IBEW Local 300 Benefit Trust Fund

Health and Welfare Plan for the Construction and Utility Groups

Summary Plan Description

Effective July 1, 2021

IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
802-864-5864

Dear Participants and Eligible Dependents:

We are pleased to provide you with this updated Summary Plan Description ("SPD"), which describes in detail the benefits available to you and your Eligible Dependents through the IBEW Local 300 Health and Welfare Plan (the "Plan"). The SPD is intended to constitute the written SPD and Plan Document in accordance with the Employee Retirement Income Security Act of 1974 ("ERISA").

This Summary Plan Description describes all benefits available to Participants in the Health and Welfare Plan. If a benefit, treatment, coverage or other related item is not specifically described in this document, it is not covered by the Health and Welfare Plan.

We all recognize the need for a comprehensive personal medical coverage program that provides hospital, doctor, prescription drug, vision care, and dental benefits. It is also important for you to have continuation of income during periods of total disability, and the benefit of Life Insurance to provide financial protection for your family.

However, many of us would find the costs of such coverage beyond our financial means if we had to pay for all of it out-of-pocket. The Trustees are pleased to be able to provide these benefits to you and your Eligible Dependents through the IBEW Local 300 Health and Welfare 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 SPD can continue to be made available to you.

You and your family will be able to take full advantage of the benefits offered through this Plan, only if you are aware of all of the provisions of the Plan and the wide scope of services the Plan covers. This SPD furnishes a description of the benefits to which Participants and Eligible Dependents are entitled, the rules that govern these benefits, and the procedures that must be followed when making a claim. We have also included, in the back of this SPD, certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Trustees reserve the right to amend, modify, or discontinue all or part of this plan whenever, in their judgment, conditions so warrant. The Trustees have complete discretionary authority to determine eligibility for benefits under the Plan or to construe and interpret the terms of the Plan, including ambiguous or disputed terms and meanings, and any other instruments or policies of the Plan. The Trustees have discretionary authority to make all factual findings.

This SPD replaces all other Summary Plan Descriptions previously published by the Trustees. We suggest you read this SPD carefully in order to fully understand the benefits to which you and your Eligible Dependents may be entitled. If you have any questions on claims payment, benefit coverage, or eligibility rules, please call the Fund Office at (802) 864-5864 ext. 14.

Sincerely,

Board of Trustees, IBEW Local 300 Health and Welfare Plan

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SECTION 1. IMPORTANT NOTICES

TRUSTEES' AUTHORITY AND DISCRETION

The Trustees have complete discretionary authority to interpret and apply the provisions of the Plan including, but not limited to, determinations of eligibility for benefits, the right of individuals to participate, the manner by which contributions are credited and the level, extension or discontinuance of benefits. The Trustees have complete discretionary authority to construe and interpret the terms of the Plan and/or any other policy or instrument including ambiguous or disputed terms and meanings. Furthermore, the Trustees have discretionary authority to make all factual findings.

LIMIT ON AUTHORITY OF NON-TRUSTEES

No Local Union, Local Union Officer, Business Agent, Local Union Member, Employer or Employer Representative, Fund Office employee, attorney or consultant is authorized to speak for or to commit the Board of Trustees on any matter without express written authority from the Trustees.

TRUSTEES' RIGHT TO AMEND, MODIFY OR DISCONTINUE BENEFITS AT ANY TIME

The Trustees reserve the right to amend, modify, or discontinue all or part of these benefits provided by this Plan whenever, in their judgment, conditions so warrant. Benefits, rules governing eligibility and other provisions may change after the date of this SPD. Benefits are not vested. Contact the Fund Office if you have questions regarding current benefits.

YOUR RESPONSIBILITY FOR SELECTION OF PROVIDERS

The selection of medical professionals and service providers is your 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 of Trustees disclaims any responsibility for the qualification or action of any provider of goods or services under the Plan.

FOREIGN LANGUAGE ASSISTANCE/SI NO HABLA INGLES

If you do not understand English and have a question about the benefits or the rules of the Plan, contact the Fund Office for assistance.

Si usted no entiende inglés y tiene una pregunta acerca de los beneficios o las reglas del Fondo, llame la oficina de Fondo para asistencia.

SECTION 2. BASIC INFORMATION

NAME OF PLAN

IBEW Local 300 Health and Welfare Plan

ADDRESS OF PLAN

3 Gregory Drive

South Burlington, VT 05403

(802) 864-5864

EMPLOYER IDENTIFICATION NUMBER / PLAN NUMBER

23-7293087 / 501

FISCAL YEAR OF THE PLAN (PLAN YEAR)

July 1 through June 30. However, medical benefits run on a calendar year basis. For example, deductibles and out-of-pocket limits accrue from January 1 through December 31.

TYPE OF PLAN

The IBEW Local 300 Health and Welfare Plan is a group health plan that provides medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment and short-term disability benefits.

PLAN SPONSOR/PLAN ADMINISTRATOR

IBEW Local 300 and Contributing Employers established and maintain the Plan. Participants of the Plan can receive from the Fund Office, upon written request, information as to whether a particular Employer or Employee organization is a Contributing Employer to the Plan. If the Employer or Employee organization is a Contributing Employer to the Plan, the Fund Office will provide the Employer's address. Pursuant to ERISA, the Board of Trustees is considered to be the Plan Sponsor and Plan Administrator. The address of the Board of Trustees is:

Board of Trustees
IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403

TYPE OF ADMINISTRATION OF THE FUND

The Plan is administered and maintained by a joint Board of Trustees consisting of three (3) Union Trustees and three (3) Employer Trustees. The Board of Trustees is governed by the Trust Agreement established and maintained in accordance with Collective Bargaining Agreements.

The Fund Office currently handles the day-to-day administration of the benefits under this Plan, including your medical and hospitalization benefits, on behalf of the Trustees. Certain benefits under the Plan are fully insured, such as the life insurance and accidental death and dismemberment benefits. Some benefits, such as medical coverage, are self-insured by the Plan.

SUMMARY OF BENEFITS

The Plan provides group health coverage through a High Deductible Health Plan ("HDHP"). In order to help Participants cover out-of-pocket health care expenses, the Plan also makes available to Participants either a Health Reimbursement Arrangement ("HRA") or a Health Savings Account ("HSA"). The HRA and HSA are both currently administered by Further. Eligibility to participate in the HRA is limited to those Participants who are ineligible to participate in the HSA or have Eligible Dependents who are ineligible to participate in the HSA. This SPD provides you with general information about both the HSA and HRA, and how they work. Please note, however, that while the Plan has chosen to include general information concerning the HSA in this SPD, the HSA is an individually-owned account that is not a part of the Plan nor covered by the Employee Retirement Income Security Act of 1974 ("ERISA"). In addition, you must meet the HSA eligibility requirements on an on-going basis, therefore, you cannot rely on the Plan to make this determination as the Fund Office will not always be aware of certain factors that may affect your HSA eligibility.

The Plan provides Life and Accidental Death & Dismemberment coverage through an insurance carrier, currently The Union Labor Life Insurance Company (ULLICO). This SPD includes a certificate of insurance from ULLICO which sets forth the benefits payable, exclusions for which no benefits will be paid, conversion rights, and rules pertaining to continuation of the Life Insurance in the event of total disability.

The Plan provides Disability coverage which is self-funded by the IBEW Local 300 Plan and administered by Northeast Benefits Management. This SPD includes a summary of the benefits payable and exclusions for which no benefits will be paid with respect to this benefit.

The Plan provides Dental coverage through an administrative arrangement with CBA BLUE. This SPD provides a summary of benefits offered by the Plan through the arrangement with CBA BLUE Dental Plan that outlines the services covered, and the amount of co-insurance payments to the provider you are responsible for when you receive dental services.

For Vision care, the CBA BLUE EPO medical provides routine eye exams once every year. In addition, the Plan maintains a Vision coverage program through VSP to cover Participants' annual cost of eyeglasses, lenses and certain other optical equipment supplies. This SPD provides a summary of these benefits as offered by the Plan that outlines coverage and the amount of the allowed benefits under the terms of the Plan.

BOARD OF TRUSTEES

Union Trustees	Management Trustees
Mr. Timothy J. LaBombard IBEW Local Union No. 300 3 Gregory Drive South Burlington, VT 05403 Phone: ..... (802) 864-5864 Fax: ..... (802) 864-5495	Ms. Jane Brown Brown Electric Company, Inc. 440 Shunpike Road Williston, VT 05495 Phone: ..... (802) 863-2060 Fax: ..... (802) 660-4341
Mr. Timothy J. Watkins IBEW Local Union No. 300 3 Gregory Drive South Burlington, VT 05403 Phone: ..... (802) 864-5864 Fax: ..... (802) 864-5495	Mr. Kenneth Douglas, Jr. Sherwin Electric Company, Inc. 7A Morse Drive Essex Junction, VT 05452 Phone: ..... (802) 878-4041 Fax: ..... (802) 879-2788
Mr. Brian Ritz IBEW Local Union No. 300 3 Gregory Drive South Burlington, VT 05403 Phone: ..... (802) 864-5864 Fax: ..... (802) 864-5864	Mr. Jeffrey Peck Peck Electric Company 4050 Williston Road, Suite 511 South Burlington, VT 05403 Phone: ..... (802) 658-3378 Fax: ..... (802) 658-3527

The Trustees have complete discretionary authority to determine eligibility for benefits under the Plan or to construe and interpret the terms of the Plan, including ambiguous terms and meanings, and any other instruments or policies of the Plan.

PLAN ADMINISTRATION / FUND OFFICE

Pursuant to ERISA, the Board of Trustees is considered the "Plan Administrator." The Plan is administered by and for the Trustees through the Fund Office:

IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
Telephone Number: (802) 864-5864 ext. 14
Fax Number: (802) 862-6379

The Fund Office is open Monday through Friday, excluding holidays, from 8:00 a.m. until 4:30 p.m.

AGENT FOR THE SERVICE OF LEGAL PROCESS

Aaron Krakow, Attorney
Krakow Souris & Landry, LLC
225 Friend Street
Boston, MA 02114-1896
Telephone Number (617) 723-8440

Service of legal process also may be made on any Trustee or on the Plan Administrator.

LEGAL COUNSEL

Aaron Krakow, Attorney
Krakow Souris & Landry, LLC
225 Friend Street
Boston, MA 02114-1896
Telephone Number (617) 723-8440

COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to various Collective Bargaining Agreements. You may obtain copies of these Agreements upon written request to the Plan Administrator or the Union, and they are available for examination at the Health and Welfare Fund Office.

Participants in the Plan can receive from the Fund Office, upon written request, information as to whether a particular Employer or employee organization is a Contributing Employer under the Plan, as well as the Contributing Employer's address.

Copies of the latest Collective Bargaining Agreement or Agreements are available for examination by visiting the Fund Office or may be obtained for a nominal charge by writing to the Fund Office.

SOURCE OF CONTRIBUTIONS

Contributions to the Plan are made primarily by Contributing Employers in accordance with Collective Bargaining Agreements. The Collective Bargaining Agreements generally require contributions to the Plan at a fixed rate per hour.

Employees and their Eligible Dependents generally do not contribute to the Plan except in the following circumstances for which continuation of coverage on a self-payment basis is permitted by the Plan: (1) Eligible Employees and Eligible Dependents may self-pay to continue coverage under COBRA; and (2) Eligible Employees who take a qualified military leave of absence exceeding thirty-one (31) days may self-pay to continue coverage under USERRA. In such cases, the Board of Trustees will determine the amount of the required self-payments

based upon the cost of providing the coverage and any additional amounts for related administrative costs as permitted by law.

FUNDING MEDIUM

The Trustees hold the assets and reserves of the Health and Welfare Plan in trust, in a Trust Fund pursuant to the Agreement and Declaration of Trust. Contributing Employers contribute to the Plan at the hourly rates established by and in accordance with the Collective Bargaining Agreements.

INSURANCE COMPANIES

The Plan's life insurance benefits and accidental death and dismemberment benefits are provided under a group insurance policy issued to the Plan by:

The Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910

The Plan's vision benefits are provided under a group insurance policy issued to the Plan by:

VSP
333 Quality Drive
Rancho Cordova, CA 95670

SELECTION OF PHYSICIANS AND FACILITIES

The Plan pays benefits for certain health care expenses, but the Plan does not act as provider of hospital or medical services. Accordingly, the Plan is not responsible for any acts or omissions by hospitals or other facilities, or by physicians, other medical professionals, or any facility staff member or employee thereof.

NO RETROACTIVE RESCISSIONS OF COVERAGE

The Plan will not retroactively rescind its coverage of medical, prescription drug, dental or vision benefits. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, this does not apply if you commit fraud or make an intentional misrepresentation of a material fact. You are obligated by law to disclose information to the Plan, for example, Medicaid eligibility, divorce, and remarriage (you or your ex-Spouse). Coverage that is terminated due to the failure to pay premiums, where applicable, is not considered a rescission. In such a case, coverage will be terminated effective from the beginning of the period for which the premium was due.

PLAN CHANGE OR TERMINATION

The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits available under the Plan and the eligibility rules for extended or accumulated eligibility, even if eligibility already has been extended or accumulated. The Board of Trustees also reserves the right to change or increase the cost of coverage charged to all Employees, or to any class or classes of Employees.

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

1. Are not guaranteed;
2. Are not vested;
3. May be changed or discontinued by the Board of Trustees at any time;
4. Are subject to the Trust Agreement which establishes and governs the Plan's operations; and
5. Are subject to the provisions of any group insurance policies purchased by the Board of Trustees. The nature and amount of benefits under the Plan are always subject to the actual terms of the Plan as it exists at the time the claim for benefits is made.

> **Note:** Your Health Savings Account (HSA) is an individually-owned account and is **not** a plan benefit, nor is it subject to ERISA.

If the benefits under the Plan are changed or discontinued, it will not affect you or your Eligible Dependent's right to the payment of any benefit if, and to the extent that, the claim for benefits has already been made.

> **ANY BENEFITS NOT DESCRIBED IN THIS DOCUMENT ARE NOT PART OF THE IBEW LOCAL 300 HEALTH AND WELFARE PLAN UNLESS AMENDED BY THE TRUSTEES.**
>
> **BENEFITS AND ELIGIBILITY RULES DESCRIBED IN THIS DOCUMENT ARE THE ONLY BENEFITS AND ELIGIBILITY RULES THAT APPLY TO PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS UNLESS AMENDED BY THE TRUSTEES.**

From time to time, you may receive one or more "Summary of Material Modifications (SMM)" that will notify you of certain modifications that were made to the SPD. These SMMs are considered a part of this SPD and Plan Document. We suggest you keep all SMMs with this SPD/Plan Document in a safe place.

SECTION 3. ELIGIBILITY RULES FOR THE CONSTRUCTION GROUP

BASIC ELIGIBILITY RULES

Eligibility Rules for Employees except Construction Wiremen and Construction Electricians

The following Employees may become eligible for coverage if required contributions are paid to the Plan on their behalf and if they:

1. Are Employees of Contributing Employers; and

2. Are working under the jurisdiction of a Collective Bargaining Agreement entered into with a Union that requires the Contributing Employer to make periodic payments to the Health and Welfare Plan for the purpose of providing and maintaining coverage for medical and certain welfare benefits, or under an agreement requiring reciprocation of such payments, or under the terms of a Participation Agreement between the Employer and the Board of Trustees to make such payments.

After your coverage becomes effective, your eligibility will continue during each calendar month for which sufficient contributions are made to the Plan on your behalf because of credited hours of Covered Employment from one or more Contributing Employers and shall continue for the period until all banked hours are exhausted.

Subject to the Plan's generally applicable eligibility requirements, apprentices in the Construction Group are eligible for benefits under the Plan for themselves only, until they have completed Period 4 of the Apprenticeship Program. Any Dependent of a Construction Group apprentice is not eligible to receive benefits under the Plan until the first day of the calendar month following the month in which the Participant completes Period 4 of the program.

Eligible Dependents (for all classifications except Construction Wireman and Construction Electricians)

- **Eligible Dependents** for the purposes of this Plan are defined as the Participant's Spouse (the individual to whom the Participant is legally married under federal and state law and with whom the Participant can file a joint federal income tax return), and the Participant's children (biological, legally adopted, placed with the Participant for adoption and stepchildren) through the end of the month in which such children turn age 26. Remember, when you add or remove your Spouse or Eligible Dependents, your type of membership (individual, two-person, or family) may change.

- You may add or remove your Spouse or Eligible Dependents from your membership under the conditions noted in this Section. To add or remove your Spouse or Eligible Dependent(s), please contact the Fund Office.

- You must cover either all of your Eligible Dependents or none of your Dependents who are eligible under the Plan unless otherwise ordered by a court of law.

Coverage for Incapacitated Adult Dependent Children

Coverage may continue under the eligibility rules with respect to incapacitated Dependent children over age 26. To be eligible for this coverage, the Plan will require you to provide proof of the continuing existence of a qualifying disabling condition of the incapacitated Dependent child. If you elect this coverage, you will be required to submit the following documentation to the Fund Office:

- An application form for incapacitated Dependent child(ren), which can be obtained from the Fund Office; and
- A physician certification of the extent and nature of the disability.

The Fund Office will review this information and determine whether the Dependent is incapacitated under the terms of the Plan before providing/continuing coverage. To avoid interruption of coverage, the Fund Office must receive the above information within 60 days of the date the individual would otherwise lose coverage under the Plan. If the Fund Office receives the above information later than 60 days after the date the individual would no longer be an Eligible Dependent, coverage will begin the first day of the month after the Fund Office receives the required information. This could result in interruption of coverage for the incapacitated Dependent child. If a Dependent who is 26 years old or older ceases to be incapacitated, the Dependent becomes ineligible for coverage at the end of the month in which the incapacity ceases, and you must remove the Dependent from your membership by contacting the Fund Office.

Incapacitated Adult Dependent Child Coverage.

Incapacitated adult Dependent children who are enrolled in Medicare may qualify for partial reimbursement of their monthly Medicare Supplement and Medicare Part D premiums. The benefit will be available to the incapacitated adult Dependents of Medicare-eligible Participants who retire and participate in the IBEW Local 300 Health & Welfare Fund retiree reimbursement program for their Medicare Supplement and Medicare Part D policies. If the incapacitated adult Dependent is also enrolled in Medicare and was eligible for coverage under the Plan at the time of the Participant's retirement, the Dependent will receive a 50% reimbursement of their monthly Medicare Supplement and Medicare Part D premiums. Reimbursement shall be paid following receipt by the Fund Office of satisfactory proof that the premiums for the respective policies have been paid.

Eligibility for Construction Wireman and Construction Electricians

If you are working as a Construction Wireman or Construction Electrician as described in the IBEW Local 300 Unit 1 Collective Bargaining Agreement, you are eligible for coverage for only yourself, unless your Employer chooses to remit contributions on behalf of your family. If you transfer to another classification at any time, you will be offered coverage for your Eligible Dependents.

OPEN ENROLLMENT

Open Enrollment is the period of time each year, as designated by the Plan Administrator, during which Eligible Employees and qualified beneficiaries eligible for COBRA may make the elections specified below. In addition, retirees will have the opportunity to opt out of retiree coverage during this time. Enrollment forms and information regarding electing coverage or opting out of coverage may be obtained from the Fund Office.

Currently, Open Enrollment is held twice each calendar year: from June 1 through June 30 and from December 1 through December 31. Elections made during the June Open Enrollment period generally become effective July 1. Elections made during the December Open Enrollment period generally become effective January 1.

The Trustees reserve the right to change the dates of the Open Enrollment periods and/or discontinue offering one or both Open Enrollment periods.

Elections Available During Open Enrollment

During the Open Enrollment period, you may elect to enroll yourself and your Eligible Dependents who are eligible for coverage under the Plan. You may also add/drop Eligible Dependents to/from the coverage or opt out of the coverage being offered under the Plan.

Restrictions on Elections During Open Enrollment

No Dependent may be covered unless you are covered. You and all your covered Eligible Dependents must be enrolled in the same coverages. In order to ensure that your coverage will begin on the applicable effective date, all relevant parts of the enrollment form must be completed and the form must be submitted to the Fund Office along with proof of Dependent status (as requested) before the end of the Open Enrollment period.

Start of or Changes to Coverage Following Open Enrollment

If you or your Spouse or Dependent Child(ren) are enrolling for the first time or discontinuing coverage during an Open Enrollment period, such changes will become effective on the first day of the month following the end of the applicable Open Enrollment period.

Failure to Enroll During Open Enrollment

If you fail to enroll yourself and/or any of your Eligible Dependents within the Open Enrollment period, you will not be able to enroll yourself and/or any of your Eligible Dependents until the next Open Enrollment period (assuming you are benefits-eligible at that time), unless you have a Special Enrollment event, as described below.

SPECIAL ENROLLMENT

If you decline enrollment for yourself or your Eligible Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Eligible Dependents in this Plan if you or your Eligible Dependents lose eligibility for that other coverage (or if the Employer stops contributing toward your or your Eligible Dependents' other coverage). However, you must request enrollment within 60 days after your or your Eligible Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

If you or your Eligible Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under this Plan, the Plan must allow you to enroll if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in this Plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

To request special enrollment or obtain more information, contact the Fund Office.

ENROLLMENT PAPERWORK

In order to become covered under the Plan, you must enroll yourself and any Eligible Dependents for coverage within thirty (30) days following the satisfaction of your eligibility requirements. Construction Group Participants currently become eligible for coverage under the Plan on the first day of the calendar month following the month in which you accumulate (and the Plan receives contributions for) 500 hours of Covered Employment within the previous 12 months for one or more Contributing Employers.

You and your Dependents (if eligible for Dependent coverage) will be enrolled when a benefit enrollment form is completed, signed, and delivered to the Fund Office within this 30-day time limit. If you do not return the completed, signed benefit enrollment form within thirty (30) days following the satisfaction of your eligibility requirements, you will be enrolled in Employee-only coverage using information received from the Union. If your Dependents are eligible for coverage, they will not be enrolled until the next open enrollment period (provided the Participant is eligible for Plan coverage), unless they become eligible through a special enrollment period. The current open enrollment periods occur in June (for July 1st coverage) and December (for January 1st coverage).

TERMINATION/CHANGES OF COVERAGE

Termination of Coverage

Coverage will terminate on the earliest of the following dates:

1. The date the Plan terminates;
2. The date you no longer satisfy the eligibility rules for such coverage; or
3. The date you die (See "Spouse and Dependents' Coverage After a Participants' Death" for additional information).

The Trustees may, in their sole discretion, from time to time, change or discontinue all or any part of the benefits for Participants and Eligible Dependents. Such change or discontinuance may be retroactive as determined in the sole discretion of the Trustees. This right to change, modify, or discontinue 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.

ELIGIBILITY AND "HOURS BANK" PROVISIONS: COLLECTIVELY BARGAINED EMPLOYEES

Date of Eligibility

You will become eligible for coverage under the Plan on the first day of the calendar month following the month in which you accumulate 500 hours of Covered Employment within the previous 12 months for one or more Contributing Employers. This is true only if the required contributions have been made on your behalf to the Plan by the Contributing Employers.

For newly organized Employees, an amount that would allow "Initial Eligibility" (currently 500 hours times the contribution rate in effect) can be accepted as a lump sum payment from Contributing Employers on behalf of such Employees. Any such Employees are afforded coverage on the first of the month after the contributions are credited on their behalf.

Newly organized Employers with Employees previously covered under a different health plan and transferring to coverage under this Plan may pay to the Plan a lump sum in the amount that would allow "Initial Eligibility" (152 hours times the contribution rate currently in effect). Employees who work in excess of 152 hours in the first month with the newly organized Employer will have the excess hours credited to their "Hours Bank." Employees who work less than 152 hours in the first month may purchase "buy-in" coverage for the difference between the hours worked and the minimum 152 hours. Employees who previously had single coverage will be eligible for single coverage under the Plan and Employees who previously had family coverage will be eligible

for family coverage under the Plan, unless there is a Special Enrollment event or Qualifying Event (described later in this SPD).

Hours Bank

You will be credited with one hour in your "Hours Bank" for each hour you work in Covered Employment for which the Health and Welfare Plan receives contributions from a Contributing Employer on your behalf at the full contribution rate. (See additional information under the Section entitled, "If you are working in another Local Union Jurisdiction").

The maximum number of hours you can accumulate in your bank is 912 hours (6 months of coverage).

Continuation of Coverage

Your bank will be credited with hours reported by a Contributing Employer on your behalf, for which the Health and Welfare Plan receives contributions. These contributions generally are made monthly, in the month following the month in which you worked. One hundred and fifty-two (152) hours will be deducted on the first of the month from your Hours Bank for each month of coverage. If you are credited with more than 152 hours during a month (based on contributions received by the Health and Welfare Plan), the excess hours will remain in your Hours Bank, up to the maximum allowable amount of 912 hours (6 months of coverage).

"Buy-In" of Coverage

If your bank falls below 152 hours after you have established eligibility, but you have at least 110 hours in your bank, to ensure coverage you may "buy in" up to 60 hours per month at the hourly rate in effect. You will then be eligible for coverage in the following month.

Number of hours short	Contribution Rate	Amount due for coverage
60	$7.70	$462.00
60	$4.50 – (for CWs, CEs and apprentices <Period 4)	$270.00
60	$2.70 – (opt-out coverage)	COBRA Rates*

*COBRA rates will be lower than paying 60 hours at the contribution rate.

The amounts shown in the table above will decrease if you are short less than 60 hours in a month. However, if you do not have at least 110 hours in your eligibility bank you must pay the full COBRA amount to maintain Plan coverage.

Reinstatement

If you lose eligibility because you do not have enough hours in your Hours Bank, you will not be eligible for coverage under the Plan until your Hours Bank reaches 500 hours. Specifically, you will become eligible for

coverage under the Plan on the first day of the calendar month following the month in which you accumulate 500 hours of work in Covered Employment within the previous 12 months. If there are hours remaining in your Hours Bank, at the time you lose eligibility, these hours may be counted towards the 500 hours required for reinstatement of eligibility. Any hours worked before the time that you lost eligibility may not be counted towards the 500 hours requirement if such hours were previously deducted from your Hours Bank to maintain your coverage.

If you are working in another IBEW jurisdiction

A Participant working in a Local Union with a lower hourly contribution rate will have his/her hours credited at the current IBEW Local 300 Health and Welfare Plan rate.

