistance
Phone: (800) 401-2678
Policy # 994054
www.Aigbenefits.com