January 1, 2020

Dear Participant:

This booklet is a description of the I.B.E.W. Local 910 Welfare Plan for Active Participants (and Retirees under Age 65) in effect on January 1, 2020. There have been some changes in the Plan since the last booklet was written. We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

This booklet has eight sections:

The Plan is governed by a Board of Trustees of which half represents the I.B.E.W. Local Union No. 910 ("Union") and half represents the participating employers. Our role, as Trustees of the Welfare Fund, includes the responsibility for collecting contributions (which are required by an agreement between your employer and the Union or between your employer and the Trustees).

The Board of Trustees has the ultimate responsibility for the management of Plan assets. In addition, the Board of Trustees has the sole power to amend the Plan. The Board of Trustees is assisted in these and other tasks by professional advisors whom we hire from time to time. These include an actuary, an accountant, an attorney and one or more investment managers.

The Plan Manager, Mark A. Capone, maintains the daily operation of the Plan. Mr. Capone and his staff are available to answer any questions or as a resource to obtain additional information about the Plan.

If, after going through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Fund Office. If your questions are not answered to your satisfaction by the staff, you may direct them to the Plan Manager or to the Trustees, in writing.

Sincerely,

Board of Trustees
I.B.E.W. Local 910 Welfare Fund

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret or extend or change in any way the provisions of insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. This booklet describes the Plan as it exists on January 1, 2020.

CAUTION

This booklet and the personnel at the Fund Office are authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them with regard to the Welfare Fund. No employer, union representative, supervisor or shop steward is in a position to discuss your rights under the Plan with authority.

COMMUNICATIONS

If you have a question about any aspect of your participation in the plan, you should, for your own permanent record, write to the Plan Manager or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

NO GUARANTEE OF INCOME TAX CONSEQUENCES

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under this Plan will be excludable from the participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any participant. It shall be the obligation of each participant to determine whether each payment under the Plan is excludable from the participant's gross income for Federal and State income tax purposes, and to notify the Fund Office if the participant has reason to believe that any such payment is not so excludable.

GRANDFATHERED PLAN STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at (315) 782-5941 or (800) 801-2201. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Directory

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Syracuse, NY 13204

Plan Manager

Mark A. Capone
I.B.E.W. Local 910
25001 Water Street
Watertown, NY 13601

Table of Contents

Important Aspects

- **Familiarize yourself with the whole booklet.**
- **You must apply for all benefits.**
- **Make sure that the Fund Office is aware of all your dependents and your current address.**
- **Make sure your Death Benefit beneficiary designation is up to date.**
- **All claim forms must be completely filled in; incomplete claims will be returned.**

Plan Change or Termination

The Trustees reserve the rights to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Benefits provided by the Plan:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested at any time;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such right to modify or terminate is not contingent on financial necessity.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

Modification of Benefits and Eligibility Rules

This Summary Plan Description includes information concerning the benefits provided by the Plan to participants, and their dependents, and the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits, that a participant or dependent might otherwise reasonably expect a plan to provide.

The benefits and eligibility rules applicable to participants and dependents have been established by the Trustees as part of an overall benefit plan for participants. The right to amend or modify the eligibility rules and plan of benefits for participants and dependents is reserved by the Trustees in accordance with the Restated Agreement and Declaration of Trust. The continuance of benefits for participants and dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their responsibilities and authority contained in the Restated Agreement and Declaration of Trust.

In accordance with the rules and regulations of the Plan and the Restated Agreement and Declaration of Trust, no participant or dependent has a vested right or contractual interest in the benefits provided. In addition to the right to terminate benefits of participants and/or dependents at any time, in the event of termination of the Plan, the Trustees also reserve the right to terminate the plan of benefits for participants and/or dependents and there shall not be any vested right by any participant or dependent or beneficiary nor contractual rights after the disposition of Plan assets in connection with the termination of this Plan. The provisions for participants' and dependents' coverage shall be reviewed periodically by the Trustees.

Some written agreements requiring contributions to the I.B.E.W. Local 910 Welfare Fund ("Welfare Fund") and I.B.E.W. Local 910 Annuity Fund ("Annuity Fund") require an allocation to be made of the aggregate Welfare Fund and Annuity Fund contributions such as currently contained in the attached Exhibit A. The Trustees authorize the Plan Manager making the allocation of the aggregate Welfare Fund and Annuity Fund contributions as provided in the attached Exhibit A, or as amended thereafter.

Section I. Eligibility Requirements

This Section describes how you and your dependents can qualify and continue to qualify for benefits under the I.B.E.W. Local 910 Welfare Plan.

A. IN GENERAL

The I.B.E.W. Local 910 Welfare Plan has been a personal account plan since January 1, 1995. Employer welfare contributions are made to the personal account plan. A portion of such contributions will be credited to a personal account for you. The Trustees will determine the portion of the contributions that will be credited to your personal account. This determination may change from time to time depending upon the financial requirements of the Plan as a whole.

Your account will grow with all the contributions that are made to it. Your account will be decreased by any benefit distribution or Health Care Benefit premium made from it. No more will be paid out to you under this Plan than has come into your personal account by way of contributions made on behalf of your work and special allocations.

Administration charges may be levied against each participant's account, on an equitable basis, if, for instance, the investment yield on the Plan reserves is not sufficient to offset the costs of administration of the Plan.

If contributions are made to the Plan for you before you satisfy the eligibility requirements and the contributions cannot be used and/or are insufficient to satisfy the eligibility requirements, such contributions will be forfeited and used for Plan administrative costs. Likewise, if there is no activity (for example, work requiring contributions to be tendered to the Plan or payment of benefits) in your account for a consecutive two-year period, the balance in your account will be forfeited and used for Plan administrative costs.

Those individuals who are unavailable for Covered Employment for reasons other than retirement under the I.B.E.W. Local 910 Pension Plan, or disability, shall forfeit the Plan assets allocated into their then-existing Personal Account Plan to the general treasury of the Fund. Availability for Covered Employment is determined by the Union.

There are two separate Personal Account Plans—one for Active Participants and one for Retired Participants. The PAP balance for any participant who is retired under the I.B.E.W. Local 910 Pension Plan is transferred to the Retiree Personal Account Plan ("Retiree PAP Plan") at retirement.

Any employer contributions received after the date of the transfer, for your work in Covered Employment prior to retirement will also be transferred to the Retiree PAP Plan upon receipt.