Example: *A Participant working in another IBEW Jurisdiction works 100 hours. That IBEW Jurisdiction has an hourly contribution rate for its health plan of $5.00 per hour. Based on the current IBEW Local 300 Health and Welfare Plan rate ($7.70), the Participant will be credited with **64.9 hours** in this Plan. Calculated as follows:*

100 hours x $5.00 = $500
$500 ÷ $7.70 = 64.9 hours

Forfeiting Your Hours Bank upon Leaving Covered Employment

If you no longer work in Covered Employment and you are not available for work pursuant to the rules of your home Union or the Union in whose jurisdiction you worked in Covered Employment, you will forfeit your Hours Bank. However, you will be immediately offered COBRA coverage.

Please note that this forfeiture *does not apply* to Participants unable to work due to a disability, the Family Medical Leave Act, or who are absent because of military service.

See "Effect of Transfer of Membership" section for situations where you can transfer to an IBEW Local that does not participate in the Plan.

Effective Date of Coverage

You will be covered on the first day of the calendar month following the month you qualify for coverage. Each of your Eligible Dependents will be covered on the date you become covered, or if later, the date the person becomes your Eligible Dependent).

Eligibility While Disabled

If you are disabled and receive Weekly Disability Income Benefits from the Health and Welfare Plan, or you are disabled on the job and receive benefits under a Workers' Compensation Program pursuant to a Workers' Compensation Law, and the Health and Welfare Plan is not receiving contributions on your behalf, any accumulated

Hours Bank will be depleted first, and once the hours in your Hours Bank is depleted, you will be offered COBRA at a rate of 50% of the applicable current COBRA rate. You will continue to maintain eligibility during this period, up to a maximum of a six-month extension (see "COBRA" Section for further details).

If you are working in Covered Employment in an effort to reinstate coverage and become disabled, you will be offered COBRA coverage. If you elect COBRA coverage, you will be eligible to receive Weekly Disability Income benefits.

Collectively Bargained Participants Who Go To Work In Non-Collectively Bargained Employment

A collectively bargained Participant, who leaves employment covered by a Collective Bargaining Agreement to work for a Contributing Employer in non-collectively bargained employment, may either run out his or her Hours Bank, or request the Fund Office, in writing, to freeze his or her Hours Bank. A Participant who requests that his or her Hours Bank be frozen must notify the Fund Office when he or she leaves non-collectively bargained work with the Contributing Employer.

ELIGIBILITY PROVISIONS: NON-COLLECTIVELY BARGAINED EMPLOYEES

With the approval of the Board of Trustees, an Employer currently contributing (Contributing Employer) to the Plan on behalf of Employees covered by a Collective Bargaining Agreement with a Participating Union can provide coverage under the Plan to its Employees who:

(a) Do not work in employment covered by a Collective Bargaining Agreement with a Participating Union; and

(b) Who are not members of another Union.

Such an Employer may limit such participation, with the approval of the Board of Trustees, to its Employees who are "Alumni Employees." "Alumni Employees" are Employees who previously worked in employment covered by a Collective Bargaining Agreement with a Participating Union, which was the basis of their participation in the Health and Welfare Plan before accepting their current employment with the respective Employer.

A Contributing Employer in good standing must submit a request to the Board of Trustees and must sign a Participation Agreement before the Plan will accept contributions on behalf of its non-collectively bargained Employees. The Employer has two choices for a Participation Agreement:

- **If the Employer selects to use the "Alumni Only" Participation Agreement**, only those Employees who formerly participated in the Plan based on their employment that was covered by a Collective Bargaining Agreement with a Participating Union may be included. Under this option, the Employer is required to provide coverage for all Alumni Employees unless an Eligible Employee opts out of the coverage.

- **If the Employer chooses the Non-Collectively Bargained Participation Agreement**, the Employer must provide coverage under the Plan for all of its non-collectively bargained Employees unless an Eligible Employee opts out of the coverage.

A non-collectively bargained Employee can "opt out" of coverage under either of the above Participation Agreements by signing an affidavit stating that the Employee has other medical coverage (from a Spouse or other source).

For its non-collectively bargained Employees to participate in the Plan, the Contributing Employer must agree to the following:

1. The Employer's covered Employees shall include all full-time and regular part-time Employees, who are scheduled to work at least twenty (20) hours per week and who have not opted out of coverage; and

2. Contributions on behalf of the non-collectively bargained Employees will be made monthly at rates determined by the Board of Trustees. These rates are subject to change at any time at the discretion of the Trustees.

3. Contributions of 152 hours per month will be made consistently at the current contribution rate (applicable for construction workers) or 173.3 hours per month at the current contribution rate (applicable for utility workers) and at the same time contributions are made for the Employer's collectively bargained plan Participants.

4. If both a husband and wife are non-collectively bargained Employees of a Contributing Employer and the Contributing Employer remits 152 hours per month for construction, or 173.3 hours per month for utility on behalf of one of them, special rules will apply. Under the applicable rules, rather than making contributions for both non-collectively bargained Employees under the provisions of this Section, the Employer will contribute on behalf of the Spouse (at a special rate to be determined by the Board of Trustees, subject to change at any time at the discretion of the Trustees) and the Spouse will receive the same Life Insurance benefit and Dental, Vision, Accidental Death and Dismemberment coverage, and Weekly Accident and Sickness benefits that are afforded to all non-collectively bargained Participants.

Initial Eligibility

Non-collectively bargained Employees of Employers who have agreed to contribute to the Plan on behalf of the non-collectively bargained Employees at the required monthly rate will become covered on the first day of the month following the receipt by the Plan of the current month's contributions.

Continuation of Health Coverage

Health coverage will continue on a monthly basis as long as the monthly contributions are remitted to the Plan on a timely basis.

Termination of Coverage

Eligibility for benefits will terminate on the last day of the month after the earliest occurs:

- You stop working for a Contributing Employer;
- Your Employer is no longer a Contributing Employer;
- Your Employer fails to make contributions for your coverage; or
- The Plan terminates or no longer allows coverage for non-collectively bargained Employees.

For example, if you leave Covered Employment on July 2, your coverage will terminate on July 31 and you will be offered COBRA coverage effective August 1.

Reinstatement

Non-collectively bargained Employees do not have any rights to reinstatement under the Plan. They will be offered COBRA coverage when they leave employment pursuant to the COBRA rules beginning on page 833.

Hours Bank

Non-collectively bargained Employees do not accrue an Hours Bank.

Non-Collectively Bargained Employees who are Retired

Each month worked by a non-collectively bargained Employee for whom the required contributions are received by the Plan is recognized as a full-month worked when determining if the employee meets the 5,000-hour requirement to be eligible for retiree benefits. If the non-bargained Employee does not meet the 5,000-hour requirement, the Employer may remit one hundred and sixty (160) or two hundred (200) hours a month at the contribution rate in force for the non-collectively bargained Employee, until the requirement is met. The Board of Trustees may adjust this hour requirement at any time.

Non-Collectively Bargained Participants Who Go To Work In Employment Covered By A Collective Bargaining Agreement

A non-collectively bargained Participant who leaves such employment to immediately work in employment covered by a Collective Bargaining Agreement that provides for contributions to the Health and Welfare Plan must meet all requirements to become Initially Eligible under the terms of the Plan. This Participant's Employer may continue to remit monthly contributions pursuant to the previously executed Participation Agreement in addition to the contributions under the Collective Bargaining Agreement until the Participant meets the requirements for Initial Eligibility, or the Participant may be offered COBRA coverage and the option to self-pay for benefits until he or she meets the Initial Eligibility rules as set for the Plan.

OPT-OUT PROVISION (PARTICIPANTS)

You will have the option of declining the Medical Insurance coverage benefit of the IBEW Local 300 Health and Welfare Plan, provided you have alternate group medical insurance coverage as follows, and you can provide proof of this coverage to the Plan Administrator. For example, if you have:

- Coverage under your Spouses' Medical Policy;
- Military Coverage;
- Eligibility to be covered under the IBEW Local 300 Health and Welfare Plan through a parent; or
- Eligibility to be covered under your parent's coverage, you are under the age of 26, and your parents elected to opt out of the coverage offered for the applicable coverage period.

Eligible Employees who opt-out of coverage will have the contributions made, on their behalf, at a reduced rate for Health and Welfare benefits. The opt-out coverage will include Dental, Vision, Life Insurance, AD&D Insurance and Short-Term Disability benefits. If you lose your alternate coverage, you will be eligible for full coverage under the Plan on the first of the month following the date your coverage under the other group plan terminates.

An Eligible Dependent under the age of 26 will have the option of declining ("opting out of") the Medical Insurance coverage benefit of the Plan, provided such Eligible Dependent has alternate group medical insurance coverage through a parent and can provide proof of this coverage to the Plan Administrator. If the Eligible Dependent opts out of the Medical Insurance coverage, the Eligible Dependent's coverage will consist of Dental and Vision coverage benefits only unless specifically declined on the "Opt Out" form. If the Eligible Dependent loses his or her alternate coverage, the Eligible Dependent will be eligible for full coverage under the Plan on the first of the month following the date his or her coverage under the other group plan terminates, provided such Eligible Dependent meets all other eligibility requirements and all enrollment materials are timely completed and provided to the Fund Office.

OPT-OUT PROVISION (DEPENDENTS)

A Dependent under the age of 26 will have the option of declining ("opting out of") the Medical Insurance coverage benefit of the Plan, provided such Dependent has alternate group medical insurance coverage through a parent and can provide proof of this coverage to the Plan Administrator. If the Dependent opts out of the medical coverage, the Dependent's coverage will consist of Dental and Vision coverage benefits only, unless such benefits are specifically declined on the "Opt Out" form. If the Dependent loses his or her alternate coverage, the Dependent will be eligible for full coverage under the Plan on the first of the month following the date his or her coverage under the other group plan terminates, provided such Dependent meets all other eligibility requirements and all enrollment materials are timely completed and provided to the Fund Office.

COVERAGE FOR RETIREES

Before Medicare Eligibility

If you retired on or after turning age 55, you and your Eligible Dependents are eligible to continue your coverage under the Plan until the earlier of when you are eligible for Medicare coverage or age 65, if you meet all of the following requirements:

1. You are eligible for Comprehensive Major Medical Benefits on your retirement date, with either hours worked or COBRA self-payments.

2. You have been credited with at least 5,000 hours worked in the seven years immediately preceding your retirement. If you do not have 5,000 hours during that period, you will not be eligible for coverage as a retiree under this Plan, but you will be eligible for COBRA coverage.

3. You agree to make the required monthly self-payments at the applicable rate. Your payments must be made on time, otherwise your coverage will cease. The monthly self-payment rate is determined annually and may change during your pre-Medicare period.

If you become eligible for Medicare and your Spouse is under age 65, he/she may continue to buy coverage from the Plan until such time as he/she becomes Medicare eligible. From age 55 to 59, your self-payment rate will be the full COBRA rate for your type of coverage (i.e., Single, Two-Person, or Family). If you are between age 59 and 65, your self-payment rate may be reduced, as determined by the Board of Trustees.

After Medicare Eligibility

REIMBURSEMENT OF RETIREE SUPPLEMENTAL COSTS

Once you meet the following requirements, you and your Spouse will be entitled to a 50% reimbursement of the costs of the Medicare Supplement coverage and the coverage for Medicare Part D prescription drugs for you and for your Spouse if:

1. You and your Spouse are eligible for Medicare;

2. You and your Spouse purchase Medicare Supplemental coverage and Medicare "Part D" coverage for prescription drugs; and

3. You meet the eligibility requirements described above in the "Before Medicare Eligibility" section.

You also will be entitled to purchase dental and vision coverage, as well as life insurance and accidental death and dismemberment (AD&D) coverage, as described in this SPD. The Plan will reimburse you and your Spouse at a rate of 50% of the cost for such coverage. Your reimbursement will be reduced by any costs paid directly by

the Plan for dental and vision coverage. Before reimbursements may be made, the Fund Office must receive proof of the monthly expenses incurred by you (the retiree) and your Spouse.

Opting Out of Retiree Programs

Upon retirement, an otherwise-eligible plan Participant may "opt out" of the retiree program if the Participant/retiree has coverage through the Participant's/retiree's Spouse's employment. Such retiree and Spouse may elect to participate in the Plan at a later date, upon the occurrence of any of the following events:

1. The retirement of the Spouse from the Spouse's Employer;
2. The death of the Spouse; or
3. The divorce of the retiree and the Spouse.

At the time of reinstatement of coverage, both the retiree (and Spouse, if applicable) must show proof of continuous coverage from the date of the "opt-out" through the date of reinstatement.

A retiree's Spouse who is actively at work may also "opt-out" of his or her retired Spouses' coverage if the active Spouse has coverage through his or her employment. Such active Spouse may elect to participate in the Plan at a later date, if:

1. The actively working Spouse retires and his or her Employer does not provide retiree health coverage; and
2. The retired Spouse continues to participate in the Plan.

At the time of reinstatement of coverage, the retired active Spouse must show proof of continuous coverage from the date of the "opt out" through the date of reinstatement, which cannot be later than three (3) months after his or her retirement date.

COVERAGE FOR DISABLED MEMBERS

Participants who become disabled before age 62 and who have used up their Hours Bank may be eligible to continue coverage under this Plan. Participants who are determined to be "Totally and Permanently Disabled" by the Social Security Administration may continue health benefits as an eligible retiree at the applicable monthly self-payment rates.

COVERAGE UPON ACTIVE MILITARY SERVICE

See the Section "Continuation of Health Coverage upon Military Leave ("USERRA")" of this SPD for additional information.

Upon your entry into Active Military Service, your coverage will terminate on the last day of the month in which you are called into Active Military Service. However, your Hours Bank will be frozen on that date.

Upon the Participant's return to Covered Employment, the Plan will perform a two-year look-back to determine the average number of hours the Participant worked, and - if necessary - the Hours Bank will be increased to account for any such additional hours.

SPOUSE AND DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH OR INCARCERATION

If you die while you are an active Participant, your Eligible Dependents may use any of your accumulated Hours Bank to continue coverage, then will be offered COBRA at the "available for work" rate for a period of 36 months.

If you die while you are an eligible non-Medicare retiree, your Spouse and your Eligible Dependents will be offered COBRA for a period of 36 months at the appropriate monthly retiree premium rate. If your Spouse remarries, coverage ceases. Eligible Dependent children who have a parent who was a Participant covered by the Plan who is either deceased or incarcerated and who was eligible for benefits through the Health and Welfare Plan prior to their parent's death or incarceration will be offered COBRA for a period of 36 months at the "reduced retiree" rate.

DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH

Eligible Dependent children who have a parent who was a Participant covered by the Plan who is either deceased or incarcerated and who was eligible for benefits through the Health and Welfare Plan prior to their parent's death or incarceration will be offered COBRA for a period of 36 months at the appropriate COBRA rate.

EFFECT OF TRANSFER OF MEMBERSHIP

A Participant who transfers their membership to an IBEW Local that does not participate in the IBEW Local 300 Health and Welfare Plan may use their Hours Bank to continue coverage. However, once the Hours Bank is exhausted, the Participant shall be deemed "Unavailable for Work in Covered Employment." The Plan, through its Administrator, shall be notified of a transfer via the Electronic Reciprocal Transfer System (ERTS) and the Participant will be offered "Not Available for Work" COBRA continuation coverage.

SECTION 4. ELIGIBILITY RULES FOR THE UTILITY GROUP

BASIC ELIGIBILITY RULES

Eligibility Rules for Employees

The following Employees may become eligible for coverage if the required contributions are paid to the Plan on their behalf and if they:

1. Are Employees of Contributing Employers; and

2. Are working under the jurisdiction of a Collective Bargaining Agreement entered into with a Union that requires the Contributing Employer to make periodic payments to the Health and Welfare Plan for the purpose of providing and maintaining coverage for medical and certain welfare benefits, or under an agreement requiring reciprocation of such payments, or under the terms of a Participation Agreement between the Employer and the Board of Trustees that requires the Employer to make such payments.

After your coverage becomes effective, your eligibility will continue during each calendar month for which sufficient contributions are made to the Plan on your behalf.

Eligible Dependents

Eligible Dependents for the purposes of this Plan are defined as the Participant's Spouse (the individual to whom the Participant is legally married under federal and state law and with whom the Participant may file a joint federal income tax return) and the Participant's children (biological, legally adopted, placed for adoption and stepchildren) through the end of the month in which such children turn age 26. Remember, when you add or remove your Eligible Dependents, your type of membership (individual, two-person, or family) may change.

You may add or remove your Eligible Dependents from your membership under the conditions noted in this Section. To add or remove your Eligible Dependent(s), please contact the Fund Office.

You must cover either all of your Eligible Dependents or none of your Eligible Dependents who are eligible under the Plan, unless otherwise ordered by a court of law.

Coverage for Incapacitated Adult Dependent Children

Coverage may continue under the eligibility rules with respect to incapacitated Dependent children over age 26. To be eligible for this coverage, the Plan will require you to provide proof of the continuing existence of a qualifying disabling condition of the incapacitated Dependent child. If you elect this coverage, you will be required to submit the following documentation to the Fund Office:

- An application form for incapacitated Dependent child(ren), which can be obtained from the Fund Office; and

- A physician certification of the extent and nature of the disability.

The Fund Office will review this information and determine whether the Dependent is incapacitated under the terms of the Plan before providing/continuing coverage. To avoid interruption of coverage, the Fund Office must receive the above information within 60 days of the date the individual would otherwise lose coverage under the Plan. If the Fund Office receives the above information later than 60 days after the date the individual would no longer be an Eligible Dependent, coverage will begin the first day of the month after the Fund Office receives the required information. This could result in interruption of coverage for the incapacitated Dependent child. If a Dependent who is 26 years old or older ceases to be incapacitated, the Dependent becomes ineligible for coverage at the end of the month in which the incapacity ceases, and you must remove the Dependent from your membership by contacting the Fund Office.

Incapacitated Adult Dependent Child Coverage.

Incapacitated adult Dependent children who are enrolled in Medicare may qualify for partial reimbursement of their monthly Medicare Supplement and Medicare Part D premiums. The benefit will be available to the incapacitated adult Dependents of Medicare-eligible Participants who retire and participate in the IBEW Local 300 Health & Welfare Fund retiree reimbursement program for their Medicare Supplement and Medicare Part D policies. If the incapacitated adult Dependent is also enrolled in Medicare and was eligible for coverage under the Plan at the time of the Participant's retirement, the Dependent will receive a 50% reimbursement of their monthly Medicare Supplement and Medicare Part D premiums. Reimbursement shall be paid following receipt by the Fund Office of satisfactory proof that the premiums for the respective policies have been paid.

OPEN ENROLLMENT

Open Enrollment is the period of time each year, as designated by the Plan Administrator, during which Eligible Employees and qualified beneficiaries eligible for COBRA may make the elections specified below. In addition, retirees will have the opportunity to opt out of retiree coverage during this time. Enrollment forms and information regarding coverage or opting out of coverage may be obtained from the Fund Office.

Currently, Open Enrollment is held twice each calendar year: from June 1 through June 30 and from December 1 through December 31. Elections made during the June Open Enrollment period generally become effective July 1. Elections made during the December Open Enrollment period generally become effective January 1.

The Trustees reserve the right to change the dates of the Open Enrollment periods and/or discontinue offering one or both Open Enrollment periods.

Elections Available During Open Enrollment

During the Open Enrollment period, you may elect to enroll yourself and your Eligible Dependents who are eligible for coverage under the Plan. You may also add or drop Eligible Dependents to/from the coverage or opt out of the coverage being offered under the Plan.

Restrictions on Elections During Open Enrollment

No Dependent may be covered unless you are covered. You and all your covered Eligible Dependents must be enrolled for the same coverages. In order to ensure that your coverage will begin on the applicable effective date all relevant parts of the enrollment form must be completed and the form must be submitted to the Fund Office along with proof of Dependent status (as requested) before the end of the Open Enrollment period.

Start of or Changes to Coverage Following Open Enrollment

If you or your Spouse or Dependent Child(ren) are enrolling for the first time or discontinuing coverage during an Open Enrollment period, such changes will become effective on the first day of the month following the end of the applicable Open Enrollment period.

Failure to Enroll During Open Enrollment

If you fail to enroll yourself and/or any of your Eligible Dependents within the Open Enrollment period, you will not be able to enroll yourself and/or any of your Eligible Dependents until the next Open Enrollment period (assuming you are benefits-eligible at that time), unless you have a Special Enrollment event, as described below.

SPECIAL ENROLLMENT

If you decline enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Eligible Dependents in this Plan if you or your Eligible Dependents lose eligibility for that other coverage (or if the Employer stops contributing toward your or your Eligible Dependents' other coverage). However, you must request enrollment within 60 days after your or your Eligible Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

If you or your Eligible Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under this Plan, the Plan must allow you to enroll if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in this Plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

To request special enrollment or obtain more information, contact the Fund Office.

ENROLLMENT PAPERWORK

In order to become covered under the Plan, you must enroll yourself and any Eligible Dependents for coverage within thirty (30) days following the satisfaction of your eligibility requirements. Utility Group and non-collectively Bargained Participants currently become eligible on the first day of the month following receipt by the Plan of the current month's contributions.

You and your Dependents (if eligible for Dependent coverage) will be enrolled when a benefit enrollment form is completed, signed, and delivered to the Fund Office within this 30-day time limit. If you do not return the completed, signed benefit enrollment form within thirty (30) days following the satisfaction of your eligibility requirements, you will be enrolled in Employee-only coverage using information received from the Union. If your Dependents are eligible for coverage, they will not be enrolled until the next open enrollment period (provided the participant is eligible for Plan coverage), unless they become eligible through a special enrollment period. The current open enrollment periods occur in June (for July 1st coverage) and December (for January 1st coverage).

TERMINATION/CHANGES OF COVERAGE

Termination of Coverage

Coverage will terminate on the earliest of the following dates:

1. The date the Plan terminates;
2. The date you no longer satisfy the eligibility rules for such coverage as set forth under the Plan; or
3. The date you die (See: "Spouse and Dependents' Coverage After a Participants' Death" for additional information).

The Trustees may, in their sole discretion, from time to time, change or discontinue all or any part of the benefits for Participants and Eligible Dependents. Such change or discontinuance may be retroactive as determined in the sole discretion of the Trustees. This right to change, modify, or discontinue 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.

ELIGIBILITY PROVISIONS: COLLECTIVELY BARGAINED EMPLOYEES

Date of Eligibility

Your eligibility for coverage under the Plan will depend on the terms of your Employer's Collective Bargaining Agreement or, in the case of a non-collectively bargained group, the Employer's Participation Agreement with

the Plan. If the Collective Bargaining Agreement or Participation Agreement does not specify your date of eligibility, you will become eligible for coverage on the first day of the month in which the Plan receives contributions from a Contributing Employer on your behalf.

Effective Date of Coverage

You will be covered on the first day of the calendar month in which the Plan receives contributions from a Contributing Employer on your behalf. Each of your Eligible Dependents will be covered on the date you become covered, or if later, the date the person becomes your Eligible Dependent.

Eligibility While Disabled

If you are disabled and receive Weekly Disability Income Benefits from the Health and Welfare Plan, or you are disabled on the job and receive benefits under a Workers' Compensation Program pursuant to a Worker' Compensation Law, and the Health and Welfare Plan is not receiving contributions on your behalf, you will be offered COBRA at a rate of 50% of the applicable COBRA rate. You will continue to maintain eligibility during this period, up to a maximum of a six-month extension (see "COBRA" Section for further details).

Reinstatement of Eligibility

If you lose eligibility because you have terminated employment with your Contributing Employer, your eligibility can be reinstated on the first day of the month following the date on which you are re-hired. This is true only if the required contributions have been made on your behalf to the Plan by the Contributing Employers.

ELIGIBILITY PROVISIONS: NON-COLLECTIVELY BARGAINED EMPLOYEES

With the approval of the Board of Trustees, a current Contributing Employer of the Plan who is making contributions on behalf of Employees covered by a Collective Bargaining Agreement with a Participating Union can provide coverage under the Plan to its Employees who:

(a) Do not work in employment covered by a Collective Bargaining Agreement with a Participating Union; and

(b) Who are not members of another Union.

Such an Employer may limit such participation to its Employees who are "Alumni Employees" with the approval of the Board. "Alumni Employees" are Employees who have previously worked in employment covered by a Collective Bargaining Agreement with a Participating Union, which was the basis of their participation in the Health and Welfare Plan before accepting their current employment with the respective Employer.

A Contributing Employer in good standing must submit a request to the Board of Trustees and must sign a Participation Agreement before the Plan will accept contributions on behalf of the Employer's non-collectively Bargained Employees. The Employer has two choices for a Participation Agreement:

- **If the Employer selects to use the "Alumni Only" Participation Agreement**, only those Employees who formerly participated in the Plan based on their work in employment covered by a Collective Bargaining Agreement with a Participating Union can be included. However, the Employer is required to provide coverage for all "Alumni Employees" unless an Eligible Employee opts out of the coverage offered.

- **If the Employer chooses the Non-Collectively Bargained Participation Agreement**, the Employer must provide coverage for all of its non-collectively bargained Employees unless an Eligible Employee opts out of coverage.

A non-collectively bargained Employee can "opt-out" of coverage under either of the above Participation Agreements by signing an affidavit stating that the Employee has other medical coverage (from a Spouse or other source).

For its non-collectively bargained Employees to participate in the Plan, the Contributing Employer must agree to the following:

1. The Employer's covered Employees shall include all full-time and regular part-time Employees, who are scheduled to work at least twenty (20) hours per week and who have not opted out of coverage.

2. Contributions on behalf of the non-collectively bargained Employees will be made monthly at rates determined by the Board of Trustees. These rates are subject to change at any time at the discretion of the Trustees.

3. Contributions of 152 hours per month will be made consistently at the current contribution rate (applicable for Employees under the construction classification) or 173.3 hours per month at the current contribution rate (applicable for Employees under the utility classification), and at the same time the Employer is making contributions for collectively bargained plan Participants.

4. If both a husband and wife are non-collectively bargained Employees of a Contributing Employer and the Contributing Employer remits 152 hours per month for construction or 173.3 hours per month for utility on behalf of one of them, special rules apply. Under the applicable rules, rather than making contributions for both non-collectively bargained Employees under the provisions of this Section, the Employer will contribute on behalf of the Spouse (at a special rate to be determined by the Board of Trustees, subject to change at any time at the discretion of the Trustees), and the Spouse will receive the same Life Insurance benefit, Dental, Vision, Accidental Death and Dismemberment coverage, and Weekly Accident and Sickness benefits that are afforded to all non-collectively bargained Participants.

Initial Eligibility

Non-collectively bargained Employees of Employers who have agreed to contribute to the Plan on their behalf at the required monthly rate will become covered on the first day of the month following the receipt by the Plan of the current month's contributions.

Continuation of Health Coverage

Health coverage will continue on a monthly basis as long as the monthly contributions are remitted on a timely basis.

Termination of Coverage

Eligibility for benefits will terminate on the last day of the month in which the earliest of the events below occurs:

- You stop working for a Contributing Employer;
- Your Employer is no longer a Contributing Employer;
- Your Employer fails to make contributions for your coverage; or
- The Plan terminates or no longer allows coverage for non-collectively bargained Employees.

For example, if you leave Covered Employment on July 2, your coverage will terminate on July 31 and you will be offered COBRA coverage effective August 1.

Reinstatement

Non-collectively bargained Employees do not have any reinstatement rights under the Plan. Rather, they will be offered COBRA coverage when they leave employment pursuant to the COBRA rules explained later in ths SPD.

Hours Bank

Non-collectively bargained Employees do not accrue an Hours Bank.

Non-Collectively Bargained Employees who Retire

Each month worked by a non-collectively bargained Employee for whom the required contributions are received by the Plan is recognized as a full month worked when determining if the Employee meets the 5,000-hour requirement to be eligible for retiree benefits. If the non-bargained Employee does not meet the 5,000-hour requirement, the Employer may remit one hundred seventy-three and 33/100 hours (173.33) a month at the applicable contribution rate, until the requirement is met. The Board of Trustees may adjust this hour requirement at any time.

Non-Collectively Bargained Participants Who Go To Work In Employment Covered By A Collective Bargaining Agreement

A non-collectively bargained Participant who leaves such employment to immediately work in employment covered by a Collective Bargaining Agreement that provides for contributions to the Health and Welfare Plan must meet the requirements for Initially Eligibility as set forth under the terms of the Plan. This Participant's Employer may continue to remit monthly contributions pursuant to the previously executed Participation Agreement in addition to the contributions under the Collective Bargaining Agreement until the Participant meets the Initial Eligibility

requirements, or this Participant may be offered COBRA coverage and the option to self-pay for benefits until he or she meets the Initial Eligibility rules of the Plan.

OPT-OUT PROVISION (PARTICIPANTS)

You will have the option of declining either the Comprehensive Major Medical Benefits ("Major Medical Group Plan") provided through the IBEW Local 300 Health and Welfare Plan, or the other group of benefits provided through the IBEW Local 300 Health and Welfare Plan (i.e., major medical, dental, vision, short-term disability, life insurance and, if otherwise eligible to participate, the HRA). If you choose to decline only the Major Medical Group Plan coverage, contributions for other Health and Welfare benefits may be made on your behalf at a reduced rate. If you choose to decline the entire group of Health and Welfare benefits offered by the Plan, your Employer will have no obligation to contribute to the Plan on your behalf.

In order to elect either of the above "opt out" options, you must have alternate group medical insurance coverage with your Spouse, or another source, and provide proof of this coverage to the Plan Administrator.

If you lose your alternate group medical insurance coverage, you will be eligible for full coverage on the first of the month following the date your coverage with the other group plan was terminated.

OPT-OUT PROVISION (DEPENDENTS)

A Dependent under the age of 26 will have the option of declining ("opting out of") the Medical Insurance coverage benefit of the Plan, provided such Dependent has alternate group medical insurance coverage through a parent and can provide proof of this coverage to the Plan Administrator. If the Dependent opts out of the medical coverage, the Dependent's coverage will consist of Dental and Vision coverage benefits only, unless such benefits are specifically declined on the "Opt Out" form. If the Dependent loses his or her alternate coverage, the Dependent will be eligible for full coverage under the Plan on the first of the month following the date his or her coverage under the other group plan terminates, provided such Dependent meets all other eligibility requirements and all enrollment materials are timely completed and provided to the Fund Office.

COVERAGE FOR RETIREES

Before Medicare Eligibility

If you retire on or after turning age 55, you and your Eligible Dependents are eligible to continue your coverage under the Plan until the earlier of when you are eligible for Medicare coverage or age 65, if you meet all of the following requirements:

1. You are eligible for benefits on your retirement date, with either hours worked or COBRA self-payments.
2. You have been credited with at least 5,000 hours worked in the seven years immediately preceding your retirement. If you do not have 5,000 hours during that period, you will not be eligible for coverage as a retiree under the Plan, but you will be eligible for COBRA coverage.

3. You agree to make the required monthly self-payments at the applicable rate. These payments must be made on time, otherwise coverage will cease. The monthly self-payment rate is determined annually and may change during your pre-Medicare period.

4. The Employer you worked for immediately preceding your retirement continues to be a Contributing Employer in the IBEW Local 300 Health Plan. (This requirement is continuing in nature. You and your Spouse's coverage will terminate on the last day of the month following the month in which your former Employer ceases to be a Contributing Employer.)

If, when you become eligible for Medicare, your Spouse is under age 65, he/she may continue to buy coverage from the Plan until such time as he/she becomes Medicare eligible.

From age 55 to 59, your self-payment rate will be the full COBRA rate for your type of coverage (i.e., Single, Two-Person, or Family). If you are between age 59 and 65, your self-payment rate may be at a reduced rate as determined by the Board of Trustees.

After Medicare Eligibility

Once you meet the following requirements, you and your Spouse will be entitled to a 50% reimbursement of the costs of the Medicare Supplement coverage and coverage under the Medicare Part D prescription drug program for you and for your Spouse's coverage:

1. You and your Spouse are eligible for Medicare;

2. You and your Spouse purchase a Medicare Supplemental Policy and Medicare "Part D" coverage for prescription drugs; and

3. You meet the eligibility requirements described above in the "Before Medicare Eligibility" section.

You also will be entitled to purchase dental and vision coverage, as well as life insurance and accidental death and dismemberment (AD&D) coverage, as described in this SPD. The Plan will reimburse you and your Spouse at a rate of 50% of the cost for such coverage. Your reimbursement will be reduced by any costs paid directly by the Plan for dental and vision coverage. Before reimbursements may be made, the Fund Office must receive proof of the monthly expenses incurred by you (the retiree) and your Spouse.

Opting Out of Retiree Programs

Upon retirement, an otherwise-eligible plan Participant may "opt out" of the retiree program if the Participant/retiree has coverage through the Participant's/retiree's Spouse's employment. Such retiree and Spouse may elect to participate in the Plan at a later date, upon the occurrence of any of the following events:

1. The retirement of the Spouse from the Spouse's employer;

2. The death of the Spouse; or

3. The divorce of the retiree and the Spouse.

At the time of reinstatement of coverage, both the retiree (and Spouse, if applicable) must show proof of continuous coverage from the date of the "opt-out" through the date of reinstatement.

A retiree's Spouse who is actively at work may also "opt-out" of his or her retired Spouses' coverage if the active Spouse has coverage through his or her employment. Such active Spouse may elect to participate in the Plan at a later date, if:

1. The actively working Spouse retires and his or her employer does not provide retiree health coverage; and
2. The retired Spouse continues to participate in the Plan.

At the time of reinstatement of coverage, the retired active Spouse must show proof of continuous coverage from the date of the "opt out" through the date of reinstatement, which cannot be later than three (3) months after his or her retirement date.

COVERAGE FOR DISABLED MEMBERS

Participants who become disabled before age 62 may be eligible to continue coverage under the Plan. Participants who are determined to be "Totally and Permanently Disabled" by the Social Security Administration may continue health benefits as an eligible retiree at the applicable monthly self-payment rates.

COVERAGE UPON ACTIVE MILITARY SERVICE

See the "Continuation of Health Coverage upon Military Leave ("USERRA")" Section in this SPD for additional information.

SPOUSE AND DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH OR INCARCERATION

If you die while you are an active Participant, your Eligible Dependent(s) will be offered COBRA at the "available for work" rate for a period of 36 months.

If you die while you are an eligible non-Medicare retiree, your Eligible Dependents will be offered COBRA Continuation Coverage for a period of 36 months at the appropriate monthly retiree premium rate. If your Spouse remarries, coverage ceases. Eligible Dependent children who have a parent who was a Participant covered by the Plan who is either deceased or incarcerated, and who was eligible for benefits through the Health and Welfare Plan prior to their parent's death or incarceration will be offered COBRA Continuation Coverage for a period of 36 months at the "reduced retiree" rate.

DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH

Eligible Dependent children who have a parent who was a Participant covered by the Plan who is either deceased or incarcerated and who was eligible for benefits through the Health and Welfare Plan, prior to their parent's death or incarceration, will be offered COBRA for a period of 36 months at the appropriate COBRA rate.

SECTION 5. COMPREHENSIVE MAJOR MEDICAL BENEFITS

PLAN YEAR

The **Plan Year** is a fiscal year that begins on July 1 ends on the following June 30. However, medical benefits run on a calendar year basis. For example, deductibles and out-of-pocket limits accrue from January 1 through December 31.

COINSURANCE

There is no coinsurance requirement associated with your plan.

ANNUAL DEDUCTIBLE

The annual deductible is a combined deductible that applies to both covered medical services and prescription drugs. You must pay all the costs up to the deductible amount before this plan begins to pay for covered medical services and prescription drugs, except for Preventive Services. The plan pays medical and prescription drug benefits when an individual or the family meets the deductible.

For both Construction and Utility Employees, the annual deductible amount is **$1,500** per individual and **$3,000** per family. The deductible amounts apply on a calendar year basis.

Note: The deductible does not apply to covered Preventive Services. These expenses are paid at 100% with no cost share.

Note: Only expenses covered under the Comprehensive Major Medical Benefits may be used to satisfy the deductible. Both the Health Savings Account (HSA) and the Health Reimbursement Arrangement (HRA), described below and later in this document, reimburse expenses covered under Section 213(d) of the Internal Revenue Code (IRC). Although these expenses may be covered by the HSA and/or HRA, if these expenses are not covered under the Comprehensive Major Medical Benefits, they may not be used to satisfy the deductible.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is a combined out-of-pocket maximum that applies to both medical services and prescription drugs. The out-of-pocket maximum under the Plan is **$1,500** per individual and **$3,000** per family. Once you or one of your Eligible Dependents incurs and pays $1,500 in covered expenses in any one calendar year, the percentage payable for covered expenses incurred by such person changes to 100% for the remainder of the calendar year. When a family incurs and pays $3,000 in covered expenses in any one calendar year, the percentage payable for covered expenses changes to 100% for the entire family for the remainder of the calendar year.

You will notice that the out-of-pocket maximum amounts are the same as the deductible amounts under the Plan. Thus, when you satisfy the $1,500 individual deductible amount, you have also satisfied the $1,500 individual out-of-pocket maximum amount. Likewise, when you satisfy the $3,000 family deductible amount, you have also satisfied the $3,000 family out-of-pocket maximum amount.

PLAN 1 – MEDICAL COVERAGE WITH HEALTH SAVINGS ACCOUNT (HSA)

As noted above, you generally must pay all costs up to the deductible amount before the Plan begins to pay for covered medical services and most prescription drugs. Your medical coverage includes an HSA (unless you have special circumstances and are covered by an HRA which is described in Section 9 below.)

For Construction Employees, the Fund will make pre-tax contributions to your HSA in monthly amounts of $41.67 if you are enrolled in self-only coverage under the plan, for an annual total contribution of $500.00. For family coverage, the Fund will make pre-tax contributions to your HSA in monthly amounts of $83.34 for an annual total contribution of $1,000.00.

For Utility Employees, the Fund will make pre-tax contributions to your HSA quarterly amounts of $275 if you are enrolled in self-only coverage under the plan, for an annual total contribution of $1,100.00. For family coverage, the Fund will make pre-tax contributions to your HSA in quarterly amounts of $550.00 for an annual total contribution of $2,200.00.

These amounts will be deposited to your HSA on a pre-tax basis, i.e., not subject to employment tax withholding. Your HSA may be used for all qualified medical expenses as defined in Section 213(d) of the Internal Revenue Code (IRC), including eligible medical, dental and vision expenses. In other words, you can pay for eligible medical expenses incurred before you meet your deductible amount with funds from your HSA.

While the amounts described above will be deposited into your account by the Fund each month, you are also permitted to make additional deposits yourself into your account. Please refer to the charts below for the maximum allowable contribution amounts for 2022, including the contribution made by the Fund on your behalf:

Construction Employees	**Single**	**Family**
Annual Deposits made by the Fund	$500.00	$1,000.00
Maximum Amounts allowed by the IRS for 2022	$3,650.00	$7,300.00
Additional amount that you may deposit into your account yourself	$3,150.00*	$6,300.00*

Utility Employees	Single	Family
Annual Deposits made by the Fund	$1,100.00	$2,200.00
Maximum Amounts allowed by the IRS for 2022	$3,650.00	$7,300.00
Additional amount that you may deposit into your account yourself	$2,550.00*	$5,100.00*

*Should you decide you would like to make additional deposits, please contact your tax advisor, as these amounts may be tax deductible. Individual deposits into your HSA account can be done either through payroll deduction or working directly with Further to arrange a transfer from your checking or savings account into your HSA account. Please note: An additional $1,000.00 "catch-up contribution" may also be allowed if you are over age 55. If you would like to know more about these options, please contact your Employer's office or the Fund Office at (802) 864-5864 ext. 14.

Note: The HSA is your personal account, however, you must be covered under a high-deductible health plan (HDHP) with no other non-qualifying coverage to maintain your eligibility to make contributions to the HSA. The funds that accumulate in your HSA are your assets to keep. Each year, the balance remaining in the account is rolled over to the following year. You may invest the funds as you would any other investment account you hold. However, if the funds are distributed to cover non-qualified medical expenses, the amount will be subject to an excise tax in the amount of twenty percent (20%) and will be included in your taxable income in the year of the distribution. However, the funds may be held in your account to cover qualified medical expenses incurred when you retire (age 65 or older) or become disabled with no adverse tax consequences, and if used by a retiree or a disabled person for non-qualified medical expenses will not be subject to the otherwise applicable excise tax.

PLAN 2 – MEDICAL COVERAGE WITH HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If you are covered under Plan 2, your coverage includes a health reimbursement arrangement (HRA). As noted above, you generally must pay all the costs up to the deductible amount before this Plan begins to pay for covered medical services and prescription drugs.

For Construction and Utility Employees, if you have single-only coverage, the Fund will make an upfront annual contribution to your HRA in the amount of $500 for Construction Employees and $1,100 for Utility Employees. The funds held in your HRA may be used to pay for all qualified medical expenses as defined in Section 213(d) of the IRC, including eligible medical, prescription drug, dental and vision expenses covered under the Plan. Thus, the funds contributed to the HRA may be used to pay for costs you must incur to meet your deductible amount as well as your maximum out-of-pocket limit. For example, if you have $1,500 in medical expenses, you may use the $500 that has been contributed to the HRA on your behalf if you are a Construction Employee (or $1,100 if you are a Utility Employee) to pay for these expenses and $1,000 of your own out-of-pocket dollars if you are a Construction Employee (or $400 if you are a Utility Employee). After this point, you would have met both your deductible and maximum out-of-pocket requirements under the terms of the Plan, and you will therefore be eligible to have all of your allowed medical expenses paid by the Plan at 100 percent (100%).

Similarly, if you have family coverage under the Plan, the Fund will make an up-front annual contribution of $1,000 to your HRA for Construction Employees and $2,200 for Utility Employees. The funds held in your HRA may be used for all qualified medical expenses as defined in Section 213(d) of the IRC, including eligible medical, prescription drug, dental and vision expenses covered under the Plan. Thus, the funds contributed to the HRA may be used to pay for costs you must incur to meet your deductible amount as well as your maximum out-of-pocket limit. For example, if you are a Utility Employee and you have $3,000 in medical expenses, you may use the $2,200 that has been contributed to the HRA on your behalf to pay for these expenses and $800 of your own out-of-pocket dollars. After this point, you would have met both your family deductible and your maximum out-of-pocket requirements under the terms of the Plan, and therefore you and your Eligible Dependents will be eligible to have all of your/their allowed medical expenses paid by the Plan at 100 percent (100%).

Note: Eligible Employees will be permitted to roll over any unused balance in the HRA, up to a maximum of $4,999, to the next year, but see below for rules that apply when you become retired under the Plan. For Employees who terminate employment with any Contributing Employer and such Employer is no longer contributing to the Fund, the HRA balance will revert back to the Fund.

RETIREE HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The retiree HRA, for Construction and Utility retirees, only applies to retiring Participants who are participating in Plan 2 at the time of retirement.

Retirees who have maintained an HRA may roll over up to $4,999 into a retiree HRA. These funds may be used to pay qualified expenses as defined in Section 213(d) of the IRC, and/or premiums for health care coverage under a plan purchased by the retiree.

No contributions will be made to the HRA after you retire. When the balance in your retiree HRA reaches zero, your account will be closed.

SCHEDULE OF BENEFITS

The following is a summary of covered benefits provided under the Major Medical Group Plan. Use this chart for quick reference when you need these services. As shown in the table below, you will be responsible for any in-Network charges before you have met the deductible amount.

Note: This Plan does not cover out-of-Network expenses, except for hospital emergency room services, ambulance services and urgent care services. In order for these out-of-network services to be covered, the hospital emergency room services and urgent care services must be related to a true emergency and the ambulance services must be related to an emergent situation. Please check with your provider to make sure they participate with Blue Cross/Blue Shield. If you or your family are out-of-state, you will be able to see any Blue Cross/Blue Shield provider in that state. See below for steps you must take in the case of out-of-network emergency or urgent care.

Effective January 1, 2022, for out-of-Network emergency services, air ambulance services provided by out-of-Network providers, and non-emergency services provided by out-of-Network providers at in-Network facilities, the Plan will cover up to the lesser of the billed amount of the services or the "qualifying payment amount," to the extent required by the No Surprises Act. Subject to the foregoing, these services are available without preauthorization requirements, and they are subject to the same cost-sharing requirements that would apply if the same services were provided by an in-Network provider. Payments made by a Participant or Eligible Dependent for such services will be counted towards meeting the Plan's deductible and out-of-pocket maximum.

In the event that you are in an emergency situation and have been taken to an out-of-network provider, you or someone acting on your behalf should contact Blue Cross Blue Shield of Vermont ("BCBSVT") as soon as possible to notify them that you have obtained services from an out-of-network provider. In this case, your charges will be covered. Other than in an emergency situation, you will be responsible for any billed charges by the out-of-network provider.

The below summary lists the more common medical services covered by the Major Medical Group Plan:

Schedule of Benefits		
Benefits	**Participating Provider:**	**Out-Of-Network Provider:**
PHYSICIAN SERVICES		
Office visit (Preventive Care)	No charge	Not Covered
Office visit (other than Preventive Care)	Deductible applies, then no charge	Not Covered
PHYSICIAN SERVICES (HOSPITAL)		
In hospital visits and consultations Inpatient Outpatient	Deductible applies, then no charge	Not Covered
Surgery (in a physician's office)	Deductible applies, then no charge	Not Covered
INPATIENT HOSPITAL FACILITY SERVICES		
Semi-private room and board and other non-physician services Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. Private room stays may result in extra charges for the patient	Deductible applies, then no charge	Not Covered

Schedule of Benefits		
Benefits	**Participating Provider:**	**Out-Of-Network Provider:**
Inpatient Professional Services For services performed by surgeons, radiologists, pathologists and anesthesiologists	Deductible applies, then no charge	Not Covered
OUTPATIENT SERVICES		
Outpatient surgery (facility charges) Non-surgical treatment procedures are not subject to the facility copay/deductible	Deductible applies, then no charge	Not Covered
Outpatient Professional Services For services performed by surgeons, radiologists, pathologists, and anesthesiologists	Deductible applies, then no charge	Not Covered
Outpatient Physical, Speech and Occupational Therapy	Deductible applies, then no charge, maximum of 30 combined visits per calendar year	Not Covered
Outpatient Chiropractic Care	Deductible applies, then no charge	Not covered
LAB AND X-RAY		
Lab and X-ray Outpatient hospital facility Independent x-ray and/or lab facility	Deductible applies, then no charge	Not Covered

Advanced radiological imaging: Inpatient or Outpatient MRI, MRA, CAT Scan, PET Scan, etc.	Deductible applies, then no charge (some services may require prior approval or will not be covered)	Not Covered
EMERGENCY AND URGENT CARE SERVICES		
Hospital emergency room Includes radiology, pathology and physician charges Copayment waived if admitted, then inpatient hospital charges would apply Out-of-network services are covered at the in-network rate	Deductible applies, then no charge	Not Covered (unless a true emergency, see above)
Ambulance Out-of-network services are covered the same as in-network services. Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered.	Deductible applies, then no charge	Not Covered (unless emergent situation – see above)
Urgent care services Out-of-network services are covered at the in-network rate.	Deductible applies, then no charge	Not Covered (unless a true emergency, see above)
OTHER HEALTH CARE FACILITIES		
Skilled nursing facility, rehabilitation hospital and other facilities Unlimited days per calendar year	Deductible applies, then no charge	Not Covered
Home health care	Deductible applies, then no charge	Not Covered
OTHER HEALTH CARE SERVICES		
Durable medical equipment	Deductible applies, then no charge (some items may require prior approval or will not be covered)	Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		

Inpatient mental health services	Deductible applies, then no charge	Not Covered
Outpatient mental health services	Deductible applies, then no charge	Not Covered
Inpatient substance abuse services	Deductible applies, then no charge	Not Covered
Outpatient substance office services	Deductible applies, then no charge	Not Covered
PRESCRIPTION DRUG BENEFIT		
Generic	Deductible applies, then no charge	Not Covered
Preferred Brand	Deductible applies, then no charge	Not Covered
Non-Preferred Brand	Deductible applies, then no charge	Not Covered
CLINICAL TRIALS	Deductible applies, then no charge	Not Covered

SECTION 6. COMPREHENSIVE MAJOR MEDICAL BENEFITS – GUIDELINES FOR COVERAGE

GENERAL GUIDELINES

- The Plan only pays benefits for services defined as "covered." For all services, you must use Blue Cross Blue Shield of Vermont ("BCBSVT") providers.
- The Plan does not cover services not considered "Medically Necessary." You may appeal decisions made by the Plan (see the "Appeals" Section of this SPD).
- Certain services are excluded from coverage even if they are Medically Necessary. These general and specific exclusions can be found in Section 7, Medical Plan Exclusions, beginning on page 500. General exclusions apply to all services.
- This is not a long-term care policy as defined by Vermont State law at 8 V.S.A. § 8082(5).
- You must follow these guidelines for coverage even if this coverage is secondary to other health care coverage for you or one of your Eligible Dependents.

PRIOR APPROVAL PROGRAM

The Plan requires prior approval for all non-emergency hospital admissions and durable medical equipment or prosthetic devices in excess of $3,500. This does not include hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. When a doctor recommends that the Employee or Dependent be admitted to a hospital or receive durable medical equipment or prosthetic device(s) in excess of $3,500, it is the Employee's responsibility to notify the Plan and to obtain pre-certification and authorization of the hospital admission, durable medical equipment or prosthetic device(s) in excess of $3,500. It is the Employee's responsibility to be sure that in the event of an emergency admission, the Plan is notified within seventy-two (72) hours. In the event that an Employee or Eligible Dependent incurs expenses for services which have not been pre-certified and authorized, a thorough review will be conducted of the services to determine medical necessity at the point of claim. If the review process identifies care which is not Medically Necessary, services will not be covered under the Plan.

The Plan's prior approval list can change. You will be notified of these changes through newsletters or other mailings.

The Plan does not require prior approval for Emergency Medical services.

How to Request Prior Approval

To get prior approval, your network provider must send a letter with supporting clinical documentation to BCBSVT. Forms are available on the BCBSVT website at www.bluecrossvt.org. You may also get them by calling BCBSVT's customer service team. The phone number is located on the back of your ID card.

CASE MANAGEMENT PROGRAM

The Plan's case management program is a voluntary program through BCBSVT. It is available in certain circumstances. Your case manager will work with you, your family and your provider to coordinate medical care for you.

Your case manager will help you manage your benefits. He or she may also find programs, services and support systems that can help. To find out if you are eligible for the program, call (888)-222-9206.

CHOOSING A NETWORK PROVIDER

The Plan offers you access to in-network providers in Vermont and across the country. In Vermont, you will use the BCBSVT (PPO/EPO) network of providers. For outside of Vermont, you will have access to the providers within the BCBS National BlueCard (PPO/EPO) network. Your local and national networks offer a wide array of in-network primary care providers, specialists, and facilities.

In most instances network providers will save you money. Also, network providers will:

- Secure prior approval for you;
- Bill BCBSVT directly for your services, so you don't have to submit a claim;
- Not ask for payment at the time of service (except for deductible amounts you owe); and
- Accept BCBSVT's allowed amount as full payment (you do not have to pay the difference between their total charges and BCBSVT's allowed amount).

If you are a new Participant and are seeing a non-network provider, BCBSVT may allow you to keep going to that provider for up to 90 days after you join or until we find you a network provider, whichever is shorter.

This can happen if:

- You have a life-threatening illness; or
- You have an illness that is disabling or degenerative.

Women in their second or third trimester of pregnancy may continue to obtain care from their previous provider until the completion of postpartum care.

BCBSVT only allows this if your non-network provider will accept the Plan's rates and follow the Plan's standards. BCBSVT's medical staff must decide that you qualify for the service. To find out, call customer service at the number on the back of your ID card.

If you want a list of BlueCard network providers or want information about one, please visit BCBSVT's website at www.bluecrossvt.org and use the network provider search tool. When accessing the network provider search tool use the YOUR PLAN drop-down menu and select BCBSVT network providers (BlueCard PPO/EPO) or use your three letter alpha prefix "VRA" on your ID card to access a list of network providers or call customer service at the number on the back of your ID card.