The Retired Participant will continue to be able to access his or her account in the Retiree PAP Plan to pay for qualified health care expenses as determined by the Trustees, until his or her account is exhausted.

The Retiree PAP Plan is described in Exhibit B to this Summary Plan Description.

B. GENERAL ELIGIBILITY REQUIREMENTS

1. Active Participants. You will become a participant eligible for benefits on the first of the month following a month during which you work in C*overed Employment**.

**Covered Employment.* *Covered Employment means work for which your employer is required to contribute to the I.B.E.W. Local 910 Welfare Fund because of a collective bargaining agreement or because your employer has a special agreement with the Fund Trustees. Reciprocal time with certain other plans, for which the I.B.E.W. Local 910 Welfare Fund receives contributions, will also count as Covered Employment.*

2. Retirees Under Age 65. If you retire under the Local 910 Pension Plan, you will be eligible for coverage under this Plan for as long as your account balance is sufficient to cover your Health Care Benefit premiums. At that time, you may be eligible to continue your retiree coverage by self-payment, if you meet each of the following requirements:

- you were covered under the Local 910 Welfare Plan on the effective date of your retirement under the I.B.E.W. Local 910 Pension Plan; and

- you were covered under the I.B.E.W. Local 910 Welfare Plan for at least half of the eight-year period ending on the day before your I.B.E.W. Local 910 retirement date; or

- you, your spouse, and dependent children are covered under your spouse's employer's health care plan, or some other employer sponsored health care plan, you may elect that you not be covered under this health insurance arrangement. However, if such other health care coverage stops you must apply immediately for pensioner health insurance coverage. If three months elapse from the day the other coverage stops, you will not be permitted to apply for pensioner coverage at a later date.

If you retire after July 1, 1993, you will be bound by the conditions listed above unless the following requirement is met:

- you must be covered by the I.B.E.W. Local 910 Welfare Plan on the effective date of your pension under the I.B.E.W. Local 910 Pension Plan and you must have worked an average of at least 1,800 hours per year for the number of years that you retire prior to age 65. For example: if you retire at age 62, you would need to have an average of 1,800 hours per year for the three years prior to your retirement date. If you retire at age 64, you would need to

average 1,800 hours for the one year prior to your retirement date.

- If your monthly self-payment is not received by the 10th of the month for which you are to be covered, your coverage will stop. Once you stop making your payments or choose to end coverage under this Plan, you will not be able to start again. Further, you can only make self-payments to continue coverage, not to start it.

3. **Loss of Eligibility and Benefits.** Participants will remain covered until the earliest of the following events:

- the date your account balance is depleted or is insufficient to cover your Health Care Benefit premium for the month. Unless you are self-paying for the Health Care Benefit or, for Active Participants, the Trustees determine that there is a lack of sufficient Covered Employment, in that case, Active Participants will be allowed to run a deficit in their account of up to $1,500. [Please note that an active individual may utilize the self-pay benefit as long as they are actively seeking employment through the I.B.E.W. Local 910's referral procedures.];

- the date you cease making timely self-payments;

- the date the Welfare Plan ceases;

- the date the Plan ceases coverage for the class of covered persons for which you belong; or

- for dependents, the date your dependent ceases to satisfy the Plan's eligibility requirements for dependents. However, if you die while covered as an Active Participant, your eligible dependents who are covered at that time will be able to continue their coverage until the sooner of the following:

  - the end of the period for which you would have been eligible, had you survived;

  - the date your dependent becomes eligible for other group health benefits or Medicare;

  - the date your dependent ceases to satisfy the Plan's eligibility requirements for dependents; or

  - the date the Plan ceases.

- for retirees, the date you reach age 65 or the date you become eligible for Medicare, whichever occurs first. Your eligible dependents that are covered on that date, may continue to be covered under this Plan if the retiree is covered by the I.B.E.W. 910 Plan for

Medicare-Eligible Retirees. This Dependent coverage will continue until the sooner of:

- the date your dependent becomes eligible for other group health benefits or Medicare;
- the date your dependent ceases to satisfy the Plan's eligibility requirements for dependents; or
- the date the Plan ceases.

- For retirees, the date you choose to end coverage under the Plan and choose alternate coverage, (retirees are then unable to return to coverage under the Plan at a future time).

The benefits for Medicare-eligible pensioners, including any remaining Personal Account Plan monies, are described in a separate document called the Summary Plan Description Plan for Medicare-Eligible Retirees. Please contact the Fund Office to receive a copy of this document. Active Participants over age 70½ who are receiving a pension benefit from the I.B.E.W. Local 910 Pension Plan but have not retired from Covered Employment must satisfy the eligibility requirements for Active Participants, as outlined above. They are not covered as pensioners in the Plan for Medicare-Eligible Retirees as long as they are still working.

The failure of an individual to cooperate and/or repay the Plan monies alleged by the Plan as being owed to it by the individual shall entitle the Trustees to provide notice of loss of eligibility (effective in the future) for benefits for the individual until the claimed debt is paid. Such loss may include forfeiture of any amount in the individual's personal account maintained by the Plan. The above-referenced loss of eligibility may include the individual's spouse and dependents.

You, your spouse, and/or your dependents may be ineligible for benefits if the expenses relate to an Injury, condition, or disease resulted from directly or indirectly being engaged in, or incurred while committing, an Illegal Act. For the purpose of this exclusion, the term "Illegal Act" means any action or omission that is contrary to, or in violation of, any statute, rule, regulation, ordinance, court order, or other established custom having the force and effect of law. The Plan's Trustees reserve the exclusive right to determine, in their sole discretion, whether an action or omission is an Illegal Act based upon the facts and circumstances involved in the case and regardless of whether a criminal prosecution or conviction resulted. In accordance with the source of Injury rules established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the term "Illegal Act" shall not be interpreted to exclude coverage related to injuries incurred as a result of domestic violence and/or self-inflicted injuries that are the result of depression or mental illness.

C. ELIGIBLE CLASSES OF DEPENDENTS

For the purpose of the benefits, eligible dependents are your lawful spouse and your children who are under the age of twenty six (26) as defined in part (2) below.

1. Spouse. The term "spouse" shall mean the person recognized as the person you are married to, under the laws of the state of New York. The Plan Manager may require documentation proving a legal marital relationship.