PRIMARY CARE PHYSICIANS

When you become eligible for coverage under the Major Medical Group Plan, you can select a Primary Care Provider (PCP), but you are not required to select a PCP from the BlueCard Network of Primary Care Providers. To get preferred benefits for most services, you must receive services from your PCP or another network provider. You have the right to designate any PCP who is available to accept you or your family members. Each family member may select a different Primary Care Provider. For instance, you may select a pediatrician for your child.

Your coverage does not require you to get referrals from your Primary Care Provider when you use other providers.

ACCESS TO CARE

BCBSVT requires their Preferred Providers in the state of Vermont to provide care for you:

- Immediately when you have an Emergency Medical Condition;
- Within 24 hours when you need Urgent Services;
- Within two weeks when you need non-Emergency, non-Urgent Services;
- Within 90 days when you need Preventive care (including routine physical examinations); and
- Within 30 days when you need routine laboratory, imaging, general optometry, and all other routine services.

If you live in the state of Vermont, you should find:

- A network Primary Care Provider (like a family practitioner, pediatrician or internist) within a 30-minute drive from your home;
- Routine, office-based mental health and/ or substance abuse care from a Preferred Provider within a 30-minute drive; and

- A Preferred pharmacy within a 60-minute drive.

You'll find specialists for most common types of care within a 60-minute drive from your home. They include optometry, laboratory, imaging and inpatient medical rehabilitation providers, as well as intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services.

You can find network providers for less common specialty care within a 90-minute drive. This includes kidney transplantation, major trauma treatment, neonatal intensive care and tertiary-level cardiac care.

BlueCard's Vermont network providers offer reasonable access for other complex specialty services including major burn care, organ transplants and specialty pediatric care. BCBSVT may direct you to a "center of excellence" to ensure you get quality care for less common medical procedures.

ASSISTANT SURGEONS

Benefits are payable for the professional services of a legally qualified physician in rendering technical assistance to the operating surgeon when required in connection with a surgical procedure performed on an inpatient basis (benefits will not exceed ten percent (10%) of the maximum allowable benefit when the assistant is a physician's assistant).

NON-NETWORK PROVIDERS

Non-network provider services are not covered except for hospital emergency room services, ambulance services and urgent care services. In order for these out-of-network services to be covered, the hospital emergency room services and urgent care services must be related to a true emergency and the ambulance services must be related to an emergent situation. Additional out-of-network services are covered effective as of January 1, 2022; see the *Schedule of Benefits* in Section 5 for more information.

OUT-OF-STATE PROVIDERS

If you need care out of state, you may save money by using providers that are considered participating providers within their local Blue Plan.[1]

THE BLUE CROSS BLUE SHIELD GLOBAL CORE PROGRAM

If you need emergency services when traveling outside the United States, the Blue Cross Blue Shield Global Core program provides hospital and professional coverage through an international network of healthcare providers.

[1] Independent clinical laboratories, durable medical equipment suppliers and specialty pharmacies must contract directly with the Blue Plan in the state where the services were ordered, performed or delivered in order for you to receive preferred provider benefits. To verify the participation status of a laboratory, durable medical equipment supplier or specialty pharmacy, please call customer service at the number on the back of your ID card.

With this program, the covered person is assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use the Blue Cross Blue Shield Global Core Program:

- Call the Blue Cross Blue Shield Global Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week, for the names of participating doctors and hospitals. Outside the U.S., the covered person may use this number by dialing an AT&T Direct Access Number. The covered person can also visit the website at www.bcbsglobalcore.com.

- Show your BCBSVT ID card at the hospital. If the covered person is admitted, they will only have to pay for expenses not covered by the plan, such as deductibles and personal items. Remember to call BCBSVT within forty-eight (48) hours, or as soon as reasonably possible.

- If you receive outpatient hospital care or care from a doctor in the Blue Cross Blue Shield Global Core program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by visiting the Blue Cross Blue Shield Global Core website at www.bcbsglobalcore.com. Mail the claim to the address on the form. You will receive reimbursement less any amount above the allowed amount.

AFTER-HOURS AND EMERGENCY CARE

Emergency Medical Services

In an emergency, you need care right away. The Plan defines an Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- A condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn Child) in serious jeopardy;

- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

Examples of an Emergency Medical Condition might include:

- Broken bones;

- Heart attack; or

- Choking.

You will receive care right away in an emergency.

If you have an emergency at home or away, call 9-1-1 or go to the nearest doctor or emergency room. You do not need approval for Emergency Care. If an out-of-area hospital admits you, call BCBSVT as soon as reasonably possible.

If you receive Medically Necessary, covered Emergency Medical Services from a non-network provider, the Plan will cover your Emergency Care as if you had been treated by a preferred provider. You must pay any deductible amounts required under the Plan as if you received those services from a network provider. If a non-network provider requests any payment from you other than your deductible amounts, please contact BCBSVT at the number on the back of your ID card, so that they can work directly with the provider to resolve the request.

Care After Office Hours

In most non-emergency cases, call your doctor's office when you need care—even after office hours. He or she (or a covering doctor) can help you 24 hours a day, seven days a week. Do you have questions about care after hours? Ask now before you have an urgent problem. Then keep your doctor's phone number handy in case of late-night illnesses or injuries.

Emergency Dental Services

In the event of a dental emergency, you must contact CBA BLUE as soon as possible after the event for approval of continued treatment. The Plan covers only the following dental services under Comprehensive Major Medical Benefits:

- Treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident;
- Surgery to correct gross deformity resulting from major disease or surgery (surgery must take place within six (6) months of the onset of disease or within six (6) months after surgery, except as otherwise required by law);
- Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer; and
- Facility and anesthesia charges for members:
  - Who are 7-years old or younger;
  - Who are 12-years old or younger with phobias or a mental illness documented by a licensed physician or mental health professional; and
  - With severe disabilities that preclude office-based dental care due to safety consideration (examples include, but are not limited to, severe autism, cerebral palsy, hemorrhagic disorders and severe congestive heart failure). Please note the professional charges for the dental services may not be covered.

Note: You must get prior approval from CBA BLUE for the following dental services: oral surgery, dental trauma, orthognathic surgery, except oral lesion excision and biopsy (the Plan does not cover wisdom teeth extraction).

The following dental services are excluded under Comprehensive Major Medical Benefits:

- Surgical removal of teeth, including removal of wisdom teeth;
- Gingivectomy;
- Tooth implants;
- Care for periodontitis;
- Injury to teeth or gums as a result of chewing or biting;
- Pre- and post-operative dental care;
- Orthodontics (including orthodontics performed as an adjunct to orthognathic surgery or in connection with an accidental injury);
- Procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or
- Charges related to non-covered dental procedures or anesthesia (for example, facility charges, except when Medically Necessary, as noted above).

HOW ARE YOUR BENEFITS DETERMINED

When BCBSVT receives your claim, they determine:

- If this Plan covers the medical services you received; and
- Your benefit amount.

In general, BCBSVT pays its allowed amount (explained later in this Section) but may subtract any:

- Benefits paid by Medicare;
- Deductibles (explained below); or
- Amounts paid or due from other insurance carriers through “coordination of benefits.”

Your deductible amounts are described in detail in Section 5.

PAYMENT TERMS

Allowed Amount

The "allowed amount" is the amount the Plan considers reasonable for a covered service or supply.

Note:

- Network providers accept the Plan's allowed amount as full payment. You do not have to pay the difference between their total charges and the Plan's allowed amount.
- If you use a non-network provider for hospital emergency room services, ambulance services or urgent care services and the emergency room services and urgent care services are related to true emergency services or the ambulance services are related to an emergent situation, the Plan will cover such services as if you had been treated by a network provider. Effective January 1, 2022, the Plan will also cover all emergency services, air ambulance services, and services provided by an out-of-Network provider at an in-Network facility to the extent required by the No Surprises Act. See the *Schedule of Benefits* in Section 5 for more information. You must pay any deductible amounts required under the Plan as if you received those services from a network provider.

If you use a non-network provider for services other than those services described above, the Plan will not pay for such services and you will be responsible for the provider's total charge.

Your deductible amounts are shown in Section 5. **You must meet your deductibles each calendar year** before the Plan makes payment on certain services. Amounts applied toward your deductible also count toward your out-of-pocket limit for each calendar year. Once you have met your deductible for the calendar year, you have also met your out-of-pocket limit for that calendar year. Deductibles can apply to certain services or certain provider types.

When your family meets the family deductible, no one in the family needs to pay deductibles for the rest of the Plan Year.

The Plan has an aggregate overall deductible. This means that if you are on a family plan, any combination of covered family members may meet the family overall deductible and the Plan will pay post-deductible benefits.

Copayment

You do not have copayments on your Plan.

Coinsurance

You do not have coinsurance on your Plan.

Out-of-Pocket Limit

Section 5 lists your out-of-pocket limit. We apply your deductible toward this limit. After you meet your out-of-pocket limit, you pay no out-of-pocket cost for the rest of that Plan Year. Please check Section 5 for details.

When your family meets the family out-of-pocket limit, all covered family members are considered to have met their individual out-of-pocket limits.

Self-Pay Allowed by HIPAA

Federal law gives you the right to keep your provider from telling us that you received a particular health care item or service. You must pay the provider our allowed amount. The amount you pay your provider will not count toward your deductible, other cost sharing obligations, or your out-of-pocket limits.

PREVENTIVE CARE

You do not pay a deductible for Preventive Care. Such care is covered at 100% of our allowed amount, with no deductible.

OUT-OF-AREA SERVICES

BCBSVT has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of the Vermont service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between BCBSVT and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside of the service area, you will obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating health care providers. Our payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you obtain out-of-area covered health care services within the geographic area served by a Host Blue, BCBSVT will remain responsible for fulfilling their contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers.

Whenever you access covered health care services outside BCBSVT's service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSVT would then calculate your liability for any covered health care services according to applicable law.

When covered health care services are provided outside of BCBSVT's service area by non-participating health care providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment BCBSVT will make for the covered services as set forth in this paragraph.

In certain situations, BCBSVT may use other payment bases, such as billed covered charges, the payment BCBSVT would make if the health care services had been obtained within their service area, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount BCBSVT will pay for services rendered by non-participating health care providers.

In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment BCBSVT will make for the covered services as set forth in this paragraph.

As a reminder, the only non-participating provider services covered under the Plan are hospital emergency room services, ambulance services and urgent care services. In order for these out-of-network services to be covered, the hospital emergency room services and urgent care services must be related to a true emergency and the ambulance services must be related to an emergent situation.

SECTION 7. MEDICAL PLAN EXCLUSIONS

The Plan pays benefits for covered services only as described in this SPD. The SPD and any of your Summaries of Material Modification ("SMMs") may contain specific exclusions.

In addition to the specific exclusions listed elsewhere in this SPD, the following general exclusions apply. The Plan does not cover services and supplies that are not medically necessary. Also, the Plan does not cover the following even if these services and products are determined by another source to be medically necessary:

1. Services that a prior health plan must cover as extended benefits.
2. Services you would not legally have to pay if you did not have coverage under this Plan or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require because you committed or attempted to commit a felony or engaged in an illegal occupation, other than as a result of an act of domestic violence.
6. Services over the limits or maximums under the Plan.
7. Services or drugs that the Plan determines are investigational, mainly for research purposes or are experimental in nature. To the extent required by law, however, the Plan covers routine costs for patients who participate in approved clinical trials.
8. Services not provided in accordance with accepted professional medical standards in the United States.
9. Services beyond those needed to restore your ability to perform activities of daily living or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
10. Acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. The Plan covers medically necessary covered services when performed within the scope of a naturopathic physician's license.
11. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation (TENS) devices or neuromuscular stimulators for which you have received prior approval.)
12. Automatic ambulatory home blood pressure monitoring or equipment.
13. Biofeedback or other forms of self-care or self-help training.
14. Bulk immunizations (those provided to a group of people, such as Employees in an office setting) or fluoride treatments performed in school.
15. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion services for blood and blood components the patient donates for his or her own use in the absence of a covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components and blood derivatives.)
16. Care for which there is no therapeutic benefit or likelihood of improvement; Maintenance Care.

17. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
18. (Routine) Circumcision.
19. Clinical ecology, environmental medicine, inpatient confinement for environmental change or similar treatment.
20. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
21. Communication devices and communication augmentation devices. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
22. Consultations, including telephone consultations, except when they occur between providers and the providers attach a written report to the patient's medical record.
23. Correction of near- or far-sighted conditions or aphakia (where the lens of the eye is missing either congenitally or accidentally or has been surgically removed, as with cataracts) by means of "laser surgery," or refractive keratoplasty procedures such as keratomileusis, keratophakia and radial keratotomy and all related services.
24. Cosmetic procedures and supplies that are not reconstructive. Unless expressly covered in other parts of this Plan or required by law, the Plan does not cover:
    - Excision of excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fatpad) and all other areas not specified;
    - Suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
    - Breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast cancer surgery;
    - Surgery to improve the appearance of the ear (otoplasty);
    - Mastectomy for gynecomastia;
    - Blepharoplasty repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
    - Surgery to improve the appearance of the nose (rhinoplasty).

    Note: This exclusion does not apply to: (1) surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; or (2) medically diagnosed congenital disease or birth abnormality of an Eligible Dependent child.

25. Custodial Care, Rest Cures.
26. Dental services and dental related oral surgery, unless specifically provided under the Plan; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).

27. Treatment of developmental delays. (This exclusion does not apply to mandated treatment of autism spectrum disorder up to age 21 as defined by Vermont law).
28. Eyeglasses or contact lenses for refractive purposes unless you need them to replace the lens of an eye (and the lens was not replaced at the time of surgery).
29. Education, educational evaluation or therapy, therapeutic boarding schools, services that should be covered as part of an evaluation for, or inclusion in, a child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved participating providers).
30. Foot care or supplies that are palliative or cosmetic in nature, including supportive devices and treatment for bunions (except capsular or bone surgery), flat-foot conditions, subluxations of the foot, corns, callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. This exclusion does not apply to necessary foot care for treatment of diabetes.
31. Hearing aids or examinations for the prescription or fitting of hearing aids.
32. Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, furniture or "barrier- free" construction, even if prescribed by a provider.
33. Illnesses or injuries that are:
    - A result of an act of war (declared or undeclared); or
    - Sustained in active military service.
34. Infertility services, including:
    - Surgical, radiological, pathological or laboratory procedures or medication leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

    Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile. In addition, the Plan may cover up to four months of fertility medications per calendar year when you attempt to conceive through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygote intrafallopian transfer or any variations of these procedures).

35. An inpatient stay determined not medically necessary while you are waiting for a different level of care, such as a skilled nursing facility or home care, whether or not it is available to you.
36. Treatment for willfully uncooperative or intractable patients.
37. Institutional or custodial care for the physically or mentally handicapped.
38. Mandated treatment, including court-ordered treatment, unless such treatment is medically necessary, ordered by a physician and covered under the Plan.
39. Non-medical charges, such as:

- Taxes;
- Postage, shipping and handling charges;
- A penalty for failure to keep a scheduled visit; or
- Fees for completion of a claim form.

40. Nutritional counseling beyond three visits per calendar year, except as otherwise covered under "Preventive Care Services Provided At No Charge In-Network." This limit does not apply to the treatment of diabetes or any mental or behavioral health diagnosis (including eating disorders).
41. Nutritional formulae or supplements, except for "medical foods" prescribed for the medically necessary treatment of an inherited metabolic disease or prescription formulae and supplements administered through a feeding tube.
42. Orthodontics, including orthodontics performed as adjunct to orthognathic surgery or in connection with accidental injury.
43. Pain management programs.
44. Personal hygiene items.
45. Personal service, comfort or convenience items.
46. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
47. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g., knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.
48. Pneumatic cervical traction devices.
49. Specialized examinations, services or supplies required by your Employer or for sports/recreational activities (e.g., driver certifications, pilot flight physicals, etc.).
50. Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, music or art therapy, recreational therapy, tobacco cessation therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy.
51. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
52. "Store and forward telemedicine" or telemedicine not conducted at a preferred facility.
53. Travel (other than Ambulance transport), lodging and housing (when it is not integral to a medically necessary level of care, even if prescribed by a provider).
54. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
55. Treatment of obesity, except as otherwise covered under "Preventive Care Services Provided At No Charge In-Network" and except for surgical treatment when determined medically necessary through prior approval.
56. Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are covered by workers' compensation or should be so covered. (This provision does not require an individual, such as a sole

proprietor or an owner/partner to maintain worker's compensation if he or she does not legally need to be covered.)

57. The drug Stelara®.
58. Gene therapy, genetically engineered products and services related to cloning. Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies, such as Kymriah and Yescarta, as well and Luxturna and Zolgensma.
59. Services and supplies not specifically described as Covered.

PROVIDER EXCLUSIONS

Also, the Plan does not cover services prescribed or provided by a:

- Provider that the Plan does not approve for the given service or that is not defined in our "Definitions" section as a provider;
- Professional who provides services as part of his or her education or training program;
- Member of your immediate family or yourself;
- Veterans Administration Facility treating a service-connected illness or disability; or
- Non-preferred provider if the Plan requires use of a Preferred Provider as a condition for coverage under the Plan.

NONDISCRIMINATION OF PROVIDERS

This Plan does not discriminate with respect to participation in the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

SECTION 8. HEALTH SAVINGS ACCOUNT (HSA)

THE BASICS

An HSA is a tax-advantaged account that can be used to pay for qualified health expenses that you or your Eligible Dependents incur, while covered under a high deductible medical plan. HSA contributions:

- Accumulate over time with interest or investment earnings;
- That are not used are rolled over from year-to-year;
- Are portable and remain yours if you become ineligible to participate in the HSA; and
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis, with the application of an excise tax in certain circumstances.

Note: Your HSA is an individually-owned account and is not considered part of this plan nor is it subject to ERISA.

ELIGIBILITY

For you to make contributions to an HSA, you must satisfy the following eligibility requirements:

- You must be covered by a high deductible medical plan;
- You cannot be claimed as another person's tax Dependent;
- You must not be enrolled in Medicare;
- You must not participate in a health care Flexible Spending Account (FSA) except a limited purpose health care FSA; and
- You must not be covered under any other health care coverage (or non-qualifying health coverage) other than qualifying high deductible coverage such as the Comprehensive Major Medical plan offered by the Plan. This means that if you are covered under your Spouse's non-high deductible health plan coverage, including a full-purpose health flexible spending account, you are not eligible for an HSA.

WHAT CAN I USE MY HSA FOR?

Under IRS rules, HSA accounts can be used to cover **qualified health care expenses** incurred by:

- You and your covered Spouse;
- Any individual you claim as a Dependent on your federal tax return; and
- Any individual you could have claimed as a Dependent on your federal tax return except where that the person has filed a joint return, had gross income over the personal exemption amount for the year; or your covered Spouse, if filing jointly, could not be claimed as a Dependent on someone else's federal tax return.

Note: A child of parents who are divorced, separated or living apart for the last six (6) months of a calendar year is treated as the Dependent of both parents whether or not the custodial parent releases the claim to the child's exemption.

Examples of **qualified health care expenses** include:

- Acupuncture
- Alcohol and drug addiction treatment
- Breast reconstruction surgery
- Dental treatment
- Diagnostic tests and devices
- Doctor's visits
- Prescriptions
- Eyeglasses, contact lenses and exams
- Fertility enhancements
- Heading aids and batteries
- Operations/surgery (non-cosmetic)
- Nursing services
- Physical therapy
- Psychiatric care
- Smoking cessation

For a full list of qualified medical expenses, please go to: www.irs.gov/publications/p502/index.html or visit the Fund Office.

IMPORTANT INFORMATION ABOUT YOUR HSA

You have discretion on when and how you use the money in your HSA. Under federal law, HSA funds can be used for anything, however, to avoid penalties and taxes, the funds must be used on qualified medical, dental, vision and prescription expenses for you and your tax dependents.

You may make changes to your pre-tax contribution amount up to one time per month.

You do not pay federal income or FICA taxes on your contributions to your HSA.

You do not pay state income taxes on your contributions to your HSA.

HOW THE HSA WORKS

Each Plan Year, Construction Employees will receive a deposit of $500 (if single) or $1,000 (if family) that will be contributed to your HSA. Utility Employees will receive a deposit of $1,150 (if single) or $2,200 (if family) that will be contributed to your HSA. You may also elect to make additional tax-free contributions to your account,

up to the federal limits (2022 – $3,650 for single coverage; $7,300 for family coverage less any amount contributed by the Plan). You choose how to pay for qualified medical expenses. For example:

- You may pay claims on your own using a debit card issued by Further that draws from your HSA.
- You may choose the automatic claim forwarding option, allowing claims to be paid directly to your doctor, hospital, or other facility so you don't have to do anything. Your claims are paid automatically while there is money in your HSA.
- You may choose to cover your expenses using your own personal funds. This option allows you to save your HSA dollars for qualified medical expenses in future years or at retirement. The balance in your savings account will earn interest.

Any money left in your HSA at the end of the Plan Year will be rolled over for you to use towards future medical expenses. If you leave Covered Employment or change medical plans with funds remaining in your account, the money is still yours to pay for eligible medical expenses. However, you will not be able to continue making contributions unless you have coverage under another High Deductible Health Plan.

If you withdraw money from your account for non-eligible expenses before age 65, you will be subject to a 20% penalty on those funds. In addition, the money will be treated as ordinary income and will be subject to taxes. However, if you become disabled before age 65, the 20% penalty will not apply.

MORE INFORMATION

More information about your HSA is available at the Fund Office or by contacting Further at (800) 859-2144. Also, remember that there are many rules and tax implications associated with the HSA so it is important that you consult with a tax advisor to ensure you are compliant.

SECTION 9. HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Plan also offers access to a Health Reimbursement Arrangement account ("HRA") for eligible Participants. An HRA is a type of Employer-funded health benefit plan that reimburses Employees for certain out-of-pocket medical expenses the Employee, his Spouse or Eligible Dependents incur. As discussed more fully below, Participants eligible for coverage in the Major Medical Group Plan may only enroll in an HRA if they, or their Eligible Dependents, cannot meet the eligibility requirements for an HSA. The HRA is administered through Further.

HRA ELIGIBILITY

1. What Are the Eligibility Requirements for the HRA?

   If you or any of your Eligible Dependents are not otherwise eligible to participate in the HSA, you will be automatically enrolled in the HRA once you become eligible to participate in the Plan (unless you choose to opt-out of the HRA).

2. When is My Entry Date?

   Your entry date is the date you satisfy the eligibility requirements for health care coverage as discussed above.

3. Are There Any Employees Who Are Not Eligible?

   Yes. Employees who are eligible to participate in the Plan and the HSA offered by the Plan are not eligible to participate in the HRA. Likewise, Employees who are not covered by the Plan are also not eligible to participate in the HRA.

4. Who Meets the Definition of an Eligible Dependent under this Plan?

   Eligible Dependents for the purposes of this Plan are defined as the Participant's Spouse (the individual who is legally married to the Participant, as determined under federal law and with whom the Participant can file a joint income tax return and pursuant to state law) and the Participant's children (biological, legally adopted, and stepchildren) up to age 26.

YOUR HRA BENEFITS

1. *What medical expenses are reimbursable with my HRA?*

   The funds held in your HRA may be used to pay for all qualified medical expenses as defined in Section 213(d) of the IRC, including eligible medical, prescription drug, dental and vision expenses covered under the Plan.

2. *How much will my HRA Account be credited each calendar Year?*

   The first day of each calendar Year, Participants with "Employee Only" coverage under the Plan will have $1,100 credited to their HRA account. Construction Participants with "Employee Plus Spouse," "Employee Plus Child(ren)" or "Employee Plus Spouse" coverage will have $1,000 credited to their HRA account. Utility Participants with "Employee Plus Spouse," "Employee Plus Child(ren)" or "Employee Plus Spouse" coverage will have $2,200 credited to their HRA account. If you are a new hire and enter the plan mid-year, the HRA amount provided to you will be prorated on a monthly basis. Any amounts reimbursed under the HRA may not be claimed as a deduction on your personal income tax return or reimbursed from any other source including any other health plan coverage.

3. *Does my HRA have a maximum account balance?*

   The Trustees may establish a maximum account balance for each class of Participants unless the maximum is provided for in a Collective Bargaining Agreement or Participation Agreement. If your HRA account balance equals or exceeds your maximum balance on any determination date, no additional Employer contributions will be credited to your account until the account has paid benefits that are sufficient to reduce your balance below the maximum.

4. *What happens if my HRA has a balance at the end of the calendar year?*

   If the maximum amount available for reimbursement for a calendar year is not utilized in its entirety, the remaining balance will be carried over to the next calendar year, subject to any maximum account balance rules adopted by the Plan.

5. *What is the "Coverage Period"?*

   The "Coverage Period" begins January 1st and ends December 31st.

6. *How are payments made from the HRA?*

   The Plan will submit to the Claims Administrator requests for reimbursement of expenses you have incurred during the course of a coverage period for medical and prescription deductibles. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. All claims need to be submitted for reimbursements no later than ninety (90) days after the end of the coverage period. If the request qualifies as a benefit or expense that the HRA has agreed to pay, the Claims Administrator will pay your provider directly. You will be responsible for paying your provider for any expenses not covered by this HRA. Remember, reimbursements made from the HRA are generally not subject to federal income tax or tax withholding, including Social Security taxes. You may not claim any amounts reimbursed under the HRA as a deduction on your personal income tax return nor can it be reimbursed from any other source.

7. *What happens if my coverage in the Plan terminates or I am no longer working in Employment Covered by a Collective Bargaining Agreement with IBEW Local 300 ("Covered Employment")?*

Your HRA account will no longer be credited with Employer contributions beginning on the earlier of: (a) the date that your coverage in the Plan is terminated, or (b) the date you leave Covered Employment ("Termination Date"). You will not be eligible to be reimbursed for any expenses that are incurred after your Termination Date. You must submit claims for any expenses incurred prior to your termination of coverage under the Major Medical Group Plan within ninety (90) days after your Termination Date. Any unused amounts in the account after such date will be forfeited.

8. *What Happens if I Die?*

   Any HRA account balance you maintain at the time of your death will be forfeited.

9. *Can I Opt-Out of the HRA?*

   You may at any time permanently opt-out of the HRA and waive any future benefits by submitting a form to the Fund Office. Contact the Fund Office for a copy of this form. If you permanently opt-out of the HRA and waive future benefits, any amounts in your HRA account at such time will be forfeited. Note that the HRA constitutes minimum essential coverage under the Affordable Care Act, and coverage under the HRA will make you ineligible for a premium subsidy if you purchase health insurance on the Marketplace (also known as the Exchange). Therefore, you may wish to opt-out of coverage under this HRA if you have no other group health plan coverage and would otherwise qualify for premium assistance for the purchase of coverage on the Marketplace.

HOW CLAIMS ARE SUBMITTED AND PAID

The Plan will submit all claims to the Claims Administrator for processing. The Claims Administrator will process your claims according to the terms of the HRA and send your provider a check for the amount that is eligible for reimbursement through this HRA. You are responsible for paying your provider for amounts billed that are not covered by the HRA.

Claims for any medical and prescription deductibles incurred in any Plan Year shall be paid as soon after a claim has been received as administratively practicable. If any claim is not submitted within ninety-two (92) days immediately following the end of the Plan Year (that is, by March 31), the claims shall not be eligible for reimbursement.

Payments of reimbursable amounts under this HRA shall be made directly to the provider.

DEBIT CARD

In addition, a Participant in the HRA may use his or her debit card. This card permits Participants to pay the medical and prescription drug deductible and dental and vision expenses at qualified merchants or health care providers with the debit card instead of paying out-of-pocket money for such expenses and submitting them for reimbursement. Each Participant in the HRA will be issued a debit card and will certify upon enrollment in the HRA and each calendar year thereafter that the card will only be used for the medical and prescription drug

deductible and dental and vision expenses. Participant-cardholders will also certify that any medical and prescription drug deductible and dental and vision expenses paid with the card have not been reimbursed elsewhere and that the Participant will not seek reimbursement for such expenses under any other plan covering health benefits. Participant-cardholders must acquire and retain sufficient documentation for any expense paid with the debit card, including invoices and receipts where appropriate. Upon the Participant's termination of employment, the debit card will be automatically cancelled.

The following requirements relate to the use of the debit card:

- If the dollar amount of the transaction at a health care provider equals the dollar amount of the medical and prescription drug deductible and/or dental and vision expenses for that service under the Plan, the charge is fully substantiated without the need for submission of a receipt or further review.
- There will be automatic reimbursement, without further review, of recurring expenses that match medical and prescription drug deductible and dental and vision expenses previously approved as to amount, provider, and time period.
- If the dollar amount of the transaction does not equal the dollar amount of the medical and prescription drug deductible and/or dental and vision expenses for that service under the Plan, the charge may require substantiation and the need for submission of a receipt or further review.

If your card is lost or stolen, please call Further immediately or go on-line to report your card lost/stolen.

CLAIM DENIALS AND APPEALS

Please refer to Sections 16 and 17 of this SPD for a description of rules relating to the denial of claims and your appeal rights.

SPECIAL COORDINATION OF BENEFITS RULES (HRA ONLY)

Coverage under the HRA is intended to pay benefits for eligible medical and prescription deductibles that are not reimbursable from another source, such as from insurance or any other benefit plan. If a medical or prescription deductible is reimbursable from another source, that other source should pay before any amount of the claim is submitted for reimbursement under the HRA, unless otherwise stated.

If the amounts of your medical or prescription claims are covered by a Health Flexible Spending Account (also known as a Section 125 plan), then the HRA will pay reimbursements only after the maximum annual amount available under the Health Flexible Spending Account or Section 125 Plan has been paid out. You cannot be reimbursed for more than one hundred percent (100%) of any eligible medical expense that you incur, regardless of whether the reimbursement is paid only from the HRA, or from a combination of the HRA and other sources.

SPECIAL COBRA CONTINUATION COVERAGE RULES (HRA ONLY)

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the HRA will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA Continuation Coverage") where coverage under the HRA would otherwise end. This notice is intended to inform Participants and Eligible Dependents, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any other rights under the law.

COBRA Continuation of coverage - Because the HRA is part of the Health and Welfare Plan, the law requires that the Plan must offer qualified beneficiaries the opportunity to elect to continue their coverage under the HRA by making contributions to the HRA after a Qualifying Event paid from personal funds (self-paid by Participant). Please read below for additional information on the different rules for access to COBRA Continuation Coverage under the HRA after a Qualifying Event.

If you are no longer eligible for coverage - If a Participant and his/her Dependents lose eligibility for Health and Welfare Plan benefits because of the Participant's termination of employment covered by the Plan or a reduction in hours of employment covered by the Plan, the Participant and his or her Dependents have a Qualifying Event pursuant to COBRA. If eligibility is not otherwise extended under one of the Plan's rules, the Participant and his or her Dependents will be offered the opportunity to extend eligibility under the Health and Welfare Plan by electing COBRA Continuation Coverage under the HRA and by paying the required COBRA premiums.

You must pay COBRA premiums for this coverage on an after-tax basis. However, you will continue to be eligible to receive reimbursements from your HRA using those COBRA contributions plus any account balance that was in the HRA at the time of the Qualifying Event. If you elect COBRA and contribute to your HRA from your personal funds, those amounts are subject to HRA rules and may only be paid to you as described in this section.

You are not required to elect COBRA Continuation Coverage to continue to receive reimbursements from your HRA, but you may only receive reimbursement up to the amount of any non-forfeited account balance at the time of the Qualifying Event.

If you lose eligibility because of death of the Participant - If an Eligible Dependent loses eligibility for Health and Welfare Plan benefits because of the death of the Participant, they have a Qualifying Event. If eligibility is not otherwise extended under one of the Plan's rules, they will be offered the opportunity to extend eligibility under the Health and Welfare Plan HRA by electing COBRA Continuation Coverage and self-paying the required COBRA premiums.

However, in the case of the death of the Participant, the surviving Spouse and Eligible Dependent(s) are NOT required to elect COBRA Continuation Coverage under the HRA or pay COBRA premiums to continue reimbursements from the HRA. They will continue to have access to the HRA and receive reimbursements from the HRA so long as the account balance is sufficient to cover their claims. In fact, any outstanding balance in the HRA may be used to pay the required COBRA premiums for coverage under the Health and Welfare Plan if that coverage is elected for COBRA continuation rights.

The surviving Spouse and Eligible Dependent(s) must be offered the opportunity to elect continued coverage under the HRA on an after-tax basis following the Qualifying Event. If they elect the COBRA coverage and contribute to the HRA from their personal funds, those contributions are subject to HRA rules and may be paid only as described in this section.

If you lose eligibility because of divorce of the Participant and Spouse or because you no longer meet the definition of "Eligible Dependent" under the Plan - If you lose eligibility for Health and Welfare Plan benefits because of the divorce of the Participant or because you no longer meet the definition of "Eligible Dependent" under the Plan, you have a Qualifying Event. If eligibility is not otherwise extended under one of the Plan's rules, you will be offered the opportunity to extend eligibility under the Health and Welfare Plan by electing COBRA Continuation Coverage and self-pay COBRA premiums.

You may elect COBRA Continuation Coverage under the HRA and self-pay COBRA premiums. You will continue to receive reimbursements from the HRA for the COBRA contributions, plus any amounts that were held in the HRA at the time of the Qualifying Event. You will have access to the HRA and will be able to receive reimbursements from the HRA if you elect COBRA coverage and continue to pay the required COBRA premiums so long as the account balance is sufficient to cover your claims.

IF YOU HAVE QUESTIONS

If you have questions about your rights to COBRA Continuation Coverage, you should contact the Plan Administrator or its designee.

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through the Health Insurance Marketplace, and to locate an individual who can assist you in your area and talk to you about the different options, visit www.HealthCare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights under the Plan, you should keep the Plan Administrator informed of any changes in the addresses of yourself and/or family members. You also should keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

TAX STATUS OF HRA BENEFITS

All benefits paid from the HRA as reimbursement of claims for medical expenses are intended to be exempt from income tax. However, neither the Plan Sponsor nor the Plan Administrator is making any guarantee that any given expense reimbursement is, in fact, exempt from federal, state or local income taxes. If you have any

questions as to whether reimbursements received from this Plan are taxable to you, please consult your personal tax advisor.

If any benefits paid under the HRA are taxable to you, you are obligated to notify the Plan Administrator so that they can withhold the proper amount from the distribution or reimbursement amount. If you do not notify the Plan Administrator, you are responsible for indemnifying the Plan Sponsor for any penalty it may incur for failing to withhold taxes from such amounts.

SECTION 10. DENTAL BENEFITS

Note that dental benefits are provided through CBA BLUE. This Section contains a summary of the benefits offered through CBA BLUE.

With the CBA BLUE Preferred Dentist Program (PDP), you can visit the dentist of your choice whether it is an "in-network" dentist (a participating CBA BLUE PDP dentist) or an "out-of-network" dentist.

- Plan benefits for in-network services are based on the percentage of the PDP fee as negotiated between-CBA BLUE and the PDP dentists who have agreed to accept as such amount as payment in full.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the CBA BLUE PDP, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee as charged and what your plan will pay for the approved service.

SCHEDULE OF BENEFITS

Coverage Type	In-Network % of PDP Fee	Out-of-Network % of R&C Fee[1]
Type A	100%	100%
Type B	80%	80%
Type C	50%	50%
Orthodontia	50%	50%
Deductible: Individual/Family[2]	None	None
Annual Maximum Benefit Per Individual (Applies to Types A, B and C combined)	$1,500	$1,500
Orthodontia Lifetime Maximum Per Individual	$1,500	$1,500
	Note: Orthodontia benefit applies to child only (up to age 19)	

SELECTED COVERED SERVICES AND FREQUENCY LIMITATIONS

Note: Alternate Benefits: Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your Eligible Dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

[1] The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Customary Charge" (the 90th percentile charge of most dentists in the same geographic area for the same or similar services as determined by BCBSVT).

[2] If you are enrolled for Dependent coverage, a maximum family deductible may apply.

Type A

• Oral Examinations	1 in 5 months.
• Cleanings	4 in 1 year.
• Fluoride	Children under age 19 / 2 treatments in 12 months.
• Bitewing X-rays	Adult - 1 in 12 months / Children - 1 in 12 months.
• Full Mouth and Panoramic X-rays	1 in 1 year.
• Periodontal Maintenance	4 in 1 year less the number of teeth cleanings.
• Space Maintainers	
• Sealants (1st & 2nd permanent molars)	1 treatment per tooth in 60 months of an Eligible Dependent child under age 19.
• Emergency Palliative Treatment	

Type B

- Fillings
- Extractions
- Oral surgery (only simple extractions are covered; surgical removal of bony impacted teeth are not covered)
- Endodontics
- Periodontics
- Stainless steel crowns and repairs to stainless steel crowns
- General and local anesthesia

TYPE C

- Crowns, except stainless steel crowns
- Inlays/Onlays
- Dentures
- Bridges
- Implants
- Bruxism Appliances
- Repair of prosthetic appliances

Orthodontia

- Eligible Dependent children are covered up to their 19th birthday.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis.
- Orthodontic benefits end at cancellation of coverage.

EXCLUSIONS

The Plan will **not** pay Dental Insurance benefits for charges incurred for:

1. Expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion

applies to all covered individuals, including but not limited to, self-employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers' compensation and occupational disease, regardless of whether such coverage or coverages are required by law.

2. Expenses for services for disease or injury sustained as a result of war, or participation in riot or civil disobedience or while committing or attempting to commit a criminal act or engaging in an illegal activity, suicide, or intentionally self-inflicted injuries.
3. Expenses for services for which a charge is not usually made, for a charge that would not be made if the Employee had no dental coverage, or for services rendered by a person to his/her own family members.
4. Expenses for unnecessary care, treatment, surgery, or solely for cosmetic reasons, except as provided herein.
5. Expenses for confinement in a hospital.
6. Expenses which the Employee or their family members are not legally required to pay.
7. Expenses in excess of what is the maximum allowable benefit, as determined by the Plan.
8. Expenses for unnecessary care, treatment (including those not customarily performed for that particular dental condition), or dental procedures performed to characterize or personalize dentures or bridges.
9. Expenses for replacement of a lost, missing, or stolen prosthetic device or other device or appliance; or a bridge or denture which meets or can be made to meet generally accepted dental standards or for a duplicate set of dentures or appliances; or for the upgrading of a replacement appliance, crown, inlay, onlay, or fixed bridge (an upgrade may be chosen, however, the Plan will consider the cost of the necessary replacement).
10. Expenses for instruction in oral hygiene, plaque control, dietary control, or for the completion of any forms or failure to keep any scheduled appointment.
11. Any service or supply which is not furnished by a dentist, except a service performed by a dental hygienist working under the supervision of a dentist and x-rays ordered by a dentist.
12. Appliances, restorations, or procedures (except full dentures) for altering vertical dimension, restoring or maintaining occlusion, splinting, bite registration, bite analysis, replacement of tooth surface lost by abrasion or attrition, correcting congenital or developmental malformations (including replacement of congenitally missing teeth), myofunctional therapy, or for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ).
13. Expenses for procedures, services, or appliances (including prosthodontics) initiated or provided prior to the covered person's effective date of coverage or following the date the covered person's coverage terminates (except orthodontics, inlays, onlays and crowns which are finally inserted within thirty (30) days after termination of coverage will be covered).
14. Expenses for treatments or procedures which are experimental whether for diagnosis or treatment of any sickness or injury as determined by the American Dental Association or the appropriate dental specialty society or that do not meet common dental standards.
15. Expenses for services that are deemed to be medical services or for services and supplies received from a hospital unless otherwise provided herein.
16. Expenses for the replacement of any prosthetic appliance, crown, fixed bridge, inlay or onlay restoration within five (5) years following the date of its original installation or last replacement unless such

replacement is necessitated by damage that cannot be repaired to meet generally accepted dental standards (provided damage is not intentional or negligent) or where the loss of additional teeth requires the construction of a new appliance.

17. Expenses for veneers or similar overlays on bridges placed on the twelve (12) molar teeth or for overlays or non-restorative bonding or appliances to treat bruxism.
18. Expenses for prescription drugs or medications, except as provided herein.
19. Expenses for over-the-counter home fluoride treatments (i.e., omni gel).
20. Expenses for tooth bleaching unless done to restore color on a tooth which previously had a root canal.
21. Expenses for services which have not been completed. (Inlays, onlays, crowns, bridges, and dentures will be considered completed on the date prepared and final impressions are taken.)
22. Expenses for caries susceptibility tests.
23. Expenses for temporary or provisional restorations.
24. Expenses for temporary or provisional appliances.
25. Expenses for precision attachments.
26. Expenses for the initial installation of a fixed or permanent denture to replace one or more natural teeth which were missing before such person was covered under the dental plan, except for congenitally missing natural teeth.
27. Expenses for the surgical removal of bony impacted teeth.

SECTION 11. VISION BENEFITS

Note that vision benefits are provided through Vision Service Plan Insurance Company ("VSP"). This Section contains a summary of the benefits offered through VSP. However, the Fund Office has additional information about this coverage, which may include additional restrictions or benefits not shown in this Section. When a conflict exists between the SPD and the information available from VSP for the vision benefits, the information available from VSP shall apply.

In addition to the vision benefits provided through VSP, one routine vision exam is provided every calendar year through CBA BLUE. This benefit is for an exam only and hardware and materials are excluded.

GENERAL

This schedule lists the vision care benefits to which you are entitled, subject to any copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether member providers or non-member providers.

Member providers are the doctors who have agreed to participate in VSP's Choice Network.

PROVIDER NETWORK

The Plan uses the **VSP Choice** network.

PLAN BENEFITS

When Plan Benefits are received from a member provider, benefits appearing in the first column below are applicable, subject to any copayments as stated below. When Plan Benefits are received from non-member providers, the Participant is reimbursed for such benefits according to the schedule in the third column below minus any applicable copayments.

Benefit	Member Provider Benefit	Non-Member Provider Benefit
Well Vision Exam through VSP • Focuses on your eyes and overall wellness • Every 12 months	You pay $10 copayment for exam	Plan pays up to $45
Well Vision Exam through BCBSVT • Focuses on your eyes and overall wellness • Every calendar year	You pay $20 copayment for Exam	Not covered

Benefit	Member Provider Benefit	Non-Member Provider Benefit
Frames • $130 allowance for a wide selection of frames; $150 allowance for featured frame brands • $70 Costco frame allowance • 20% off amount over your allowance • Every 12 months	You pay $10 copayment for glasses (frames and lenses combined)	Plan pays up to $70
Lenses • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for Eligible Dependent children • Every 12 months	You pay $10 copayment for glasses (frames and lenses combined)	Single vision: Plan pays up to $30 Lined bifocal: Plan pays up to $50 Lined trifocal: Plan pays up to $65
Lens Options • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options • Every 12 months	You pay $55 You pay $95 - $105 You pay $150 - $175	Plan pays up to $50 Plan pays up to $50 Plan pays up to $50
Contact Lenses (instead of glasses) • $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	You pay up to $60 copayment	Plan pays up to $105
Extra Savings – Glasses	Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details	No extra savings
Extra Savings – Sunglasses	20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision exam.	No extra savings
Extra Savings – Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a Well Vision exam.	No extra savings

Benefit	Member Provider Benefit	Non-Member Provider Benefit
Extra Savings – Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.	No extra savings

DESCRIPTION OF BENEFITS

EYE EXAMINATION

Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations once every Plan Year beginning on October 1st.

VISION CARE MATERIALS

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency; and
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every Plan Year in lieu of all other lens and frame benefits available. When contact lenses are obtained, you will not be eligible for lenses and frames again for one Plan Year.

NECESSARY LENSES

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by your member provider or non-member provider. Prior review and approval are not required for the Participant to be eligible for Necessary Contact Lenses.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP member provider or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

Vision benefits are designed to cover visual needs rather than cosmetic materials. When the Participant selects any of the following extras, the Policy will pay the basic cost of the allowed lenses or frames, and the Participant will pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses.
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- A frame that costs more than the Plan allowance
- Contact lenses (except as noted elsewhere herein)
- Certain limitations on low vision care

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power) or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear required by an Employer as a condition of employment; or
- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

THE PLAN MAY, AT ITS DISCRETION, WAIVE ANY OF THE LIMITATIONS IF, IN THE OPINION OF THE PLAN'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE PARTICIPANT.

ADDITIONAL BENEFIT - PRIMARY EYE CARE

Primary Eye Care is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms. Under the plan, member providers provide treatment and management of urgent and follow-up services. Primary Eye Care also involves management of conditions that require monitoring to prevent future vision loss.

The member provider is responsible for advising and educating patients on matters of general health and prevention of ocular, as well as systemic disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the member provider as a Primary Eye Care Professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

SYMPTOMS

Examples of symptoms which may result in a patient seeking services on an urgent basis under the Primary Eye Care Plan include, but are not limited to:

- Ocular discomfort or pain
- Recent onset of eye muscle dysfunction
- Transient loss of vision
- Ocular foreign body sensation

- Flashes or floaters
- Pain in or around the eyes
- Ocular trauma
- Swollen lids
- Diplopia
- Red eyes

CONDITIONS

Examples of conditions that may require management under the Primary Eye Care Plan, include, but are not limited to:

- Ocular hypertension
- Macular degeneration
- Retinal nevus
- Corneal dystrophy
- Glaucoma
- Corneal abrasion
- Cataract
- Blepharitis
- Pink-eye
- Sty

PROCEDURES FOR OBTAINING PRIMARY EYE CARE SERVICES

1. To obtain Primary Eye Care Services, the Participant contacts a member provider's office and makes an appointment. If necessary, the Participant may call the Company's Customer Service Department first to determine the nearest location of a member provider's office.
2. If urgent care is necessary, the Insured may be seen by a member provider immediately.
3. The Participant pays the applicable copayment to the member provider at the time of each Primary Eye Care office visit.

4. When the member provider has completed the services, he/she will fill out the necessary paperwork and mail it to the Company. The Company will pay the member provider directly according to the Company's agreement with the provider.

COPAYMENT

The benefits described herein are available to each Participant from any participating member provider at no cost to the Insured except there shall be a copayment amount of $10.00 payable by the Participant to the member provider at the time of each Primary Eye Care office visit.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Primary Eye Care Plan is designed to cover Primary Eye Care services only. There is **no coverage** provided under the Plan for the following:

1. Costs associated with securing materials such as lenses and frames;
2. Orthoptics or vision training and any associated supplemental testing;
3. Surgical or pathological treatment;
4. Any eye examination, or any corrective eye wear required by an Employer as a condition of employment
5. Medication; or
6. Corrective vision treatment of an experimental nature such as, but not limited to, RK and PRK Surgery.

REFERRALS BY THE MEMBER PROVIDER

The member provider will refer the patient to another provider under the following conditions:

1. If the patient requires additional services that are covered by the Primary Eye Care Plan but are not provided in his/her office, the member provider will refer the patient to another member provider or to the major medical physician whose offices provide the necessary services.
2. If the patient requires emergency services beyond the scope of the Primary Eye Care Plan, the member provider will refer the patient back to the major medical physician.
3. If the patient requires emergency services beyond the scope of the Primary Eye Care Plan, the member provider will make a “STAT” (emergency) referral by calling either another member provider or the major medical physician.

DEFINITIONS

Blepharitis .....Inflammation of the eyelids.

Cataract.....A cloudiness of the lens of the eye obstructing vision.

Conjunctiva .....The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.

Corneal Abrasion.....Irritation of the transparent part of the coat of the eyeball.

Corneal Dystrophy .....A disorder involving nervous and muscular tissue of the transparent part of the coat of the eyeball.

Diplopia .....The observance by a person of seeing double images of an object.

Eye Muscle Dysfunction.....A disorder or weakness of the muscles that control the eye movement.

Flashes or Floaters .....The observance by a person of seeing flashing lights and/or spots.

Glaucoma .....A disease of the eye marked by increased pressure within the eyeball which causes damage to the optic disc and gradual loss of vision.

Macula.....The small, yellowish area lying slightly lateral to the center of the retina that constitutes the region of maximum visual acuity.

Macular Degeneration .....Degeneration of the macula.

Ocular.....Of or relating to the eye or the eyesight.

Ocular Conditions.....Any condition, problem, or complaint relating to the eyes or eyesight.

Ocular Hypertension .....Unusually high blood pressure within the eye.

Ocular Trauma .....A forceful injury to the eye due to a foreign object; e.g., fist, baseball, racquetball, auto accident, etc.

Pink-eye.....An acute, highly contagious conjunctivitis (inflammation of the conjunctiva).

Retinal Nevus .....A pigmented birthmark on the sensory membrane lining the eye that receives the image formed by the lens.

Sty.....An inflamed swelling of the fatty material at the margin of the eyelid.

Systemic Condition .....Any condition or problem relating to a person's general health.

Transient Loss of Vision .....Temporary loss of vision.

SECTION 12. LIFE INSURANCE BENEFIT

Life Insurance and Accidental Death and Dismemberment Insurance ("AD&D") are important parts of your plan of benefits. We hope these benefits help provide you peace of mind and added security when planning for your family's future.

Once you satisfy the Plan's initial eligibility requirements you will receive a booklet describing your Life and AD&D coverage as well as a beneficiary enrollment card. You may designate any person to be your beneficiary and you may change your designation (following proper Plan procedure) as often as necessary. It is important to keep your beneficiary designation up-to-date. If you have not named a beneficiary or the beneficiary you have named does not survive you, your benefit will be payable to your estate.

LIFE INSURANCE BENEFIT

Eligible Active Participants and their Dependents are covered for the Life Insurance Benefit. The Life Insurance Benefit provides a death benefit to your designated beneficiary if you die, or one of your Dependents dies while you are an eligible Active Participant. This benefit is payable as follows:

Active Participants working 30 hours or more ..... $50,000[1]

Spouse of Active Participant (working 30 hours or more) $5,000

Retired Participants under age 70 ..... $20,000

Spouse of Retired Participant under age 70 ..... $2,000

Retired Participants age 70 and over $10,000

Spouse of Retired Participants age 70 and over $2,000

The Life Insurance Benefit is insured through The Union Labor Life Insurance Company. Please refer to the certificate of insurance provided by The Union Labor Life Insurance Company for a complete description of this Benefit. The certificate of insurance from The Union Labor Life Insurance Company is incorporated with, and forms a part of, the Summary Plan Description. If there is a discrepancy between the provisions of the Summary Plan Description and the provisions of the group life insurance policy or certificates of insurance produced by the insurer, the actual provisions of the insurer's documents will prevail.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Participants are eligible for the AD&D Benefit. Eligible Dependents of such Participants are not.

[1] After age 70, an active Participant's death benefit decreases to $45,000.

Accidental Death & Dismemberment provides a benefit in the event of death or dismemberment resulting from a covered accident:

Active Participants working 30 hours or more $50,000

Retired Participants under age 70 ..... $20,000

Retired Participants age 70 and over..... $10,000

The AD&D Benefit is currently insured by The Union Labor Life Insurance Company. Please refer to the certificate of insurance provided by The Union Labor Life Insurance Company for a complete description of this benefit. The certificate of insurance from The Union Labor Life Insurance Company is incorporated with, and forms a part of, the Summary Plan Description. If there is a discrepancy between the provisions of the Summary Plan Description and the provisions of the group AD&D insurance policy or certificates of insurance produced by the insurer, the actual provisions of the insurer's documents will prevail.

SECTION 13. WEEKLY ACCIDENT AND SICKNESS BENEFITS (LOSS OF TIME)

If a Participant is unable to work because of a non-work-related illness or injury, they may be eligible to receive a Weekly Accident and Sickness benefit. In order to be eligible for this benefit, a Participant must be receiving regular care or treatment from a licensed certified medical doctor. Call the Fund Office for more information on how to determine whether or not you are eligible for this benefit. A statement of claim form must be completed by your attending physician and returned to the Fund Office in a timely fashion for eligibility determination. In addition, you will be asked to have your licensed certified medical doctor complete an Attending Physician Statement, periodically throughout your period of disability.

If you are disabled and receive Weekly Disability Income Benefits from the Plan, or you are disabled because of an incident that occurred on the job and you receive benefits under a Workers' Compensation Law, and the Plan is not receiving contributions on your behalf, any accumulated Bank of Hours will be depleted first, then you will be offered COBRA at a rate of 50% of the current COBRA rate (see COBRA Section herein).