2. Child. The term "child" shall mean a person under the age of twenty-six (26) who meets one of the following criteria:

- your natural child;
- your legally adopted child;
- a child lawfully placed with you in anticipation of adoption by an authorized placement agency;
- a step-child who lives in your household;
- your foster child placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction;
- a child for which you have been appointed legal guardian who has the same principle place of abode as you; and
- your child who is designated as an alternate payee under a Qualified Medical Child Support Order (QMCSO). You can obtain a copy of the Plan's QMCSO procedures upon request to the Plan Manager.

The Plan will not provide coverage for a dependent in any case where a court order has ordered a party other than you (the covered participant) to provide medical coverage on behalf of the dependent. Further, coverage will cease for your child if you elect to waive coverage for your child based on coverage with some other employer sponsored group coverage. The Plan will require you to demonstrate the coverage for your dependents with the other plan, except in instances after your child's 18th birthday. Even if you decide to cover your dependent with coverage provided by the Plan, you must supply the requested information about other coverage, if any, for the dependent, as required by the Fund Office to enable the Plan to coordinate benefits.

3. Disabled Dependent Child. If your covered dependent child is totally disabled, coverage may be continued beyond age twenty-six (26). To be considered totally disabled, your dependent child must be:

- incapable of self-sustaining employment by reason of mental retardation or physical handicap;
- primarily dependent upon you for support and maintenance;
- unmarried, and
- covered under the Plan when reaching age twenty-six (26).

The Plan Manager may require, at reasonable intervals during the two years following the dependent's 26th birthday, subsequent proof of the child's total disability and dependency. After the initial two-year period, the Plan Manager may require subsequent proof not more than once each year. The Plan Manager reserves the right to have a disabled dependent examined by a physician of the Plan Manager's choice, at the Plan's expense, to determine the existence of a total disability.

4. Health Expense Benefit – Dependents. For the purpose of the Health Expense Benefit, your dependents may include other people as allowed under the Internal Revenue Code, such as your brother, sister or parent. In general, to qualify, you must pay for over one-half of the person's support and the person's gross income must be less than the IRS threshold amount for that year. You should contact the Fund Office to see if a particular person can be included as your dependent for the Health Expense Benefit.

5. Status. Under this Plan, you may only be covered as either a participant or a dependent at any one time. If conditions so warrant, you may change your status from participant to dependent or dependent to participant.

If a married couple are both participants, their eligible dependent children will be covered as dependents of either parent, but not as dependents of both.

6. Duration of Dependent Coverage. Your eligible dependents will participate in the Health Care Benefit (and be covered) during the same period of time that you are covered as a participant.

D. SPECIAL ALLOCATIONS

In addition to employer contributions on your covered work, there are other ways in which your account can grow. These are called "special allocations".

1. Disability Allocation. In the event you become totally disabled while covered for the Health Care Benefit and your account is not sufficient to pay the monthly Health Care Benefit premium, you will qualify for a disability allocation.

The amount of the monthly disability allocation will be the amount necessary to pay the portion of the Health Care Benefit premium that is not available in your account. There will be no disability allocation if your personal account is sufficient to cover your Health Care Benefit premium.

No more than six (6) monthly disability allocations will be made for any one period of disability (including successive periods of disability due to the same or related causes not separated by return to active employment).

To be totally disabled, you must be unable to earn any money because of your Injury or sickness. You may have to prove your disability periodically to the Trustees upon request.

2. Financial Activity Allocation. When the Plan's financial activity permits, the Trustees may declare a bonus to be credited to eligible accounts. This will happen no more than once a year. In determining whether or not to declare this bonus and the amount of the bonus, the Trustees will take into consideration the investment results on the Plan's assets, the expenses of administration of the Plan, the amount of any other allocations and reserve requirements for the future.

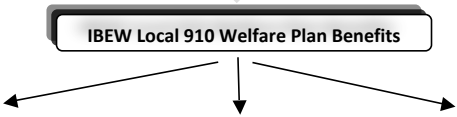
E. REINSTATEMENT AFTER TERMINATION OF ELIGIBILITY

If you are an Active Participant and your coverage is terminated, you must once again satisfy the initial eligibility requirements to have your coverage reinstated.

Section II. Description of Benefits

This Section contains descriptions of each individual benefit available under the Plan. Any special eligibility requirements or any limitations specific to a particular benefit is also covered in this Section. General eligibility requirements are discussed in Section I. and the claims procedure and related limitations and/or exclusions are covered in Section VI.

The Local 910 Welfare Fund offers the following benefits:



Medical Benefits

- (Self-Insured) Heath Care Benefit (Administered by Excellus BlueCross BlueShield)
- Prescription Drug Benefit (Administered by Sav-Rx)

Pooled Benefits

- Life Insurance Benefit
- Accidental Death & Dismemberment Insurance Benefit

Personal Account Plan Benefits

- Health Expense Benefit

The Personal Account Plan Health Expense Benefit is reimbursement coverage.

Each of these benefits may have different conditions and maximum benefit amounts. Also, not all classes of covered persons are entitled to all of the available benefits.

The following table is intended to give you a quick reference to the benefits available under the I.B.E.W. Local 910 Welfare Fund, the covered persons receiving each benefit, and brief information regarding each benefit. A detailed Schedule of Benefits is also included in this Section II.

	Covered Persons	Benefit
(Self-Insured) Health Care Benefit	– Participants & Their Dependents	Self-Insured - Third-Party Administrator – Excellus BlueCross BlueShield See the Schedule of Benefits in this Summary Plan Description
Prescription Drug Benefit	– Participants & Their Dependents	80% Administered by Sav-Rx.
Life Insurance Benefit	– Active Participants	$10,000 – Pooled Benefit Insured by ULLICO
Accidental Death & Dismemberment Insurance Benefit	– Active Participants	Pooled Benefit Insured by ULLICO. Paid in accordance with schedule.
Health Expense Benefit	– Participants & Their Dependents	Reimbursement from your account for health care expenses.

BY LAW, THE PLAN MUST PROVIDE THE FOLLOWING DESCRIPTION OF ITS SPECIAL ENROLLMENT RIGHTS TO ANYONE WHO BECOMES ELIGIBLE FOR COVERAGE:

If you are declining enrollment for yourself or your dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

This group health plan will permit a participant who is eligible, but not enrolled, under the terms of the plan (or a dependent of such a participant if the dependent is eligible but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the Plan if either of the following conditions are met:

Termination of Medicaid or CHIP Coverage. The participant or dependent is covered under a Medicaid plan or under a State child health insurance plan (CHIP) and the coverage of the

participant or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the participant requests coverage under this plan not later than 60 days after the Medicaid or CHIP coverage ends.

Eligibility for Employment Assistance under Medicaid or CHIP. The participant or dependent becomes eligible for premium assistance through Medicaid or CHIP and the participant requests coverage under this plan not later than 60 days after the participant or dependent is determined to be eligible for such assistance

A. HEALTH CARE BENEFIT

For eligible participants and dependents, the self-insured Health Care Benefit is a benefit administrated by a third-party administrator, Excellus BlueCross BlueShield. You should review the Health Care Benefit Schedule of Benefits below for information regarding your benefits.
Coverage Options

When you are eligible for the Health Care Benefit, you will automatically receive coverage for yourself and your eligible dependents, including your spouse and children. You will be entitled to waive Plan coverage for yourself and/or your dependents. Active Participants may only waive coverage if they confirm that the individual for whom the waiver is sought has group coverage sponsored by another employer that provides "minimum value" as that term is defined by applicable Federal law. Note, if you waive coverage for yourself, dependent coverage must be waived as well.

During the annual open enrollment period and upon termination of your employment, you also have the option to permanently "opt out" of your personal account and waive future reimbursements from the account. You will lose any monies in your account as of the date you "opt out." Additionally, you are not required to waive or "opt out" of Plan coverage for yourself or your dependents. It is your choice to decide on the medical coverage arrangements that are best for you and your family.

Regardless of whether you choose to waive Plan coverage for yourself or your dependents, the Fund Office will provide you with enrollment forms including requests for information about other employer sponsored group coverage available to you and/or your dependents. If you fail to complete the required forms, your account will be charged for family coverage and the Plan will take the appropriate action concerning the coordination of benefits. Although automatically enrolled in the Plan's medical coverage, the Plan will not process your claims until the Plan receives the necessary enrollment forms. Until all the completed forms are received by the Fund Office, the Fund's Trustees reserve the rights to hold claims in abeyance and even deny coverage.

You may change your Health Care Benefit coverage option during open enrollment. Open enrollment is twice a year, during the months of September and March, for coverage effective the following October 1 and April 1, respectively.

You may also change your enrollment at any time if you do so within 90 days of a change in family status and the change is commensurate with the change in family status. Otherwise you may only change enrollment during open enrollment. A change in family status means a change in your marital status, the death, birth or adoption of a child, your spouse's termination of employment or change from full-time employment to part-time, or a significant change in benefits under any other plan of health care benefits in which you or your spouse are enrolled.

HEALTH CARE BENEFIT
SCHEDULE OF BENEFITS

Applies to: Active Participants, Retirees under 65, COBRA beneficiaries, and their dependents.
Claims must be filed within 180 days after the claim is incurred or the claim will be denied. A detailed description of all Plan benefits, including the following benefits, can be found in the section of this Summary Plan Description entitled "DETAILED DESCRIPTION OF BENEFITS".

TYPE OF SERVICE	BASIC BENEFITS Benefits are limited to 365 days of care for each spell of Illness. The days of care may be for any combination of inpatient Hospital care, care in a skilled nursing or rehabilitation facility, home health care, or maternity care in a Hospital or birthing center, or inpatient treatment of Mental Illness or Substance Abuse. In and Out-of-Network benefits are combined.		MAJOR MEDICAL BENEFITS These benefits apply only after the Basic benefits, if any, have been paid or exhausted. All benefits are subject to the Major Medical deductible, except where noted. The Allowable Expense is limited as described in "Definitions" below.
	IN-NETWORK PROVIDER The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	
Hospital (also see Mental Illness, Substance Abuse, and maternity care for inpatient benefits)			
• **Inpatient**	100%	80%	80%
• **Outpatient Hospital**			
-Emergency room (Does not include Emergency room physician)	100%	80%	See Basic benefits
-Emergency room physician	See Major Medical benefits	See Major Medical benefits	80%
-Outpatient surgical center	100%	80%	See Basic benefits
-Clinic	See Major Medical benefits	See Major Medical benefits	80%
-Laboratory	See Major Medical benefits	See Major Medical benefits	80%
-X-rays	See Major Medical benefits	See Major Medical benefits	80%
-Diagnostic tests	See Major Medical benefits	See Major Medical benefits	80%
-Radiation	100%	80%	80%
-Chemotherapy	100%	80%	80%
-Respiratory therapy	100%	80%	See Basic benefits
-Physical/speech therapy	100%(1)	80%(1)	80%
-Occupational therapy	See Major Medical benefits	See Major Medical benefits	80%
-Dialysis or hemodialysis	100%	80%	80%
Freestanding Surgical Facility	100%	80%	See Basic benefits
Urgent Care Facility	See Major Medical benefits	See Major Medical benefits	80%
Ambulance	See Major Medical benefits	See Major Medical benefits	80%
Preadmission Testing	100%	80%	See Basic benefits
Convalescent/Skilled Nursing and Rehabilitation Facility			
• -Inpatient	100%	80%	80%
• -Outpatient	100%	80%	80%

(1) Limited to a maximum of 20 visits per participant or dependent per calendar year for physical therapy and 20 visits per participant or dependent per calendar year for speech therapy.

TYPE OF SERVICE	BASIC BENEFITS Benefits are limited to 365 days of care for each spell of Illness. The days of care may be for any combination of inpatient Hospital care, care in a skilled nursing or rehabilitation facility, home health care, or maternity care in a Hospital or birthing center, or inpatient treatment of Mental Illness or Substance Abuse. In and Out-of-Network benefits are combined.		MAJOR MEDICAL BENEFITS These benefits apply only after the Basic benefits, if any, have been paid or exhausted. All benefits are subject to the Major Medical deductible, except where noted. The Allowable Expense is limited as described in "Definitions" below.
	IN-NETWORK PROVIDER The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	**OUT-OF-NETWORK PROVIDER** The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	
Home Health Care	100%	80%	80%
Hospice Care [(2)]			
• Inpatient	100%	80%	80%
• Home	100%	80%	80%
Private Duty Nursing (not covered if the patient is receiving home health care services)	See Major Medical benefits	See Major Medical benefits	80%; up to 30 visits per calendar year
Mental Illness Services			
• Inpatient (Hospital or behavioral health care facility)	100%	80%	80%
• Outpatient (Hospital clinic, facility, office)	See Major Medical benefits	See Major Medical benefits	80%
• Emergency room treatment (Does not include Emergency room physician)	100%	80%	See Basic benefits
• Emergency room physician	See Major Medical benefits	See Major Medical benefits	80%
Substance Abuse Treatment			
• Inpatient (Hospital or behavioral health care facility).	100%	80%	80%
• Outpatient (Hospital clinic, facility, office)	100%	80%	80%
• Emergency room treatment (Does not include Emergency room physician)	100%	80%	See Basic benefits
• Emergency room physician	See Major Medical benefits	See Major Medical benefits	80%

(2) Limited to 210 days of treatment; in and out-of-network benefits combined; also includes coverage for five (5) bereavement counseling visits for the patient's family members.