If you are working in Covered Employment in an effort to reinstate coverage and you become disabled, you will be offered COBRA coverage. If you elect COBRA coverage, you will be eligible to receive Weekly Disability Income benefits as set forth under the terms of this benefit.

ELIGIBILITY

To be eligible for the Weekly Accident and Sickness benefit described in this Section, you must be eligible for benefits as an active or as a COBRA Participant, and you must be unable to work because of a non-work-related accidental injury or illness. If such eligibility is based on illness, the first weekly benefit will not be paid until you have completed a seven (7)-day waiting period. No benefit will be payable if you apply for such benefits later than the last day of the sixth (6^{th}) month following the month in which you became disabled. Periods of disability due to the same or related causes will be considered one period of disability unless they are separated by at least two (2) consecutive weeks of active work.

The Plan will not pay more than twenty-six (26) weeks of Weekly Accident and Sickness benefit during any fifty-two (52)-week period. The fifty-two (52)-week period begins on the first day that a Participant begins receiving Weekly Accident and Sickness benefits.

This benefit is payable to Participants on COBRA, regardless of their work status.

A Participant may request an extension of weekly disability benefits through the duration of the Participant's eligibility based on the Participant's Bank of Hours if the Participant has applied for Social Security disability benefits. The Trustees have the discretion to approve such requests. The Participant must agree, in writing, to reimburse the Plan for such extended disability benefits if Social Security determines that he/she is disabled and eligible for Social Security benefits during the period he/she received disability benefits from the Plan. Proof of your application for Social Security disability benefits must be provided to the Trustees.

Note: Monthly contributions from Contributing Employers continue to be due and payable when a non-collectively bargained Participant is being paid Weekly Benefits.

AMOUNT OF WEEKLY BENEFIT

A weekly benefit, currently $500, will be payable to you if you satisfy the eligibility requirements. Such amount shall be subject to FICA taxes and reduced by any requested withholding taxes. The Board of Trustees pays the "Employer" portion of any FICA taxes from the Plan.

WEEKLY BENEFITS

Weekly Accident and Sickness Benefits will begin on the first (1st) day you are unable to work due to an accident, or the eighth (8th) day you are unable to work due to an illness, as long as you satisfy the eligibility requirements.

If you are not covered but working in Covered Employment to become reinstated for benefits under the Plan and become disabled, you will be offered COBRA coverage.

RESTRICTION ON PAYMENT: OTHER INCOME

In the following situations, your Weekly Benefits will be reduced or eliminated:

1. If you are retired and are receiving pension benefits from an IBEW Pension Fund or Social Security, Workman's Compensation, you are not eligible to receive Weekly Income Benefits from the Plan.
2. If you are receiving benefits via an Automobile No-Fault provision, you will be eligible for Weekly Income Benefits only if the monthly benefit you are receiving under the Automobile No-Fault provision is less than the Weekly Income Benefit payable by the Plan. Under those circumstances, the Plan will pay you the difference between the Weekly Income Benefit and the amount you are receiving from the Automobile No-Fault provisions.
3. If you are receiving recurring periodic disability payments that is either weekly, monthly, quarterly, or annually from any IBEW Pension Fund or Social Security, or you are receiving payments under a Workers' Compensation statute, you will not be entitled to Weekly Accident and Sickness benefits from the Plan.
4. If you are receiving weekly disability benefits from an outside plan, your Employer or your Local Union, this Plan will pay you the full weekly benefit, up to the Plan's maximums and pursuant to all guidelines.

TERMINATION OF WEEKLY BENEFIT

The Weekly Accident and Sickness benefit of the Plan ends at the **earliest of**:

1. You having received twenty-six (26) Weekly Accident and Sickness benefit payments;
2. Your death;
3. The date you no longer satisfy the eligibility requirements for the benefit;
4. The date you are determined not to be disabled by your licensed certified medical doctor;
5. The date you are reemployed regardless of part-time or full-time status;

6. The date the Trustees, in their sole discretion, determine that you are able to return to work.

The Trustees have the right to change, limit, or discontinue benefits under the Plan at any time. The Trustees also have the right to require a second opinion from a licensed certified medical doctor selected by the Plan, which will be paid for by the Plan. If the Trustees eliminate the Weekly Accident and Sickness benefit, in whole or in part, the effective date of such amendment will be the date on which a Participant's accident and sickness benefits terminate.

EXTENSION OF WEEKLY BENEFIT

You may be entitled to an extension of Weekly Accident and Sickness benefits. The conditions for the extensions require that you meet **all** of the following:

1. You are totally and permanently disabled (proof of which must be submitted by your provider and approved by a medical professional selected by the Plan);
2. You are entitled to the Weekly Accident and Sickness benefit;
3. You have applied for Social Security disability benefits; and
4. You agree, in writing, to reimburse the Plan for any extended disability benefit paid to you by the Plan, if you are awarded Social Security disability benefits.

SEPARATE PERIODS OF DISABILITY

Separate periods of disability resulting from the same or related causes will be considered one period of disability, unless:

- Separated by your return to active work with a Contributing Employer for more than two (2) consecutive weeks, or
- Your availability for work pursuant to the rules of your home Union for more than two (2) consecutive weeks.

Separate periods of disability resulting from unrelated causes will be deemed one period of disability, unless separated by your return to active work, or you are available for work for at least one (1) full day.

WORK RELATED INJURY

If you are disabled on the job and receive benefits under a Workers' Compensation Law and the Plan is not receiving contributions on your behalf, the Plan will freeze your Bank of Hours for the period of time you are receiving either Weekly Disability Income or Workers' Compensation, if applicable. You will continue to maintain eligibility during this period, up to a maximum of six (6) months. If you are still disabled after six (6) months, the Plan will begin deducting 152 hours per month from your Bank of Hours. Once your Bank of Hours has been exhausted, you will be offered COBRA coverage (see "COBRA" Section below).

SECOND OPINION

The Trustees, in their sole discretion, have the right to request a second opinion regarding a Participant's ability or inability to return to work. The Plan will pay for any such second opinion.

SECTION 14. COBRA CONTINUATION COVERAGE

If your coverage under your group health plan or any related Health and Welfare Plan benefit such as your health FSA or HRA is terminated, you may be entitled to continue your coverage on a self-pay basis in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

This Section contains important information about your right to COBRA Continuation Coverage, which is a temporary extension of coverage under the Plan. This Section explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA Continuation Coverage.

The right to COBRA Continuation Coverage was created by a federal law and can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30)-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA Continuation Coverage is a continuation of the coverage you and/or your Spouse and Eligible Dependents had under the Plan when such coverage would otherwise end because of a life event. This also is called 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." You and your Eligible Dependents could become qualified beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay the required premiums for COBRA Continuation Coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the Spouse of an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your Spouse dies;

- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Eligible Dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child fails to meet the eligibility requirements for coverage under the terms of the Plan as an "Eligible Dependent child."

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator determines, or 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 Employees 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 that generally lasts for eighteen (18) months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of thirty-six (36) months of coverage.

There are also ways in which this eighteen (18)-month period of COBRA Continuation Coverage can be extended:

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is under COBRA coverage and is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional eleven (11) months of COBRA Continuation Coverage, for a maximum of twenty-nine (29) months. The disability would have to have started at some time before the sixtieth (60^{th}) day of COBRA Continuation Coverage and must last at least until the end of the eighteen (18)-month period of COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event during the eighteen (18) months of COBRA Continuation Coverage, the Spouse and Eligible Dependent children in your family can get up to eighteen (18) additional months of COBRA Continuation Coverage, for a maximum of thirty-six (36) months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Eligible Dependent children who are receiving COBRA Continuation Coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Eligible Dependent child stops being eligible under the Plan as an Eligible Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Eligible Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

If you die with or without a balance in your HRA and/or HSA, your Eligible Dependent children and Spouse will qualify for COBRA Continuation Coverage. Dependents of members of the Construction Unit who still have a balance in their bank of hours will be allowed to use up the bank of hours first.

If, while you are receiving COBRA Continuation Coverage, you have a newborn child or adopt a child, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change. The child will be covered for the remaining period of your COBRA coverage.

Your Employer has the obligation to notify the Fund Office of your death or your eligibility for Medicare. The Trustees have determined that because Employees frequently work for more than one Employer making contributions to the Plan, and because of the difficulty this can pose to Employers in providing this notice, the Plan Administrator will deem employment to terminate when your regular group health care coverage terminates.

You, your Spouse, or one of your Eligible Dependent children who is eligible for COBRA Continuation Coverage has the obligation to notify the Fund Office of your divorce or your child's loss of status as an Eligible Dependent. This notice must be given within sixty (60) days after the occurrence of the event. After the Fund Office receives notice of the occurrence of the events, it will notify each eligible individual of his or her right to elect COBRA Continuation Coverage and will send the materials necessary to make the proper election.

In general, the Fund Office will notify eligible individuals of their COBRA rights within fourteen (14) days after receiving notice of the occurrence of one of the events described above, or after it has determined that your regular group health care coverage has terminated.

Any person eligible for COBRA Continuation Coverage will have a period of at least sixty (60) days from the date he or she would otherwise have lost coverage under the Plan to advise the Fund Office that he or she wants to elect COBRA Continuation Coverage. If no election of COBRA Continuation Coverage is made, the individual's group health coverage will terminate.

If election is made to continue coverage and the election is due to termination of your employment or a reduction in your hours, COBRA Continuation Coverage will end eighteen (18) months after your other coverage

ended. However, if you, your Spouse or one of your Eligible Dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within sixty (60) days thereafter, each covered individual can receive a total of twenty-nine (29) months of COBRA Continuation Coverage. For all other situations, such coverage is available for thirty-six (36) months. COBRA Continuation Coverage will end at an earlier time for any of the following reasons:

- The Employer ceases to provide group health coverage;
- Failure to pay the monthly premium on time;
- The individual becomes covered under another group health plan (other than one sponsored by the Employer);
- The individual becomes eligible for Medicare; or
- Circumstances are such that the individual's participation could be cancelled if the individual were an active Participant.

Each month, any individual electing COBRA Continuation Coverage will be required to make a payment to the Fund Office to continue the coverage. The monthly premium will be based on the average cost which the Plan incurs annually per Participant plus a two-percent (2%) administrative charge. The extra eleven (11) months of COBRA Continuation Coverage available to disabled Participants will be assessed at a monthly charge based on one and one-half times (150%) the average annual per Participant cost incurred under the Plan.

With respect to a Participant who is both disabled and eligible for Medicare, any Dependent of that Participant shall be eligible for coverage under the Plan on a self-pay and/or COBRA basis for no more than thirty-six (36) months following the date that the Participant became eligible for Medicare. After this thirty-six (36) month period, any such Dependent will no longer be eligible for 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 you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your rights to COBRA Continuation Coverage should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act ("ERISA"), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights to benefits under the Plan, let the Plan Administrator know about any changes in your or the addresses of your family members. You also should keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
(802) 864-5864

SECTION 15. COORDINATION OF BENEFITS

HOW COORDINATION OF BENEFITS WORKS

Members of a family may be covered by more than one group health insurance plan. As a result, two or more plans are paying for the same expense. Since it is not intended that greater benefits be received than the actual medical expense incurred, the amount payable under this Plan will take into account any coverage you or your Eligible Dependent has under any other group-type plan. Benefits will be coordinated to provide up to 100% reimbursement for expenses covered under either plan. Coordination of Benefits (COB) requires that one plan be designated as the "primary" payer, while the other plan or plans are designated as "secondary" payer. The following rules explain how this Plan coordinates payment of its benefits with other plans under which you or your Dependents may be covered.

DEFINITIONS

For purposes of this Section, the term "plan" includes any plan providing benefits or services for, or by reason of, hospital, medical, or dental care that is provided by:

1. Group, franchise or blanket coverage, whether insured or non-insured.
2. Group Blue Cross, Blue Shield, hospital, HMO, PPO and other prepayment coverage provided on a group basis, except for which the subscription charge or premium payment is made directly by the person covered to the organization providing the coverage.
3. Any coverage under labor-management Trusteed plans, Union welfare plans, employer organization plans, employee benefit organization plans, or any other arrangements of benefits for individuals of a group.
4. Any coverage under governmental programs and any coverage required or provided by any statute, such as Medicare, Medicaid and Workers Compensation.
5. Any student coverage under a plan or program sponsored by or provided through an educational institution.
6. Any coverage under an individual no-fault policy.

"Plan" shall be construed separately with respect to each policy, contract or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and the portion that is not considered covered under the Plan.

"This Plan" means the portion of the Plan that provides benefits for medical, prescription drug, dental, and vision benefits and that are subject to this provision.

"Allowable Expense" means any necessary, usual, reasonable and customary item of expense, at least a portion of which is covered under one or more Plans that cover the individual for whom a claim is made.

"Claim Determination Period" means a Calendar Year or any portion thereof during which you or your Eligible Dependent is covered under this Plan.

ORDER OF DETERMINATION

When a Plan has no coordination of benefits provision nor any limitation against payments made under any other group plans, then it shall be considered the primary plan and render payment first.

In the event two or more of the plans involved do provide a coordination of benefit provision to preclude duplicate payment of benefits, then the following rules shall apply:

1. *Non-Dependent/Dependent*. The benefits of the plan that covers the person as an Employee (that is, other than as a Dependent) are determined before those of the plan that covers the person as a Dependent and shall be the primary Payer.

2. *Dependent Child/Not Separated or Divorced*. The primary plan for children's expenses when the parents are not separated or divorced shall be determined by the birth dates of the parents, excluding year of birth. The plan of the parent whose month and day of birth is earlier in the year shall be the primary payer. If both parents have the same birthday, or if the other plan does not have a rule similar in intent to this, then the plan that covered the parent longer shall be the primary payer and the plan that covered the other parent for a shorter period shall be the secondary payer.

3. *Dependent Child of Separated or Divorced Parents*. For children's expenses when the parents are separated or divorced, if there is a court decree that establishes responsibility for providing coverage for medical, dental, or other health care expenses with respect to the child(ren), the benefits are determined in accordance with the court decree. Otherwise, benefits for the child(ren) are determined in this order:

    a. The plan of the parent with custody of the child;

    b. The plan of the Spouse of the parent with custody of the child; then

    c. The plan of the parent not having custody of the child.

4. *Joint Custody*. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for providing coverage for the health care expenses of the child, the plans covering that child will follow the order of benefit determination rules described in item 2 above.

5. *Active/Inactive Employee*. If the rules above do not create an "Order of Benefit Determination," the primary plan will be the one that has covered the person for the longer period of time, with the following exception:

The benefits of a plan covering the person as a laid-off or retired Employee, or Dependent of such person, shall be determined after the benefit of any other plan covering the person as an Employee.

6. *Continuation Coverage*. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the order of benefit determination will be as follows:

   a. The benefits of a plan covering the person as an Employee (or as that person's Dependent);

   b. The benefits under the continuation coverage.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. If the other plan lacks a Coordination of Benefits Provision, it is the primary plan.

8. *General Provisions*. When this Plan pays reduced benefits due to the Coordination of Benefits provision, only the reduced amount will be charged against the limits of the Plan.

If another plan pays benefits that should have been reduced because of coordination of benefits, the Plan may, at its option, pay to the other plan the amount by which the benefits should have been reduced. Amounts so paid will be deemed benefits paid under this Plan, and will reduce the Plan liability to the extent of such payment.

If the Plan has made payment of any expense that is in excess of that permitted by Coordination of Benefits, the Plan has the right to recover such amount from any party that has received such payment.

If another plan is primary under this Plan's coordination of benefits rules and it contains a provision capping its benefits for an eligible individual or his Dependents having the effect of shifting primary coverage liability to this Plan in a manner designed to avoid the usual operation of the National Association of Insurance Commission's (NAIC's) and this Plan's coordination of benefit rules, this Plan will not be liable to provide benefits until the primary plan provides its customary benefits determined without regard to such a limitation.

In no event will the amount paid under this Plan exceed the amount that would have been paid if there were no other plan involved. When a claim is made, the primary plan pays the benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable amount otherwise covered under the Plan. No plan pays more than it would without the COB provision.

COORDINATION OF BENEFITS WITH MEDICARE

"Medicare" means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended. Medicare benefits are available only in the United States. Resident aliens are eligible for Medicare only if they are eligible for Social Security benefits or they have lived in the United States for at least five (5) years.

The Plan will be primary Payer to Medicare only:

1. For an active Employee;
2. For an active Employee's Spouse;
3. For the first thirty (30) months of treatment for end-stage renal disease received by a Participant;
4. For disabled, Eligible Dependents of Active Employees; and
5. Where otherwise explicitly required by federal law.

The reference to active Employee throughout this Plan does not, however, include laid-off, retired, former Employees under COBRA or Self-Pay provisions of the Plan, or Participants who are not covered by reason of current employment status.

When the rules above do not apply, the Plan will pay its benefits as secondary payer and only after Medicare has paid its benefits.

Note: If you are retired and eligible for Medicare, the Plan will pay benefits only up to the amount that would be paid under the above rules, whether or not you have applied for Medicare Part A and Part B benefits. If you are planning retirement, because your benefits will be affected by Medicare, we recommend that you contact your local Social Security office for all the relevant information about Medicare eligibility and enrollment. You should do this, at a minimum, before your 65th birthday or that of your Spouse, or if you or one of your Dependents become disabled. Medicare coverage, even as a secondary payer, can provide valuable benefits.

Because benefits may not be duplicated, benefits provided under this Plan may be coordinated with any benefits the Employee or Eligible Dependent actually receives by virtue of enrolling in Medicare and receiving Medicare benefits.

As long as the Employee or Eligible Dependent remains actively employed and eligible for coverage under this Plan, all other benefits provided under the Plan will remain fully in force, whether or not they are eligible for the health benefits provided under the Medicare Program.

COORDINATION OF BENEFITS WITH MEDICAID

If you, your Eligible Dependent or Alternate Recipient are entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act, this Plan will be primary payer.

Payment for benefits will be made in accordance with any assignment of rights made by or on your behalf or that of your Eligible Dependent or Alternate Recipient as required by Medicaid under § 912(a)(1)(A) of the Social Security Act of 42 U.S.C. § 1396k(a)(1)(A). If this Plan has the legal obligation to pay benefits, and to the extent that payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state has acquired the rights with respect to you, your Eligible Dependent or Alternate Recipient to receive payment of such benefits.

In the event Medicaid files a claim directly with the Plan for services provided to an eligible Participant past the Plan's deadline for submission of claims, and the Plan is required to pay such claim under federal law, the Plan shall process such claim as an out-of-network claim, and shall pay ***the lesser of*** 100% of the Medicaid approved charges or the applicable out-of-network percentage copay of the total billed charge.

The provisions of § 1908 of the Social Security Act will apply to the extent such provisions are in accordance with state Medicaid law.

COORDINATION OF BENEFITS WITH STATE AND FEDERAL PROGRAMS OTHER THAN MEDICARE OR MEDICAID

If an Employee or Eligible Dependent is eligible for coverage under a governmental health benefit program or program established under a state or federal statute, whether or not election has actually been made to obtain such coverage, the amount of benefits paid by both plans will not exceed one hundred percent (100%) of ***the lesser of*** the Usual and Customary charges, or the PPO negotiated charges covered under this Plan.

Benefits will be paid first by the other plan, unless otherwise declared by law, after which this Plan will make its coordinated benefit payment. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if no other plan were involved.

RIGHT TO RECOVERY

If the Plan pays more to, or for, a Participant than required under the Coordination of Benefits provisions set forth herein, the Plan has the right to recover the excess payments from any person, provider or company to, for, or with respect to whom such payments were made. The Participants shall cooperate fully with the Plan by providing documentation and taking whatever action is reasonably required by the Plan to assist with recovery of the overpayment.

SECTION 16. CLAIMS & INTERNAL REVIEW PROCEDURE

FILING OF CLAIMS

Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, and Claims for Life Insurance, Accidental Death and Dismemberment Benefit: Claims for **Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, and Claims for Life Insurance, Accidental Death and Dismemberment Benefits** are to be sent to the address shown on the back of your identification card.

Most providers will submit the claims for you based on the information on your identification card. If you need to file a claim directly, claim forms can be obtained from the Fund Office:

IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
Telephone Number: (802) 864-5864 ext. 14
Fax Number: (802) 862-6379

Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the required time may result in partial or complete denial of your claim, unless the Trustees determine that it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event shall the claim be submitted later than eighteen (18) months from the date the charges were incurred. Claim forms must be submitted in accordance with the instructions on the claim form.

Short Term Disability Benefit: All initial claims for this benefit will be determined by the Plan Administrator. Claims for the self-funded Short Term Disability Benefit must be submitted to the Fund Office within 180 days from the date the disability was incurred. ***Claims submitted after the filing deadline will not be paid.***

GENERAL INFORMATION

Internal Claims and Review Procedures

This Section describes the procedures followed by the Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, dental, vision, wellness, prescription drug, health reimbursement arrangement (HRA), disability, death, and accidental death and dismemberment benefits.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated Participants and Dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical

judgment (such as a determination that a service is not Medically Necessary or appropriate, or is experimental or investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Blue Cross Blue Shield of Vermont P. O. Box 186 Montpelier, VT 04601-0186 Customer Service: (800) 247-2583	• Urgent, Concurrent and Pre-Service and Post-Service Medical Claims • Pre-Service Prescription Drug Claims
CBA BLUE P. O. Box 2365 South Burlington, VT 05407	• Post-Service Dental Claims • Post-Service Vision Claims
VSP 333 Quality Drive Rancho Cordova, CA 95670	• Post-Service Vision Claims
Blue Cross Blue Shield of Vermont P. O. Box 186 Montpelier, VT 04601-0186 Customer Service: (800) 247-2583	• Post-Service HRA Claims
Fund Office IBEW Local Union No. 300 3 Gregory Drive South Burlington, VT 05403	• Weekly Accident and Sickness Claims
The Union Labor Life Insurance Company 8403 Colesville Road Silver Spring, MD 20910	• Life Insurance Claims • Dependent Life Insurance Claims • Accidental Death and Dismemberment Claims

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Plan is administered by the Plan Administrator (which may be the Plan Sponsor or another entity appointed by the Plan Sponsor for this purpose) in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the Plan Appointed Claim Evaluator ("PACE") insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the PACE.

Except for functions reserved by the Plan to the Employer or Board of Directors, the Plan Administrator will control and manage the operation and administration of the Plan. In accordance with Section 503 of Title I of ERISA, the Plan Administrator will designate one or more named fiduciaries under the Plan, each with complete authority to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary (including, but not limited to, the denial of certification of medical necessity of hospital or medical treatment). In exercising its fiduciary responsibilities, the named fiduciary will have discretionary authority to determine whether and to what extent Participants and beneficiaries are entitled to benefits and to construe disputed or doubtful Plan terms. The named fiduciary will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. All other matters, including, but not limited to, other appeals that are "not" Final Post-Service Appeals, and matters the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan are prohibited from being referred to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

Duties and Rights of the PACE: When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

DEFINITIONS

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial in benefits;
- Failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan;
- A reduction in benefits;
- A rescission of coverage, even if the rescission does not impact a current claim for benefits;
- Termination of benefits;
- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

Claim

A claim is a request for payment or the coverage of a Plan benefit that is made by you or your covered Eligible Dependent (also referred to as "Claimant"), or your authorized representative in accordance with the Plan's reasonable claims procedures.

Claimant

A Participant of the Plan, or entity acting on the Participant's behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

Days

For the purpose of the initial claims and appeal processes, "days" refers to ***calendar days, not business days***.

Final Post-Service Appeal

A post-service appeal, which constitutes the last internal appeal available to the Claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term "Final Post-Service Appeal" shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication, and conclusion of this appeal, external review becomes available to the Claimant, assuming it is otherwise in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator or "PACE."

Health Care Professional

A health care professional, for the purposes of these claims and internal review provisions, means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Plan Appointed Claim Evaluator or PACE

An entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals, would be deemed to be binding) claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator,

Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding Plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by, and make determination in accordance with, the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

TYPES OF CLAIMS

Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance abuse, dental, vision, wellness, prescription drug, and HRA benefits.

There are four categories of health claims as described below:

- **Pre-Service Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits)** – A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before a health care service or benefit is obtained. Under this Plan, prior approval is required for certain medical, mental health, substance abuse, and prescription drug benefits.

- **Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits)** – An urgent care claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or (ii) in the opinion of the Claimant's attending health care provider with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the Claimant to obtain the pre-approval, or the pre-approval process would jeopardize the Claimant's life or health.

- **Concurrent Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits)** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- **Post-Service Claims (applicable to medical, mental health, substance abuse, dental, vision, wellness, prescription drug, and HRA benefits)** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or

electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Weekly Accident and Sickness Benefit Claims

A Weekly Accident and Sickness Benefit Claim is a request for benefits during a period of disability. Weekly Accident and Sickness Benefit Claims are filed after a Participant suffers a disability and benefits are paid if the Claims Administrator determines that the Participant has suffered a disability as defined by the terms of the Plan.

Life Insurance/Dependent Life Insurance/Accidental Death and Dismemberment Insurance Benefit Claims

A Life Insurance/Dependent Life Insurance/Accidental Death and Dismemberment Insurance Benefit Claim is a request by a designated beneficiary for benefit payment following the death or dismemberment of the Participant, or the death of a covered Eligible Dependent. A claim for Accidental Death and Dismemberment Benefits also may be filed by a Participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for urgent care claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual Participant and his/her Social Security Number;
- Name a specific Claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this Section;

- Made by someone other than you, your covered Eligible Dependent, or your (or your covered Eligible Dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

INITIAL CLAIM DECISION TIME FRAMES

Health Care Claims

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered Eligible Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as

soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Note: Claims for Dental Care Benefits are all Post-Service Claims. The only possible Pre-Service, Urgent Care, or Concurrent Claims are claims for Medical and Prescription Drug Benefits.