TYPE OF SERVICE	BASIC BENEFITS Benefits are limited to 365 days of care for each spell of Illness. The days of care may be for any combination of inpatient Hospital care, care in a skilled nursing or rehabilitation facility, home health care, or maternity care in a Hospital or birthing center, or inpatient treatment of Mental Illness or Substance Abuse. In and Out-of-Network benefits are combined.		MAJOR MEDICAL BENEFITS These benefits apply only after the Basic benefits, if any, have been paid or exhausted. All benefits are subject to the Major Medical deductible, except where noted. The Allowable Expense is limited as described in "Definitions" below.
	IN-NETWORK PROVIDER The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	**OUT-OF-NETWORK PROVIDER** The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	
Maternity Care – Mother			
• Inpatient Hospital	100%	80%	80%
• Physician for prenatal care and delivery	100%	80%	80%
Newborn Care (Prior to discharge)			
• Hospital	100%	80%	See Basic benefits
• Physician	100%	80%	See Basic benefits
• Newborn circumcision	100%	80%	See Basic benefits
Physician (except for routine care and delivery, Emergency room physicians, or treatment of Mental Illness or Substance Abuse)			
• Inpatient visit	100%	80%	80%
• Office visit	See Major Medical benefits	See Major Medical benefits	80%
• Home visit	See Major Medical benefits	See Major Medical benefits	80%
• Consultation by a Specialist			
-Inpatient	100%	80%	80%
-Outpatient	See Major Medical benefits	See Major Medical benefits	80%
-Office	See Major Medical benefits	See Major Medical benefits	80%
• Surgery			
-Inpatient	100%	80%	See Basic benefits
-Outpatient	100%	80%	See Basic benefits
-Office	100%	80%	See Basic benefits
-Assistant surgeon	100%	80%	See Basic benefits
• Second surgical opinion	100%	80%	See Basic benefits
• Second medical opinion	100%	80%	See Basic benefits
Anesthesia			
• Inpatient	100%	80%	See Basic benefits
• Outpatient	100%	80%	See Basic benefits
• Office	See Major Medical benefits	See Major Medical benefits	80%
Allergy Care			
• Treatment and serum	See Major Medical benefits	See Major Medical benefits	80%
• Testing - laboratory	100%	80%	See Basic benefits

TYPE OF SERVICE	BASIC BENEFITS Benefits are limited to 365 days of care for each spell of Illness. The days of care may be for any combination of inpatient Hospital care, care in a skilled nursing or rehabilitation facility, home health care, or maternity care in a Hospital or birthing center, or inpatient treatment of Mental Illness or Substance Abuse. In and Out-of-Network benefits are combined.		MAJOR MEDICAL BENEFITS These benefits apply only after the Basic benefits, if any, have been paid or exhausted. All benefits are subject to the Major Medical deductible, except where noted. The Allowable Expense is limited as described in "Definitions" below.
	IN-NETWORK PROVIDER The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	
· **Chiropractor** [3]	See Major Medical benefits	See Major Medical benefits	80%
Podiatrist			
• Visit	See Major Medical benefits	See Major Medical benefits	80%
• Orthotics	See Major Medical benefits	See Major Medical benefits	80%
• Surgery	100%	80%	See Basic benefits
Preventative/Well Care			
• GYN office visit (one per calendar year)	100%	80%	See Basic benefits
• Pap smear (one per calendar year)	100%	80%	See Basic benefits
• Mammogram [4]	100%	80%	See Basic benefits
• Well child care to age 19 [5]	100%	80%	See Basic benefits
• Routine adult physicals (for adults over age 50; one per calendar year)	100%	80%	See Basic benefits
• Routine PSA test [6]	See Major Medical benefits	See Major Medical benefits	80%
• Routine colonoscopy [7]	100%	80%	See Basic benefits
Pap Smear (Medically Necessary)	100%	80%	80%
Mammogram (Medically Necessary)	100%	80%	80%
Outpatient Diagnostic Tests			
• **Independent Laboratory** Laboratory/diagnostic tests, x-rays	See Major Medical benefits	See Major Medical benefits	80%
• **Physician's Office/ Freestanding Facility** Laboratory/diagnostic tests, x-rays	See Major Medical benefits	See Major Medical benefits	80%

(3) Limited to 40 visits per calendar year.

(4) Coverage for routine mammograms: a single baseline mammogram for women between ages of 35 and 39; one every calendar year for women between the ages of 40 and 49; one mammogram per calendar year for women age 50 and older. Mammograms are covered at any age for participants or dependents with a prior family history of breast cancer.

(5) The Plan will provide coverage for well child care visits in accordance with the schedule recommended by the American Academy of Pediatrics.

(6) Coverage for routine PSA tests: one diagnostic exam per calendar year for men over age 40 who have a family history of prostate cancer or who have other risk factors for prostate cancer; one exam per calendar year for men age 50 and older; standard diagnostic testing for men of any age will be covered if they have a prior history of prostate cancer.

(7) The Plan follows HCR guidelines.

TYPE OF SERVICE	BASIC BENEFITS Benefits are limited to 365 days of care for each spell of Illness. The days of care may be for any combination of inpatient Hospital care, care in a skilled nursing or rehabilitation facility, home health care, or maternity care in a Hospital or birthing center, or inpatient treatment of Mental Illness or Substance Abuse. In and Out-of-Network benefits are combined. **IN-NETWORK PROVIDER** The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	**OUT-OF-NETWORK PROVIDER** The Allowable Expense is limited as described in "Definitions" below. The deductible does not apply.	**MAJOR MEDICAL BENEFITS** These benefits apply only after the Basic benefits, if any, have been paid or exhausted. All benefits are subject to the Major Medical deductible, except where noted. The Allowable Expense is limited as described in "Definitions" below.
Outpatient Treatments			
• **Freestanding Facility**			
Chemotherapy	100%	80%	80%
Radiation therapy	100%	80%	80%
• **Physicians Office**			
Chemotherapy	See Major Medical benefits	See Major Medical benefits	80%
Radiation therapy	100%	80%	80%
Durable Medical Equipment, Prosthetics, Medical Supplies, and Oxygen	See Major Medical benefits	See Major Medical benefits	80%
Diabetic Treatment and Education	See Major Medical benefits	See Major Medical benefits	80%
Diabetic Supplies and Equipment (Includes Insulin and supplies used to control blood sugar)	See Major Medical benefits	See Major Medical benefits	100%; not subject to deductible
Outpatient Services & Therapy			
• **Freestanding Facility**			
Dialysis or hemodialysis	100%	80%	80%
Respiratory therapy	See Major Medical benefits	See Major Medical benefits	80%
Physical therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Occupational therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Speech therapy[8]	See Major Medical benefits	See Major Medical benefits	80%
Cardiac rehabilitation	See Major Medical benefits	See Major Medical benefits	80%
• **Physician's Office**			
Dialysis or hemodialysis	100%	80%	80%
Respiratory therapy	See Major Medical benefits	See Major Medical benefits	80%
Physical therapy(8)	See Major Medical benefits	See Major Medical benefits	80%
Occupational therapy(8)	See Major Medical benefits	See Major Medical benefits	80%
Speech therapy(8)	See Major Medical benefits	See Major Medical benefits	80%
Cardiac rehabilitation	See Major Medical benefits	See Major Medical benefits	80%
CALENDAR YEAR DEDUCTIBLE (Carryover applies Oct, Nov, Dec)	None	None	$250 Individual $500 Family
COINSURANCE MAXIMUM (Does not include deductible and/or copay)	None	None	$1,000 Individual
LIFETIME MAXIMUM	None	None	Unlimited

(8) Limited to a maximum of 20 visits per participant or dependent per calendar year per therapy.

DEFINITIONS

ALLOWABLE EXPENSE means the maximum amount the Plan will pay to a Provider or Facility for the services or supplies covered under this Plan before any applicable deductible, Copayment and Coinsurance amounts are subtracted. The covered family member's deductible, Copayment and Coinsurance amounts are based on the Allowable Expense, except as mentioned below. The Allowable Expense is determined as follows:

(1) The Allowable Expense for covered services received from a Facility (an institutional provider such as a Hospital, Skilled Nursing Facility, Urgent Care Facility, Home Health Care Facility, laboratory, etc.) is:

(A) The Allowable Expense for a covered service received from a Facility that is In-Network will be the amount that has been negotiated with the Facility.
(B) The Allowable Expense for a Covered Service received from a Facility that is Out-of-Network will be the lowest of the following: the amount that has been negotiated with the Facility; the Facility's billed charge; or the Reasonable and Customary charge as described below.

(2) The Allowable Expense for a covered service performed by a Provider is:

(1) The Allowable Expense for a covered service performed by an In-Network Provider will be the lower of:

(i) The amount listed on the fee schedule; or
(ii) The Provider's billed charge.

(2) The Allowable Expense for a covered service of an Out-of-Network Provider will be the lowest of:

(i) The amount that has been negotiated with the Provider; or
(ii) The Reasonable and Customary charge as described below; or
(iii) The Provider's billed charge.

BEHAVIORAL HEALTH CARE FACILITY means a facility that specializes in the treatment of Substance Abuse or Mental Illness which meets any licensing or certification standards in the jurisdiction where it is located. For covered family members who are entitled to Medicare, a Behavioral Health Care Facility must be a provider of services under Medicare.

DURABLE MEDICAL EQUIPMENT means medical equipment that satisfies all the following requirements:

(1) It is generally not useful in the absence of an Injury or a Sickness, and
(2) It is appropriate for use in the home, and
(3) It can withstand repeated use, and
(4) It is Medically Necessary, and
(5) It is not useful or convenient to other household members, and
(6) It is not a convenience item or an aid to daily living.

EMERGENCY means a condition manifesting itself with 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 the following: (1) placing the health of the individual (or, with respect to pregnant women, the health of the woman's unborn Child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

ESSENTIAL HEALTH BENEFITS means benefits as defined by the Secretary of Health and Human Services. Such benefits will include at least the following general categories of benefits:

(1) Ambulatory patient services;
(2) Emergency services;
(3) Hospitalization;
(4) Maternity and newborn care;
(5) Mental health and substance use disorder services, including behavioral health treatment;
(6) Prescription drugs;
(7) Rehabilitative and habilitative services and devices;
(8) Laboratory services;
(9) Preventive and wellness services and chronic disease management; and
(10) Pediatric services, including oral and vision care.

EXPERIMENTAL or **INVESTIGATIVE** means services, supplies, care and treatment that do not constitute accepted medical practice. When determining whether or not a procedure is Experimental or Investigative, the Plan will take into consideration appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. It will be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan will be guided by the following principles:

(1) The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, except where the laws of the state mandate coverage for any drug not approved by the FDA but recognized as appropriate treatment for a particular type of cancer by an established reference such as the AMA Drug Evaluations, or

(2) The drug, device, medical treatment or procedure, or the patient informed consent document was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval, or

(3) Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, or

(4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy compared with a standard means of treatment or diagnosis.

HOSPITAL means a licensed institution that meets all the following requirements:

(1) It primarily provides, for compensation from its patients and on an inpatient basis, all facilities necessary for medical and surgical treatments, and care of injured and sick persons by or under the supervision of a staff of physicians, and

(2) It continuously provides 24-hour-a-day nursing service by registered professional nurses, and

(3) It is not a primary place for rest, a place for the aged, or a nursing home, and

(4) It is not primarily a place providing convalescent/skilled nursing care, rehabilitation care, custodial care, hospice care, a health resort or spa, a sanitarium, an infirmary at any school, college or camp, and

(5) It is a provider of services under Medicare with respect to participants or dependents who are entitled to Medicare, and

Additionally, the following institution will qualify under this definition:

(6) A licensed birthing center that:

(A) Provides care and treatment for patients during uncomplicated pregnancy, routine full-term delivery, and immediate postpartum care, and

(B) Provides full-time skilled nursing services, and

(C) Is staffed and equipped to give Emergency care, and
(D) Has a written arrangement with a local Hospital for Emergency care, and
(E) Is a provider of services under Medicare with respect to participants or dependents who are entitled to Medicare, and
(F) Is approved for its stated purpose for ambulatory care.