PRE-SERVICE CLAIMS

For Pre-Service Claims, you will be notified of the Plan's determination (whether adverse or not) within a reasonable period, but not later than fifteen (15) days after receipt of the claim. The fifteen (15)-day period may be extended for up to fifteen (15) days for matters beyond the Plan's control if, before the end of the initial fifteen (15)-day period, you are notified of the reasons for the extension and of the date by which the third-party administrator expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the Claimant will have forty-five (45) days from receipt of the notice to provide the specified information. A decision will then be made within fifteen (15) days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, the third-party administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

URGENT CARE CLAIMS

The rules are slightly different for Pre-Service Claims that involve urgent care, i.e., Urgent Care Claims. For Urgent Care Claims, you will be notified by the third-party administrator regarding the benefit determination (whether adverse or not) as soon as possible, and not later than seventy-two (72) hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than twenty-four (24) hours after receipt of the claim, of the specific information needed to complete the claim. Notification of the decision on that claim will then be provided within forty-eight (48) hours after the third-party administrator's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within three (3) days of the oral notification.

If a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative, bypassing the need for completion of the Plan's written authorized representative form.

If you improperly file an Urgent Care Claim, the Claims Administrator will notify you as soon as possible, but in no event later than twenty-four (24) hours after receiving the claim. The written (or electronic, as applicable)

notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

POST-SERVICE CLAIMS

For Post-Service Claims, you will be notified of any adverse benefit determination by BCBSVT within a reasonable period, but not later than thirty (30) days after receipt of the claim. The thirty (30)-day period may be extended up to fifteen (15) days for matters beyond the Plan's control if, before the end of the initial thirty (30)-day period, the third-party administrator or the Plan (as applicable) notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least forty-five (45) days from receipt of the notice to provide it. A determination will then be made within fifteen (15) days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

CONCURRENT CARE CLAIMS

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially-prescribed period of time, you will be notified of the determination (whether adverse or not) within twenty-four (24) hours after receipt of the claim, if the claim is made at least twenty-four (24) hours before the end of the initially-prescribed period of time or number of treatments.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section. A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes for Pre-Service or Post-Service Claims, as applicable.

If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

WEEKLY ACCIDENT AND SICKNESS CLAIMS

Claims for Weekly Accident and Sickness benefits will be decided no later than forty-five (45) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the forty-five (45)-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by thirty (30) days due to circumstances beyond the control of the Claim Administrator; provided you are given written (or electronic, as applicable) notification before the expiration of the initial forty-five (45)-day determination period. A decision will be made within thirty (30) days of the date the Claims Administrator notifies you of the delay. The period for making a decision may be delayed an additional thirty (30) days if due to matters beyond the control of the Claims Administrator, provided you are notified of the additional delay, before the expiration of the first thirty (30)-day extension period, of the circumstances requiring the extension, and the date by which the Claims Administrator expects to render a decision.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial forty-five (45)-day determination period. Thereafter, you will have forty-five (45) days after your receipt of the notice to supply the additional information. If you do not provide the information during the forty-five (45)-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of forty-five (45) days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has thirty (30) days to make a decision and notify you in writing (or electronically, as applicable).

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If your claim for Life Insurance and/or Accidental Death and Dismemberment Benefits is denied in whole or in part for any reason, then within ninety (90) days after the insurance company receives your claim, the insurance company will send you written notice of its decision, unless special circumstances require an extension, in which case the insurance company will send you written notice of the decision no later than 180 days after the insurance company receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial ninety (90)-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the insurance company expects to render the benefit determination. However, any decision regarding life insurance coverage that is based on a finding of total and permanent disability is subject to the same rules that apply to Short-Term Disability Benefit claims.

CONTENT OF NOTIFICATION OF INITIAL ADVERSE BENEFIT DETERMINATION

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a “notice of adverse benefit determination”). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the time frame required to make a decision on a particular type of claim. In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reason(s) for the adverse determination (including a statement that the Claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review);

2. The identity of the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
3. If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
4. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;
5. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
6. A description of the plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;
7. In a case of an adverse determination involving a claim for urgent care, a description of the expedited internal and external review processes applicable to such claims;
8. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request;
9. If the adverse benefit determination is based on medical necessity or experimental treatment, or similar exclusion or limit, either an explanation of the scientific judgment for the determination, applying the plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and
10. Information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

NOTICE OF APPROVAL OF PRE-SERVICE AND URGENT CARE CLAIMS

If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you within the applicable timeframe after the Claims Administrator's receipt of the claim.

REQUESTS FOR INTERNAL APPEAL

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, for reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

    - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

    - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

DETERMINATION ON APPEAL TIME FRAMES

Pre-Service Claims

The third-party administrator will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the request for

review (except that if there are two (2) levels of appeal, the decision has to be made within fifteen (15) days at each level).

Urgent Care Claims

The third-party administrator will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than seventy-two (72) hours after receipt of the request for review.

If Urgent Care claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the third party administrator by telephone, facsimile, or other similarly expeditious method.

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20___." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such a statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation with someone unless they are sure he or she is your chosen and authorized representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You also shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Concurrent Claims

You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the appropriate Claims Administrator. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

Post-Service Claims for Medical, Prescription Drug and Dental Benefits

The appropriate Claims Administrator will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) days after receipt of the request for review (except that if there are two (2) levels of appeal, the decision has to be made within thirty (30) days at each level).

Life Insurance and Accidental Death & Dismemberment Claims

Appeals of adverse Life Insurance and/or Accidental Death and Dismemberment claims must be decided by the insurance company within sixty (60) days (plus a possible sixty (60)-day extension, if necessary).

Weekly Accident and Sickness Claims

The Fund Office will notify you of its decision on appeal within a reasonable period of time, but not later than forty-five (45) days after receipt of the request for review

All Other Claims

The Trustees at their next regularly scheduled meeting will make a determination of appeal. However, if the appeal is received less than thirty (30) days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than five (5)days after the determination is made.

Content of Adverse Benefit Determination on Review

The Plan's written notice of the Board's decision will include the following:

1. The specific reason(s) for the adverse benefit determination upon review, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
2. Reference to specific plan provisions on which the determination is based;
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act following the review;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide 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 such rule, guideline, protocol, or other criterion will be provided free of charge upon request;
6. If the adverse benefit determination is based on Medical Necessity or Experimental treatment or a similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge, upon request;

7. An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review; and
8. Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

TWO LEVELS OF APPEAL

This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. To exhaust internal appeals as required under this Plan, a Claimant or his or her authorized representative must both file an appeal of an initial adverse benefit determination, constituting the initial post-service internal appeal, and file an appeal of the adverse benefit determination issued in response to the initial internal appeal. That second internal appeal will constitute the final required level of appeal, and if the Plan issues an adverse benefit determination in response to that Final Post-Service Appeal, such adverse benefit determination will constitute the final adverse benefit determination.

Taking the steps outlined above concludes the Plan's internal review process.

THE TRUSTEES' DECISION IS FINAL AND BINDING

The Trustees' (or their designee's) final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the plan. Any legal action against this plan must be started within 90 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS

Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned the authority and duty to otherwise handle appeals, or the PACE – that benefits and/or coverage are not available from the Plan as they relate to claims for benefits submitted to the Plan, when such a final adverse benefit determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE, the determination will be final and binding on all interested parties.

LIMITATION ON WHEN A LAWSUIT MAY BE INITIATED

You may not start a lawsuit to obtain benefits until after you have exhausted all levels of appeal and final decisions have been reached on those appeals, or until the appropriate time frame described above has elapsed since you filed a request for review and you have received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed

to follow them. No lawsuit to recover Plan benefits may be started more than *(fifteen) 15 months* after the date of loss (that is, the date you incurred the expense you are seeking to have the Plan pay) upon which the lawsuit is based. Because the Plan grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, the issue in a lawsuit will be limited to whether or not the Board of Trustees (or its delegates) acted arbitrarily or capriciously in making its determination. No lawsuit to recover Plan benefits may be started more than *twelve* (*12) months* after the date the Board of Trustees makes its final decision on an appeal or after the date the Plan was required, but failed, to act in accordance with its appeal procedures.

AUTHORIZED REPRESENTATIVE

The Plan recognizes an authorized representative as any person at least eighteen (18) years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan. An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care professional with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a Claimant) along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form that is available from the appropriate Claims Administrator or Plan Administrator.

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.*, notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is your legal Spouse, parent, grandparent, or child over the age of eighteen (18)).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from, and to be returned to, the appropriate Claims Administrator or Plan Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual or that the person will act in your best interest.

ELIMINATION OF CONFLICT OF INTEREST

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

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Eligible Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

SECTION 17. EXTERNAL REVIEW PROCEDURE

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

CLAIMS ELIGIBLE FOR THE EXTERNAL REVIEW PROCESS

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

CLAIMS NOT ELIGIBLE FOR THE EXTERNAL REVIEW PROCESS

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment;
- A determination that you or your Eligible Dependent are not eligible for coverage under the terms of the Plan;
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review;
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies);
- Claims that relate to benefits other than health care benefits (such as disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits); and
- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review of an Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy, or in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

EXTERNAL REVIEW OF A STANDARD (NON-URGENT CARE) CLAIM

Your request for external review of a standard (not Urgent Care) claim must be made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, submit your request for external review to the Fund Office at:

IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
Telephone Number: (802) 864-5864 ext. 14
Fax Number: (802) 862-6379

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan, or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
- Your request is incomplete. In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within forty-eight (48) hours after you receive notification that your request is not complete.

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these 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 claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If the Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo*, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within forty-five (45) days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) 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), and the reason for the previous denial.
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.
- A statement that judicial review may be available to you.
- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

EXPEDITED EXTERNAL REVIEW OF AN URGENT CARE CLAIM

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin the expedited external review of an Urgent Care Claim, submit your request for expedited external review to the Fund Office at:

IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
Telephone Number: (802) 864-5864 ext. 14
Fax Number: (802) 862-6379

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met, as described above for the standard claim external review process. The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims and rotates assignments among those 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 claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

WHAT HAPPENS AFTER THE IRO DECISION IS MADE?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the

reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA Section 502.

SECTION 18. SUBROGATION AND REIMBURSEMENT

THE FUND'S RIGHT TO SUBROGATION

If you or your Eligible Dependent is hurt or injured in any type of accident, as identified below, to the extent the Plan makes payment for benefits related to such illness or injury under the terms of the Plan, the Plan shall be fully subrogated to all the rights of recovery of you and/or your Eligible Dependent arising out:

1. Any claim or cause of action which may accrue because of the alleged negligent conduct of any third party and/or the insurers, including any claim against your or your Eligible Dependent's own insurer arising under the Uninsured Motorists Coverage provisions of a Policy of Insurance or a Homeowner's Policy issued to the Employee or Eligible Dependent; and

2. Any claim or cause of action which may accrue because of an event giving rise to a claim under the Products Liability Laws of any state.

The Plan shall make payment of any such claims only upon your and/or your Eligible Dependent's certification that no other sums have yet been paid in satisfaction thereof; that your claim assertable against a third party is disputed, that the tortfeasor and/or his insurer are withholding payment pending resolution of that dispute; and only upon your and/or your Eligible Dependent's execution of a written Agreement, and that of his or their attorney, if applicable, in which you/your Eligible Dependent agrees, as follows:

1. To reimburse the Plan out of the proceeds of any recovery received from any third party, including you or your Eligible Dependent's own Uninsured Motorist Insurer, whether by way of litigation, settlement or otherwise, prior to the payment of any other claims;

2. To reimburse the Plan from any gross amount recovered by you or your Eligible Dependent, before any payment of attorneys' fees and costs by you or your Eligible Dependent;

3. To provide to the Plan all information and documents necessary and reasonable in the Trustees' sole discretion, and to otherwise assist the Trustees in recovering all amounts paid out by the Plan that are subject to the Agreement;

4. To execute and deliver all necessary instruments as the Trustees may require to facilitate the enforcement of its rights;

5. To recognize that the Plan has no obligation to pay to you, your Eligible Dependent or your attorneys any amounts expended by you in attorneys' fees and costs of litigation in pursuing your claims against others, including your own Insurers;

6. To reimburse the Plan and otherwise make the Plan whole for any and all attorneys' fees and costs expended by the Trustees and/or the Plan in pursuing litigation or other actions, in whatever forum, to

enforce the terms of the Plan and/or the Subrogation, and Reimbursement Agreement executed by the Claimant;

7. That no settlement shall be made with nor release granted to any third party or insurer without the written consent of the Trustees; and

8. To protect the Plan's right to recovery under the Subrogation and Reimbursement Agreement and to do nothing that would in any way prejudice these rights. The Trustees shall have the sole discretion to determine the amount of recovery from any third party, their insurer, or from Workers' Compensation.

9. To serve as constructive trustee over any and all proceeds recovered by you/your Eligible Dependent(s) from a responsible third party, whether by settlement, award or judgment and recognize that a failure to hold such funds in trust will be deemed as a breach of your/your Dependents' duties under this Article.

The Plan has an equitable lien on any and all proceeds recovered by you/your Eligible Dependent(s) up to the total amount of medical benefits that the Plan has paid to you/your Eligible Dependent(s). This equitable lien shall attach to any money or property that is obtained by anybody (including, but not limited to, you/your Eligible Dependent(s) or an attorney, and/or a trust) as a result of an exercise of your/your Eligible Dependent(s) right of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds.

The Plan shall be entitled to reimbursement or subrogation regardless of whether you/your Eligible Dependent(s) have been made whole. The Plan's rights shall not be subject to reduction under any common fund doctrine, attorney's fund doctrine or any similar claims or theories.

In the event you fail to fully cooperate with the Trustees in accordance with this Section or the written Agreement, the Plan shall cease making payments in connection with the accident or injury giving to the Plan's subrogation and reimbursement rights, and all amounts previously paid by the Plan shall immediately become due and payable to the Plan.

THE FUND'S RIGHT TO REIMBURSEMENT

Upon reimbursement to the Plan of any or all amounts owed for claims paid relating to an accident or injury, the Plan will have no obligation to pay any additional future related claims, and the Plan will impose a deductible in the amount of you or your Eligible Dependent's net recovery, if any, to offset any future related claims that may be submitted by you or your Eligible Dependent(s), or on your behalf.

The Trustees may institute legal action against you to recover the benefits paid or, at their discretion, the Trustees may withhold payment of and/or implement a deductible against unrelated subsequent or previously existing claims to recoup amounts owed to the Plan, in the event you or your Eligible Dependent refuses or fails to reimburse the Plan upon recovery of any sums.

The Plan shall automatically have a first priority lien upon the proceeds of any recovery by you/your Eligible Dependent(s) from the third party to the extent of any benefits provided to you or your Eligible Dependent(s) by the Plan. You/your Eligible Dependent(s) or your representative shall execute such documents as may be required to secure the Plan's rights. The absence of a separate written Agreement shall in no manner invalidate the Plan's Rights of Subrogation and Reimbursement as set forth in this Section.

In the event the Plan pays benefits for claims not covered under the Plan, the Trustees are authorized to offset any such payment from any and all future claims submitted by you or your Eligible Dependents until such repayment is recouped in full. Alternatively, the Trustees may institute legal action against you or your Eligible Employees to recover overpaid benefits. If litigation is instituted for this purpose, the Trustees are authorized to recover, on behalf of the Plan, all costs, expenses and attorney fees expended in obtaining the reimbursement of such overpaid benefits.

OVERPAYMENTS AND IMPROPER PAYMENTS

In the event the Plan pays a claim in error, overpays a claim or makes an improper payment on a claim, to or for a Participant or former Participant for any reason, the Trustees shall have the right to secure reimbursement for such payment directly from the Participant, former Participant or any third party to whom payment was made, and the Participant, former Participant or third party shall be obligated to reimburse the Plan for such payment.

The Trustees shall also have the right to secure reimbursement through an offset of any related or unrelated subsequent or previously existing benefits due to or for the Participant or former Participant. In addition, if a Participant fails to comply with the notification requirements described in Section 14, including but not limited to the failure to notify the Plan timely of a change in address, change in Eligible Dependent status or other change affecting coverage under the Plan, and as a result the Plan (i) makes an erroneous payment, improper payment or overpayment, including but not limited to payment to or for an individual who is no longer covered or payment that is mailed to the wrong address and then cashed by an unauthorized person, and (ii) does not recover such payment after notice and demand, then the Participant and any third party receiving payment shall be obligated to reimburse the Plan for such payment, and the Trustees shall have the right to secure reimbursement for such payment directly from the Participant or third party or through an offset of any related or unrelated existing or future benefits due to the Participant or any covered family member.

ERRONEOUS REPRESENTATIONS

The Trustees may withhold or deny payment of any claim which they reasonably believe is based on false or misstated facts or representations by any Participant or beneficiary or provider of covered services or supplies, and shall have the right to secure reimbursement for any payments made on the basis of such false or misstated representations from the Participant or from any third party to whom payment was made on the Participant's behalf to the full extent described in this SPD with respect to erroneous payments, improper payments and overpayments. In addition, if a Participant knowingly makes false statements on any document which is the

basis for the Plan's payment of claims, the Trustees shall have the authority to declare such Participant ineligible for coverage under the Plan for a period not to exceed four (4) consecutive calendar quarters.

SECTION 19. YOUR RIGHTS UNDER ERISA

As a Participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine without charge, at the Fund Office, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated 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 Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review the Plan description, Section 14, on the rules governing your COBRA continuation rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, your union, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance,

- If you request a copy of the Plan documents or the latest annual report from the Fund Office and do not receive them within thirty (30)- -days, you may file suit in a federal court. In such a case, the court may require the Plan's administrator to provide the materials and pay you up to $110 a day until you receive the materials – unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits that is denied or ignored – in whole or in part – you may file suit in federal court.
- If you disagree with the Plan's decision or lack of response to your request concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim to be frivolous.

Help with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SECTION 20. NOTICE OF HIPAA PRIVACY PRACTICES

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

The Federal Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended) provides privacy protection of your verbal, written, and electronic records under an employer-sponsored health care benefits plan. On April 14, 2003, in compliance with HIPAA requirements, this Plan introduced new privacy policies and procedures to protect you and your family's health information under the various health plans maintained at the Fund Office. Please read the privacy notice carefully and share the information with family members as appropriate. If you have any questions, please call the Fund Office at (802) 864-5864 ext. 14.

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 IBEW Local 300 Health and Welfare Plan.

The Plan's Duties with Respect to Health Information about You

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your 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 Plan.

How the Plan May Use or Disclose Your Health Information

The privacy rules generally allow the use and disclosure of your health information without your 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 you with physicians who are treating you.
- **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 your coverage or the expenses you have 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 your 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 you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan May Share Your Health Information with the Fund Office

The Plan may disclose your health information without your written authorization to the Fund Office for plan administration purposes. The Fund Office may need your health information to administer benefits under the Plan. The Fund Office agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Only the Plan Administrator will have access to your health information for plan administration functions.

Here is how additional information may be shared between the Plan and the Fund Office, as allowed under the HIPAA rules:

- The Plan may disclose "summary health information" to the Fund Office if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes Participants' claims information, but from which names and other identifying information has been removed.
- The Plan may disclose to the Fund Office information on whether an individual is participating in the Plan.

In addition, you should know that the Fund Office cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the Fund Office 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 Your Health Information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care.

Information describing your 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). You will generally be given the opportunity to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed to your legal representative without authorization.

The Plan is also allowed to use or disclose your health information without your 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 your 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 Food and Drug Administration 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 you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you 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 you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you 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 you agree 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 your 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 your health information to the Department of Health and Human Services (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 your written authorization. For example, the Plan must generally obtain your written authorization before using or disclosing psychotherapy notes about you from your psychotherapist, using or disclosing your PHI for marketing purposes if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed, and receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Plan has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Plan has already made.

It is the Plan's procedure, upon request for assistance, to disclose your health information to your Spouse or your domestic partner (if applicable), and your Spouse's or your domestic partner's (if applicable) health information to you, and to disclose the health information of your over-age enrolled Eligible Dependent (for example, your child who is over the age of 26) to you or your Spouse or your domestic partner (if applicable), unless the person whose health information would otherwise be disclosed chooses to opt out of this default procedure.

For example, if you and your Spouse are enrolled for Plan benefits and believe that the Plan has paid only a portion of the service fee it should have for a service provided to your Spouse, the Plan will work with you to obtain the correct payment for the service rendered, even if doing so requires sharing with you some health information about your Spouse. (And the reverse would be true: your health information would be shared with your Spouse in such a situation.)

You may request the Plan not share your health information with your Spouse or your domestic partner (if applicable) by opting out of this default procedure. To opt out, you must contact the Fund Office at (802) 864-

4042. Your Spouse, domestic partner (if applicable), and/or your over-age enrolled Eligible Dependent may also opt out of this procedure by contacting the Fund Office at (802) 864-5864 ext. 14. Once an individual has opted out of this default, the Plan generally will not disclose any of the individual's health information to family members, unless some other part of the HIPAA regulations permits or requires it (for example, that individual becomes incapacitated). Any individual may change the opt-out election at any time by contacting the Fund Office at (802) 864-5864 ext. 14.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This Section of the Summary Plan Description describes how you may exercise each individual right.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death, or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS

If you think that disclosure of your health information by the usual means could endanger you 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 you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your 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, you do 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 your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within thirty (30) days of receipt of your request, the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than thirty (30) more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree 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, you will be informed of where to direct your request.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

You have a right to request that the Plan amend your health information in a Designated Record Set; however, there are certain exceptions. The Plan may deny your request for a number of reasons. For example, your 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 (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within sixty (60) days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or

- Provide a written statement that the time period for reviewing your request will be extended for no more than thirty (30) more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You 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.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules went into effect). You do not have a right to receive an accounting of any disclosures made:

1. For Treatment, Payment, or Health Care Operations;
2. To you about your own health information;
3. Incidental to other permitted or required disclosures;
4. Where authorization was provided;
5. To family members or friends involved in your care (where disclosure is permitted without authorization);
6. For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
7. As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your 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 you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than thirty (30) more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any twelve (12)-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO RECEIVE A PAPER COPY OF THE NOTICE OF PRIVACY PRACTICES

You have the right to request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

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 material changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice. The revised notice will be posted on the Plan's website no later than the effective date of the material revision(s) and thereafter sent to covered individuals with the Plan's next annual mailing.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and/or with the Plan.

To file a complaint with the Plan, contact the Privacy Official at:

Privacy Official
IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
Telephone Number: (802) 864-5864 ext. 14
Fax Number: (802) 862-6379

To file a complaint with the Secretary of Health and Human Services, contact the U.S. Department of Health and Human Services at:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
Telephone Number: (877)696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

You will not be retaliated against if you file a complaint.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, please call the Fund Office at (802) 864-5864 ext. 14.

The Plan supports your right to the privacy of your protected health information. The Plan will not retaliate against you in any way for filing a complaint with it or the U.S. Department of Health and Human Services.

The Plan's Legal Duty

The Plan is required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. In addition, the Plan is required to notify affected individuals following a breach of unsecured Protected Health Information.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or desire additional information, please contact the following:

Privacy Official:
IBEW Local 300 Health and Welfare Plan
3 Gregory Drive
South Burlington, VT 05403
Telephone Number: (802) 864-5864 ext. 14
Fax Number: (802) 862-6379

THE BOARD OF TRUSTEES AND YOUR 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 your Protected Health Information as are imposed on the Trustee himself.

Each Trustee that receives or has access to Protected Health Information has agreed in writing to observe each of the following restrictions and provisions relating to his use or disclosure 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 that was 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 Department of Health and Human Services 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 21. OTHER LEGAL REQUIREMENTS

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

Under this federal law, you may have the right to take up to twelve (12) weeks of unpaid leave in a twelve (12) -month period for the birth or adoption of a child; to care for a spouse, child, or parent with a serious health condition; and when you are unable to work because of a serious health condition. If you are out of work because of a qualified Family and Medical Leave Act leave of absence, you may choose to continue coverage during your leave of absence, or you may choose to suspend coverage during your leave. If you continue coverage during your leave of absence you and your Eligible Dependents will be covered under your plan while you are absent from work.

The coverage will continue as if you were actively working until the earlier of the expiration of your FMLA leave or the date you give notice to your Employer that you will not return from your leave. You are required to pay the Employee's portion of the cost of medical coverage, where applicable.

However, if you choose to suspend coverage during your absence, you and your Eligible Dependents will become covered immediately upon your return to work without being required to give evidence of insurability. If you decide to take an FMLA leave of absence, contact the Fund Office for further information and election forms.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE ("USERRA")

If you are an Employee who is on a uniformed services leave of absence for up to thirty-one (31) days, you and your Eligible Dependents will continue to receive your medical coverage under the Plan during your leave, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and the Plan's related administrative policies.

"Service in the uniformed services" is defined under USERRA and generally means the performance of duty on a voluntary or involuntary basis in a uniformed service in:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
- The commissioned corps of the Public Health Service; or
- Any other category designated by the President in the time of war or national emergency.

A period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the employment for the purpose of performing funeral duty as authorized by Section 12503 of Title 10 or Section 115 of Title 32 is also considered service in the uniformed services.

If your uniformed services leave of absence exceeds thirty-one (31) days, you will be permitted to continue you and your Eligible Dependents' medical coverage under the Plan, at your own expense, during such leave for up

to a maximum of twenty-four (24) months. Any hours remaining in your Hour Bank Account will be frozen while you are engaged in the uniformed services. This continuation right will be provided in the same way as COBRA. This means that you must make a timely election and the required self-payments within the COBRA time periods. The continued coverage that is provided in satisfaction of your rights under USERRA will also apply to satisfy your rights under COBRA (i.e., they will run at the same time). See the section "COBRA Continuation Coverage" for a full explanation of the COBRA coverage provisions.

Your Eligible Dependent(s) may be eligible for health care coverage under TRICARE (formerly known as the Civilian Health & Medical Program of the Uniformed Services or CHAMPUS). This plan will coordinate coverage with TRICARE in a manner that complies with the law.

Coverage will not be offered for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility, as well as any hours remaining in your Hours Bank, will be reinstated on the day you return to Covered Employment, provided that you return to employment within:

- Ninety (90) days from the date of discharge if the period of your service was more than 180 days; or
- Fourteen (14) days from the date of discharge if the period of your service was at least thirty-one (31) days, but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of your service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for a recovery of up to two (2) years.