INJURY means an accidental loss, unforeseen impairment, or physical harm inflicted on the body by unexpected, external means.

MEDICALLY NECESSARY or **MEDICAL NECESSITY** means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, Injury, disease or its symptoms, and that are:

(1) In accordance with generally accepted standards of medical practice;
(2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, Injury or disease; and
(3) Not primarily for the convenience of the patient, physician, or other health care provider, and
(4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, Injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community when available. This includes Physician Specialty Society recommendations, the views of prudent physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

The fact that a physician or health care practitioner may order, recommend, or approve a service, supply or treatment does not itself make it medically necessary. The Board of Trustees or its designee has the discretion and authority to determine if a service, supply or treatment is medically necessary.

MENTAL ILLNESS means a mental or an emotional disorder as defined and classified by appropriate ICD-9 coding, regardless of cause, which is characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature.

PREFERRED PROVIDER means a Health Care Provider who is a member of the Preferred Provider Network.

PREFERRED PROVIDER NETWORK means an organization of Health Care Providers who have entered into an agreement to provide covered services at a predetermined rate.

PREFERRED PROVIDER REIMBURSEMENT SCHEDULE means the schedule of Allowable Expenses payable for any covered services by an In-Network Provider.

PROVIDER or **HEALTH CARE PROVIDER** means an individual who is operating within the scope of his license to provide Medically Necessary covered services. A physician operating within the scope of his license and who is licensed to prescribe medications, administer drugs, perform surgery or to provide Medically Necessary covered services is a Health Care Provider.

Provider will also include services of a certified nurse practitioner when services are performed directly under the supervision of a physician, and skilled nursing services rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse. Provider will also include a certified nurse midwife for any covered service that is within the lawful scope of their practice regardless of their employment status by a physician. A certified nurse midwife need not act pursuant to a physician's orders. Provider will also include a licensed dentist, or a licensed practitioner who is practicing within the scope of his license and whose license is favorably accepted by the State or other jurisdiction in which the covered services are provided. The term Provider will also include a physician's assistant, podiatrist, osteopath, optometrist, psychiatrist, psychologist, chiropractor, speech therapist, occupational therapist, or licensed physical therapist acting within the scope of his license or certificate who is performing services that are covered by this Plan. When used in the treatment of Mental Illness, this term will also include a certified and registered social worker with at least six years of post-degree experience who has been qualified by the state in which they practice.

REASONABLE AND CUSTOMARY charges vary and the Board of Trustees or its delegee, currently Excellus BlueCross BlueShield, has the sole right to determine the Reasonable and Customary amount.

For Out-of-Network (non-preferred) Facility charges, the Reasonable and Customary charge ("UCR") is the lesser of 200% of the Medicare Prospective Payment System or 100% of the charge. If the service is not listed on the Medicare Prospective Payment System, the UCR is determined by the Board of Trustees or its delegee, to be no more than 65% of the billed charge.. For Out-of-Network (non-preferred) providers, the UCR is the 85th percentile of the UCR determined by Excellus BlueCross BlueShield using the FAIR Health database.

The reasonable and customary amount will often be less than the health care provider's actual charge. If this is the case, you may be responsible for the amount of the health care provider's actual charge that is in excess of the reasonable and customary charge allowed by the Fund. This is commonly known as balance billing. This is in addition to your deductible and/or your copayment and/or your coinsurance, whichever applies. For this reason, you should discuss charges with your health care provider before you receive services.

RECONSTRUCTIVE SURGERY means surgery necessary for the repair of a body part due to a non-occupational disease or non-occupational Injury. It will also include surgery required because of trauma, infection or disease and a congenital disease or anomaly of a covered child that results in a functional defect. If a participant or dependent requires Reconstructive Surgery to a breast following a covered mastectomy procedure, the term Reconstructive Surgery will also include surgery to the opposing breast to produce a symmetrical appearance.

SICKNESS or **ILLNESS** means an unhealthy condition of the body, a disease, a mental or physical disorder, or pregnancy. The term Sickness means all such Sicknesses due to the same or related causes, including all complications or recurrences. The term Sickness does not mean an Injury.

SUBSTANCE ABUSE means the chronic abuse of alcohol or other drugs as defined and classified by the appropriate ICD-9 coding characterized by impaired functioning, debilitating physical condition, the inability to keep from or reduce consumption of the substance, or the daily use of the substance in order to function. The term Substance Abuse includes addiction to alcohol or other drugs, but not caffeine, tobacco, or food.

URGENT CARE FACILITY means a medical facility that is open on an extended basis, is staffed by physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a physician's office.

UTILIZATION MANAGEMENT AND MEDICAL REVIEW

UTILIZATION MANAGEMENT: The Plan Administrator reserves the right to incorporate a utilization management program into the Plan's benefit provisions. Utilization Management means the systems, strategies, and mechanisms needed to manage appropriate, Medically Necessary and cost effective health care services.

Utilization Management is intended to:

(1) Assure high quality care and treatment, and
(2) Propose alternative treatments to avoid unnecessary or lengthy confinements and surgeries, and
(3) Promote cost-effective health care, and
(4) Monitor the treatment plan for participants or dependents with chronic Sickness or catastrophic Injury through medical case management.

CASE MANAGEMENT: In the event of a catastrophic Injury or Sickness, a participant or dependent may require long-term, perhaps lifetime care. Case Management monitors such patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. In certain cases, the case manager may recommend care and/or treatment at a Center of Excellence, a facility with proven expertise and success rates in the specific type of care

and/or treatment needed. If the case manager's treatment plan is approved, the Plan Administrator may direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if the Plan would not normally pay those expenses.

DETAILED DESCRIPTION OF BENEFITS

This Plan only makes payment decisions based on the benefits provided. The Plan does not select or take any responsibility for the proper or improper performance of any healthcare provided.