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave of absence affects your coverage, please contact the Fund Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA")

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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 Fund Office for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

The Fund Office 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 Fund Office 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 Employee'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 an Employee.
- "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 an Employee's child or directs the Employee 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 an Employee 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

Employee 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 Employees 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 Qualified Medical Child Support Order that directs the Fund Office to effectuate coverage for an Alternate Recipient as the dependent child of the noncustodial parent who is (or will become) an Employee 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 Fund Office shall as soon as administratively possible (1) notify the Employee 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 Employee and each affected Alternate Recipient of such determination. To give effect to this requirement, the Fund Office 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 twenty (20) business days after the date of the NMSN, the state or local agency issuing the NMSN shall provide the Fund Office with the notice. Within forty (40) business days of the date of the notice, the Fund Office 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 Fund Office to obtain, without charge, a copy of the Plan's QMCSO procedures and further information.

OBLIGATION TO PROVIDE FUND WITH TRUTHFUL AND ACCURATE INFORMATION

The Plan is authorized to rescind coverage of Participants (including the coverage of Dependents) or Dependents in cases where Participants or Dependents provide false or misleading information to the Plan in order to obtain coverage or benefits to which they or their Dependents are not entitled, or fail to immediately notify the Plan if a person who is enrolled as an Eligible Dependent no longer satisfies the requirements for Eligible Dependent status under the Plan.

The Plan may recover from any Participant or Eligible Dependent any payments made by the Plan on behalf of a Participant or Eligible Dependent for benefits to which they were not entitled. The Trustees may offset, recoup or deny future claims of a Participant or Eligible Dependent which would otherwise be payable under the Plan until the plan has been reimbursed in full by such Participant or Eligible Dependent. In the event the Trustees are required to institute a civil action to recover any such amounts paid in error as a result of erroneous information, misrepresentation, non-disclosure or concealment by the Participant or Eligible Dependent, the Plan shall be entitled as a remedy under the Plan all losses owed to the Plan, with interest at a rate of twelve percent (12%) per annum from the date of the payment, its reasonable attorneys' fees incurred in collection and all other remedies provided under ERISA and applicable federal and state law.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 ("PPACA") GRANDFATHER STATUS

On March 23, 2010, the Patient Protection and Affordable Care Act of 2010 ("PPACA") was enacted. The IBEW Local 300 Health and Welfare Plan is **a "non-grandfathered" plan under PPACA**.

SECTION 22. PREVENTIVE CARE SERVICES PROVIDED AT NO CHARGE IN-NETWORK

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010. Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the Participant or Eligible Dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit unless there is no provider in the Plan's network who can provide the particular service.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

COVERED PREVENTIVE SERVICES FOR ADULTS

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults aged 50 to 75
7. Depression screening
8. Type 2 diabetes screening for adults aged 40 to 70 years who are overweight or obese
9. Diet counseling for adults at higher risk for chronic disease
10. Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
11. Hepatitis B screening

12. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945–1965
13. HIV screening for everyone ages 15 to 65, and other ages at increased risk
14. Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:
    - Diphtheria
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles
    - Meningococcal
    - Mumps
    - Pertussis
    - Pneumococcal
    - Rubella
    - Tetanus
    - Varicella
15. Lung cancer screening for adults aged 55-80 at high risk for lung cancer because they're heavy smokers or have quit in the past fifteen (15) years
16. Obesity screening and counseling
17. Sexually transmitted infection (STI) prevention counseling for adults at higher risk
18. Statin preventive medication for adults aged 40 to 75 at high risk
19. Syphilis screening for adults at higher risk
20. Tobacco use screening for all adults and cessation interventions for tobacco users
21. Tuberculosis screening for certain adults without symptoms at high risk

COVERED PREVENTIVE SERVICES FOR PREGNANT WOMEN OR WOMEN WHO MAY BECOME PREGNANT

1. Anemia screening on a routine basis
2. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
3. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs)
4. Folic acid supplements for women who may become pregnant
5. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
6. Gonorrhea screening for all women at higher risk

7. Hepatitis B screening for pregnant women at their first prenatal visit
8. Preeclampsia prevention and screening for pregnant women with high blood pressure
9. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
10. Syphilis screening
11. Expanded tobacco intervention and counseling for pregnant tobacco users
12. Urinary tract or other infection screening

OTHER COVERED PREVENTIVE SERVICES FOR WOMEN

1. Breast cancer genetic test counseling (BRCA) for women at higher risk
2. Breast cancer mammography screenings every 1 to 2 years for women over 40
3. Breast cancer chemoprevention counseling for women at higher risk
4. Cervical cancer screening:
   - Pap test (also called a Pap smear) every 3 years for women 21 to 65
   - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women aged 30 to 65 who don't want a Pap smear every 3 years
5. Chlamydia infection screening for younger women and other women at higher risk
6. Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
7. Domestic and interpersonal violence screening and counseling for all women
8. Gonorrhea screening for all women at higher risk
9. HIV screening and counseling for sexually active women
10. Osteoporosis screening for women over age 60 depending on risk factors
11. Rh incompatibility screening follow-up testing for women at higher risk
12. Sexually transmitted infections counseling for sexually active women
13. Syphilis screening for women at increased risk
14. Tobacco use screening and interventions
15. Urinary incontinence screening for women yearly
16. Well-woman visits to get recommended services for women under 65

COVERED PREVENTIVE SERVICES FOR CHILDREN

1. Alcohol, tobacco and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Bilirubin concentration screening for newborns
5. Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years

6. Blood screening for newborns
7. Cervical dysplasia screening for sexually active females
8. Depression screening for adolescents beginning routinely at age 12
9. Developmental screening for children under age 3
10. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish for all infants and children as soon as teeth are present
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
15. Height, weight and body mass index (BMI) measurements for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
16. Hematocrit or hemoglobin screening for children
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening
19. HIV screening for adolescents at higher risk
20. Hypothyroidism screening for newborns
21. Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza (Flu Shot)
    - Measles
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
22. Lead screening for children at risk of exposure
23. Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
24. Medical history for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
25. Obesity screening and counseling
26. Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
27. Phenylketonuria (PKU) screening for this genetic disorder in newborns

28. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
29. Tuberculin testing for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
30. Vision screening for all children

OFFICE VISIT COVERAGE

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition.

a. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit.

b. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100% for the office visit.

c. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost-sharing with respect to the office visit.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100%. Well woman visits are also treated as Preventive Services and paid at 100%.

PREVENTIVE SERVICES COVERAGE LIMITATIONS AND EXCLUSIONS

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service covered for diagnostic reasons are covered under the applicable Plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Participant or Eligible Dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

2. Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.

3. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus are not covered.

5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

    a. When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

    b. When related to judicial or administrative proceedings;

    c. When related to medical research or trials; or

    d. When required to maintain employment or a license of any kind.

7. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

8. Services related to a man's reproductive capacity, such as vasectomies and condoms.

SECTION 23. HINTS FOR EFFECTIVELY USING THE IBEW LOCAL 300 HEALTH AND WELFARE FUND

SEE YOUR DOCTOR REGULARLY

There is no substitute for preventive care, such as annual physicals, annual flu shots, and having your children receive immunizations. By visiting your doctor regularly, you help your doctor notice any early signs of problems, which will allow you to receive preventive treatment and review before the problem becomes more severe.

CONSIDER USING GENERIC EQUIVALENTS TO NAME-BRAND DRUGS

Generic drugs are equally as effective as their name-brand counterparts, and cost both you and the Plan less.

CONSIDER USING "MAIL ORDER" TO FILL YOUR PRESCRIPTIONS

This is especially true if you are on a maintenance drug, or one that you are taking regularly. Examples include drugs intended to reduce high levels of cholesterol and those intended to reduce high blood pressure. Our plan encourages your use of mail order by making your cost of prescriptions less if you have your prescriptions filled in this way.

USE AN EMERGENCY ROOM FOR ONLY TRUE MEDICAL EMERGENCIES

Our plan is designed to encourage you to use your regular physician because we believe treatment from your own doctor is more cost-effective and personalized than at an Emergency Room. Receiving Emergency Room care is only appropriate when your symptoms are life-threatening or severe.

REVIEW YOUR MEDICAL CHARGES AND ALL BILLS AND INVOICES FROM YOUR PROVIDERS

Although mistakes from your providers are probably rare, you can help the Plan by reviewing all bills and invoices to ensure that the listed services were actually performed.

MAKE SURE YOU UNDERSTAND WHAT IS AND IS NOT COVERED BY THIS PLAN OF BENEFITS

Your health is important, and knowing what coverage you have can help you be a smart health consumer.

WHEN YOU TRAVEL, MAKE SURE TO REVIEW THE IN-NETWORK HOSPITALS UNDER THIS PLAN

The Blue Cross Blue Shield network applies to hospitals and physicians across the country. These providers are considered "in-network" for this Plan. By reviewing the hospitals available at your destination before you leave, you will help yourself by using in-network facilities and care. You can find additional information about which hospitals are part of the Blue Cross network by logging on to www.bluecrossvt.org and following the directions given.

USE IN-NETWORK DOCTORS, HOSPITALS, AND SERVICES WHENEVER POSSIBLE

The Plan has negotiated with in-network providers to provide high-quality, cost-effective service. Your costs are less when you use in-network care, so choosing this option benefits both you and the Plan.

LIVE A HEALTHY LIFESTYLE

Many medical problems can be traced to poor eating habits, excessive smoking, lack of exercise, and other poor habits. By taking control of your own health, you will feel better, and could reduce your need for medical services.

International Brotherhood of Electrical Workers – Local 300 Health and Welfare Fund
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864

November 1, 2020

THIS IS A SUMMARY OF MATERIAL MODIFICATIONS TO THE IBEW LOCAL 300 HEALTH AND WELFARE PLAN

Dear Participant:

The IBEW Local 300 Health and Welfare Fund Trustees are committed to offering the eligible participants and their dependents quality health care benefits at the lowest cost possible. In an effort to curb cost increases, the Trustees have made the following changes to the plan to become effective January 1, 2021.

The following change is applicable to both the Construction and Utility Groups:

1. Subsidized self-pay premiums for active and retired participants will be discontinued effective with the January 1, 2021 invoicing. Currently monthly pay-in premiums are discounted 40% for active participants and 20% for non-Medicare eligible retirees. You will receive a communication from the Fund Office during November detailing the change in the specific premiums.

2. There will also be an enhancement in the vision coverage with VSP. Participants currently pay $20 per visit, regardless of if their visit includes an exam, exam and glasses, or exam and contacts. Effective January 1, 2021 there will be a $10 exam and a $10 materials copay. Participants who receive eye exams and do not purchase materials will only pay $10, compared to $20 under the current arrangement. Participants receiving eye exams and glasses will pay the same $20 copay as current. This option also waives the $10 materials copay for contact lenses, so participants receiving exams and purchasing contacts will pay $10 plus the contact fitting fee, as compared to $20 plus the contact fitting fee under the current arrangement.

3. The Trustees also made the following decision regarding participants who have an adult dependent child. Effective January 1, 2021, any Medicare-Eligible participant who retires and participates in the retiree reimbursement program for their Medicare Supplement and Medicare Part D; and who has an incapacitated adult dependent who is also enrolled in Medicare; may also enroll the dependent in the IBEW Local 300 Health and Welfare Fund retiree reimbursement program for their Medicare Supplement and Medicare Part D Policies. The Dependent will receive a 50% reimbursement of monthly cost of the policies. The Fund Office must receive monthly copies of the invoices or other proof that the premiums for premium for the policies has been paid. The dependent must be an active participant enrolled in the plan at the time of the participant's retirement.

The following changes are for the Construction Unit only:

1. There will be a reduction in the monthly deposits to the Health Savings Accounts (HSAs) and the annual amount available in the Health Reimbursement Arrangements (HRAs). Effective January 1, 2021 the deposits will be made as follows:

Type of Policy	Total Monthly Deposit	Total Annual Deposit	Notes
Single - HSA	$41.67	$ 500.00	Please see below for annual limits
Two-Person/Family - HSA	$83.34	$1,000.00	Please see below for annual limits

Two-Person/Family HRA		$1,000.00	Available Jan 1 each yr.

You may deposit additional personal funds into your HSA account.

The 2021 annual HSA contribution limit is **$3,600** for individuals with self-only HDHP coverage (up from $3,550 in 2020), and **$7,200** for individuals with family HDHP coverage (up from $7,100 in 2020). You may also deposit an additional $1,000 per year if you are over age 55. The limits include the amount you will receive from IBEW Local 300 Health and Welfare Fund of $500.00/single or $1,000.00/ two-person or family.
This can be done by either payroll deduction or working directly with Health Equity to arrange a transfer from your checking or savings account into your HSA account. If you would like to know more about these options please contact your employer's office or the Fund Office at (802) 864-5864 ext. 14.

2. There will also be a change short-hour payment provision to remain eligible on the plan. Currently, if you have at least 110 hours in your eligibility bank, you can self-pay up to 42 hours per month to remain eligible for benefits. This will increase to a maximum of 60 hours effective January 1, 2021. For example;

Number of hours short	Contribution Rate	Amount due for coverage
60	$7.70	$462.00
60	$4.50 – (CW, CE or <period 4 apprentice	$270.00
60	$2.70 – opt out coverage	COBRA Rates *

*COBRA Rates will be lower than paying 60 hours at the contribution rate

These amounts will decrease depending on the number of hours you are short to maintain your eligibility. If you do not have at least 110 hours in you eligibility bank you will owe the full COBRA amount to maintain eligibility under the Federal COBRA provision.

Please feel free to call the Jean Watkins at the Fund Office at (802) 864-5865 Ext. 14 of you would like further information.

Sincerely,

IBEW Local 300 Health and Welfare Fund Board of Trustees.

This notice is intended to be a Summary of Material Modifications (SMM) for the 2019 Edition of the IBEW Local 300 Benefit Trust Fund Health & Welfare Plan, as required by the Employee Retirement Income Security Act of 1974. It describes amendments to the Plan, and to information presented in your Summary Plan Description (SPD), Plan communications, and any previous SMMs. You should keep this notice with your SPD.

International Brotherhood of Electrical Workers – Local 300 Health and Welfare Fund
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864
Fax (802) 864-5495

August 2021

THIS IS A SUMMARY OF MATERIAL MODIFICATIONS TO THE IBEW LOCAL 300 HEALTH AND WELFARE PLAN

Dear Participant:

The Trustees of the IBEW Local 300 Benefit Trust Fund (the "Fund") would like to advise you of a change to the IBEW Local 300 Health and Welfare Plan (the "Plan").

Nutritional Counseling

One of the benefits provided by the Plan is nutritional counseling. In most cases, the Plan covers up to three Outpatient nutritional counseling visits each plan year. However, this limit does not apply to the treatment of diabetes. Effective January 1, 2019, this limit also does not apply to the treatment of any mental or behavioral health diagnosis (including eating disorders).

If you have any questions regarding nutritional counseling, or if you experience any difficulties in accessing care, please do not hesitate to contact the Fund Office.

Sincerely,

IBEW Local 300 Health and Welfare Fund Board of Trustees

This notice is intended to be a Summary of Material Modifications (SMM) for the 2019 Edition of the IBEW Local 300 Benefit Trust Fund Health & Welfare Plan, as required by the Employee Retirement Income Security Act of 1974. It describes amendments to the Plan, and to information presented in your Summary Plan Description (SPD), Plan communications, and any previous SMMs. You should keep this notice with your SPD.

International Brotherhood of Electrical Workers – Local 300 Health and Welfare Fund
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864
Fax (802) 864-5495

August 2022

THIS IS A SUMMARY OF MATERIAL MODIFICATIONS TO THE IBEW LOCAL 300 HEALTH AND WELFARE PLAN

Dear Participant:

The Trustees of the IBEW Local 300 Benefit Trust Fund (the "Fund") would like to advise you of changes to the IBEW Local 300 Health and Welfare Plan (the "Plan"). These changes are described below.

1. **Trustee Changes**. Effective December 2021, Union Trustee Tim Watkins was replaced by Jeffrey Wimette, and Management Jane Brown was replaced by Shannon Lapierre, and effective March 2022, Management Trustee Kenneth Douglas was replaced by Kerry Davis. Below is the updated list of Trustees and their contact information:

Union Trustees	Management Trustees
Mr. Timothy J. LaBombard IBEW Local Union No. 300 3 Gregory Drive South Burlington, VT 05403 Phone: (802) 864-5864 Fax: (802) 864-5495	Ms. Shannon Lapierre Peck Electric Company 400 Ave. D Williston, VT 05493 Phone: (802) 658-3378 Fax: (802) 658-3527
Mr. Jeffrey Wimette IBEW Local Union No. 300 3 Gregory Drive South Burlington, VT 05403 Phone: (802) 864-5864 Fax: (802) 864-5495	Ms. Kerry Davis Sherwin Electric Company, Inc. 7A Morse Drive Essex Junction, VT 05452 Phone: (802) 878-4041 Fax: (802) 879-2788
Mr. Brian Ritz IBEW Local Union No. 300 3 Gregory Drive South Burlington, VT 05403 Phone: (802) 864-5864 Fax: (802) 864-5495	Mr. Jeffrey Peck Peck Electric Company 400 Ave. D Williston, VT 05493 Phone: (802) 658-3378 Fax: (802) 658-3527

2. **Effective February 1, 2022**, Employees who do not return their enrollment forms to the Fund Office within thirty (30) days of meeting the Plan's eligibility requirements will not be enrolled and will not be credited with more than 500 hours until the enrollment forms are received. Upon receipt of the enrollment paperwork, Employees and their eligible Dependents will be enrolled in coverage effective the following month, and their hours will no longer be held at 500.

3. **Effective March 3, 2022**, the continuation of coverage rules for Employees in the *Construction Group* are changed. Currently, *Construction Group* Employees may receive hours credit for up to one month of health eligibility based on evidence of hours worked in covered employment, even if the contributing employer has not yet made benefit contribution payments. For example, an Employee who provides paystubs indicating 152 hours worked in August 2022 would receive credit for 152 hours for purposes of September 2022 eligibility.

   Effective March 3, 2022, Employees who work for a contributing employer whom the Trustees, in their sole discretion, designate as chronically or significantly delinquent, will only receive eligibility credit for hours which the Health Fund has received benefit contribution payments from the contributing employer.

4. **Clarification on HSA Deposits**. Health Savings Accounts (HSAs) are funded by monthly or quarterly contributions made throughout the Plan year, based on eligibility. The dollar amounts listed on pages 56-57 of the SPD ($500 (if single) and $1,000 (if family) for *Construction Group* Employees and $1,150 (if single) and $2,200 (if family) for *Utility Group* Employees) represent the total amount of deposits made over the course of a full year of eligibility.

We hope that this notice makes this change clear and concise, but if you need additional information, please contact Lindsey Brown in the Fund Office.

Sincerely,

IBEW Local 300 Health and Welfare Fund Board of Trustees

This notice is intended to be a Summary of Material Modifications (SMM) for the 2021 Edition of the IBEW Local 300 Benefit Trust Fund Health & Welfare Plan, as required by the Employee Retirement Income Security Act of 1974. It describes amendments to the Plan, and to information presented in your Summary Plan Description (SPD), Plan communications, and any previous SMMs. You should keep this notice with your SPD.

International Brotherhood of Electrical Workers – Local 300 Health and Welfare Fund
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864

July 2023

THIS IS A SUMMARY OF MATERIAL MODIFICATIONS TO THE IBEW LOCAL 300 HEALTH AND WELFARE PLAN

Dear Participant:

The Trustees of the IBEW Local 300 Benefit Trust Fund (the "Fund") would like to advise you of important changes to the IBEW Local 300 Health and Welfare Plan (the "Plan").

Coronavirus Testing and Diagnosis

Effective May 11, 2023, the federally declared Public Health Emergency related to COVID-19 ended, and the Plan will no longer waive copays, co-insurance, and deductible requirements for COVID-19-related testing and medical visits to diagnose COVID-19. Cost sharing will apply to testing and diagnostic visits provided at a doctor's office, via telehealth, at an urgent care center, or at an emergency room.

Retiree Reimbursement of Supplemental Cost

Effective January 1, 2023, the Plan will no longer reimburse Medicare-eligible retirees and their spouses for half (50%) of the premium cost of Medicare Supplement Plans. Instead, those who elect retiree coverage under the Plan will be required to pay the Plan half (50%) of the premium cost for one of two specifically designed Medicare Advantage plans offered by Vermont Blue Advantage ("VBA"), an affiliate of Blue Cross and Blue Shield of Vermont. Retirees and spouses must be enrolled in both Medicare Part A and Part B and meet the retiree eligibility requirements listed in the SPD to be eligible to participate in the IBEW Local 300 Health and Welfare Medicare Advantage plans. Additional information about the two Medicare Advantage plans is enclosed with this notice. Please note these plans are only available to IBEW Local 300 Medicare-eligible retirees and their spouses and are not available on the individual market. You may contact the Fund Office to learn more about the Plan's Medicare Advantage plans.

Retiree Benefits for Surviving Spouses

The Trustees would like to clarify the Plan's Summary Plan Description regarding the benefits available to the surviving spouse of a Medicare eligible retiree who passes away. After the death of the participant, the eligible surviving spouse may continue to receive the Plan's benefits as if he or she were the retiree. For life insurance purposes, the surviving spouse will be treated as the participant and not the participant's spouse. This means that the life insurance benefit payable to the surviving spouses' beneficiary, as of today's date, would be $10,000.

Definitions

For clarification, the Trustees would like to add two definitions to the Claims & Internal Review Procedure section of the Plan's Summary Plan Description, which starts on page 96 of the SPD.

Experimental or Investigational Services means health care items or services that are either not generally accepted by informed health care Providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

Medically Necessary Care means health care services including diagnostic testing, Preventive services, and after-care appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically Necessary Care must be informed by generally accepted Medical or Scientific Evidence and consistent with generally accepted practice parameters as recognized by health care Providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and: help restore or maintain the Member's health; or prevent deterioration of or palliate the Member's condition; or prevent the reasonably likely onset of a health problem or detect a developing problem.

If you have any questions, please contact the Fund Office.

Sincerely,

IBEW Local 300 Health and Welfare Fund Board of Trustees

This notice is intended to be a Summary of Material Modifications (SMM) for the 2021 Edition of the IBEW Local 300 Benefit Trust Fund Health & Welfare Plan, as required by the Employee Retirement Income Security Act of 1974. It describes amendments to the Plan, and to information presented in your Summary Plan Description (SPD), Plan communications, and any previous SMMs. You should keep this notice with your SPD.

International Brotherhood of Electrical Workers – Local 300 Health and Welfare Fund
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864

October 2023

THIS IS A SUMMARY OF MATERIAL MODIFICATIONS TO THE IBEW LOCAL 300 HEALTH AND WELFARE PLAN

Dear Participant:

The Trustees of the IBEW Local 300 Health and Welfare Plan would like to advise you of important changes to the Plan.

Annual Deductible

Effective January 1, 2024, the Health Fund's deductibles for both Construction Employees and Utility Employees will be increasing by $100.00 for self-only coverage and $200.00 for family coverage. Therefore, the annual deductible for a self-only or single plan will be $1,600 per year, and the deductible for a family plan will be $3,200 per year.

Health Savings Account (HSA) & Health Reimbursement Arrangement (HRA)

In light of the deductible increase, the contribution to employees' HRAs and HSAs will also be increasing effective January 1, 2024.

For Utility Employees, the annual contribution to either your HRA or HSA will increase to $1,175.00 for single-only coverage. If you are enrolled in family coverage, the annual contribution will increase to $2,350.00.

For Construction Employees, the annual contribution to either your HRA or HSA will increase to $600.00 for single-only coverage. If you are enrolled in family coverage, the annual contribution will increase to $1,200.00.

Forum Selection & Assignment of Claims

Effective for claims or actions filed on or after September 21, 2023, any claim or action by a participant or beneficiary relating to or arising under the Health and Welfare Plan may only be brought in the United States District Court for the District of Vermont. Additionally, any claim or action relating to the payment or reimbursement of healthcare services, or any other benefit provided under the Plan, may only be brought by the participant or beneficiary. Such claims or actions may not be assigned to a third-party, including the caregiver who performed the service.

If you have any questions, please contact the Fund Office.

Sincerely,
IBEW Local 300 Health and Welfare Plan Board of Trustees

This notice is intended to be a Summary of Material Modifications (SMM) for the 2021 Edition of the IBEW Local 300 Benefit Trust Fund Health & Welfare Plan, as required by the Employee Retirement Income Security Act of 1974. It describes amendments to the Plan, and to information presented in your Summary Plan Descriptions (SPDs), Plan communications, and any previous SMMs. You should keep this notice with your SPDs.

IBEW Local 300 Health and Welfare Fund
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864 Ext. 14
Fax (802) 862-6379
www.ibewlocal300.org

March 4, 2022

Dear Participant,

The Trustees of the IBEW LOCAL 300 HEALTH & WELFARE PLAN ("the Plan") would like to advise you of a change to the Plan's Summary Plan Description ("SPD").

Coverage for COVID Tests

The Plan covers the costs of diagnostic tests for COVID-19 without any cost-sharing or prior authorization, and this coverage will continue for the duration of the federally-declared public health emergency related to COVID-19. Prior to January 15, 2022, this benefit was available only for COVID tests that were prescribed or ordered by a medical provider.

Beginning January 15, 2022, the Plan will also cover over-the-counter, at-home COVID tests, in accordance with the rules below. Participants may purchase up to 8 tests in a thirty (30) day period. No prescription is needed. The tests may be used if you are experiencing symptoms of COVID or have been exposed to someone who has tested positive. Tests are not covered for non-medical uses such as employment or travel.

We encourage you to purchase your tests through an in-network pharmacy. When you purchase your tests, ask the pharmacy to submit the claim through your prescription plan, just like a regular prescription. Please contact Blue Cross Blue Shield Vermont (BCBSVT) for additional information.

If you wish to obtain reimbursement for your out-of-pocket costs for tests purchased on or after January 15, 2022, you may also submit a reimbursement claim to BCBSVT. You may obtain the reimbursement form by contacting BCBSVT. There are additional restrictions and limitations on this benefit, which are reflected on the reimbursement form. Please review the form carefully before submitting a reimbursement request.

If you have any questions regarding these changes, please contact the Fund Office.

Sincerely,

Board of Trustees of the IBEW Local 300 Health & Welfare Plan

This notice is intended to be a Summary of Material Modifications (SMM) for the 2021 SPD of the IBEW Local 300 Health & Welfare Benefit Plan, as required by the Employee Retiree Income Security Act of 1974. It describes amendments to the Plan, and to information presented in your Plan Description, Plan communications, and any previous SMMs. You should keep this notice with your Plan Description