INDEMNITY PROGRAM

Under this Plan, a participant or dependent has the option to choose to receive health care services from either a Health Care Provider who is a member of a Preferred Provider Network or from a Health Care Provider who is not a member of a Preferred Provider Network. Benefits payable under the Indemnity Program for In-Network and Out-of-Network treatment will be subject to the applicable coinsurance, maximums and deductible amounts, and any limitations as shown in the Schedule of Benefits.

If you or your covered dependent seeks care or treatment from a member of the Preferred Provider Network, medical expense benefits will be paid by the Plan according to the Preferred Provider Reimbursement Schedule. Excellus BlueCross BlueShield will pay benefits directly to the Provider for covered services less any applicable coinsurance and/or deductible.

A list of Preferred Providers is available at www.excellusbcbs.com/IBEW910.

MEDICAL EXPENSE BENEFITS

The Plan will pay benefits for a Medically Necessary expense subject to coinsurance, maximums and deductibles, and any limitations, as shown in the Schedule of Benefits and elsewhere in this Summary Plan Description. The benefit payment will be based on whether the participant or dependent chooses to receive care from an In-Network Provider or an Out-of-Network Provider.

Any covered service that is described in this section will either be paid as a Basic benefit or as a Major Medical benefit, or both. If available, any Basic benefit will be paid first. Major Medical benefits will only be paid after all Basic benefits have been paid or exhausted. See the Schedule of Benefits for specific information regarding payment of benefits.

Covered services include the charges for the following Medically Necessary services and supplies. Similar health expenses identified by the Current Procedural Terminology (CPT) developed by the American Medical Association, the Common Procedure Coding System (HCPCS) developed by the Health Care Financing Administration, or the Hospital Revenue Code application will be covered

unless they are excluded. Covered medical services may also be identified in the International Classification of Diseases, 9th edition (ICD-9). Covered services include:

(1) **Allergy Care**. The Plan covers allergy care treatment, to include but not limited to office visits, serum, scratch testing, and laboratory testing. Allergy serum that is covered under the Prescription Drug Benefit will not be covered under the medical expense benefit.

(2) **Ambulance or Paramedic Services**. The Plan covers Medically Necessary ambulance or paramedic services in connection with an inpatient confinement or outpatient Emergency treatment. Air ambulance transportation is covered if Medically Necessary and if no other mode of transportation is appropriate. Ambulance service used to transport a participant or dependent from a Hospital or other health care facility or to inpatient confinement at another Hospital or health care facility and home is also covered.

Ambulance Limitations: Transport is limited to Medically Necessary transportation to and from a local Hospital or the nearest Hospital where the appropriate treatment for an Injury or Sickness can be provided.

(3) **Anesthesia**.

(4) **Chemotherapy and Radiation Therapy**.

(5) **Chiropractic Care**. The Plan covers the Medically Necessary services of a chiropractor as described in the Schedule of Benefits. All chiropractic services will be reviewed to determine Medical Necessity.

Chiropractic Care Limitations: Maintenance therapy that seeks to prevent disease, promote health, prolong life, and enhance the quality of life is not covered.

(6) **Convalescent/Skilled Nursing Facility or Rehabilitation Facility**. The Plan covers convalescent/skilled nursing facility or a rehabilitation facility expenses for confinement in a semi-private room. A plan of treatment must be established by the attending physician and must demonstrate the Medical Necessity of the treatment, including the need for continuous care by a physician and 24 hour-a-day skilled nursing care. The physician must be qualified in the state of jurisdiction to prescribe the plan of treatment recommended, must remain available to visit the patient during the admission and provide the patient continuous care. The physician may not have any financial interest in the convalescent/skilled nursing facility or the rehabilitation facility.

The Plan covers the daily charge for room and board that does not exceed the semi-private rate. If the participant or dependent is confined in a private room, the Plan will pay an amount equal to the most common charge for a semi-private room. Outpatient care for physical, occupational, and speech therapy and other services shown in the Schedule of Benefits is covered.

Each day of care in a convalescent/skilled nursing facility or rehabilitation facility counts as one-half benefit day of care. For example, 20 days in a convalescent/skilled nursing facility or rehabilitation facility count as 10 benefit days of care toward the 365-day benefit maximum.

Convalescent/Skilled Nursing Facility or Rehabilitation Facility Limitations: Benefits in a convalescent/skilled nursing facility or in a rehabilitation facility are not provided under this Plan if the participant or dependent is eligible for reimbursement from Part A of Medicare.

(7) **Diabetic Education**. The Plan covers diabetic self-management education to ensure the participant or dependent is educated in the proper self-management and treatment of his diabetic condition.

Diabetic Education Limitations: Coverage is limited to visits for the diagnosis of diabetes, when a physician diagnoses a significant change in the participant's or dependent's symptoms or conditions which necessitates changes in the participant's or dependent's self-management, or where reeducation or refresher education is necessary. Coverage includes home visits when Medically Necessary.

(8) **Diabetic Supplies and Equipment**. The Plan covers the following equipment and supplies that are determined to be Medically Necessary for the treatment of diabetes: blood glucose monitors; blood glucose monitors for the legally blind; test strips for glucose monitors; visual reading and urine testing strips; injection aids; cartridges for the legally blind; syringes; insulin pumps and accessories; insulin infusion devices; insulin; oral agents for controlling blood sugar; data management systems. The diabetic education must be provided by a physician or other licensed Health Care Provider, or his staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian, upon the referral of a physician or other licensed Health Care Provider.

(9) **Diagnostic Tests**. The Plan covers diagnostic tests performed both inside and outside a Hospital including; diagnostic laboratory services, diagnostic x-ray tests, and diagnostic tests (EKG, EEG, etc.).

(10) **Dialysis and Hemodialysis**. The Plan covers dialysis and hemodialysis rendered by a licensed technician.

(11) **Durable Medical Equipment, Prosthetics, Medical Supplies, and Oxygen**. The Plan covers the following services, supplies, and equipment subject to review for Medical Necessity and the patient's condition:

(A) **Durable Medical Equipment**. The Plan covers the rental or, at the Plan's option, the purchase of Durable Medical Equipment. When the Plan covers the purchase of such equipment, the Plan also covers necessary maintenance and repairs. Maintenance and repairs can be paid on a per session basis or through an approved maintenance agreement. The Plan also covers the replacement of purchased equipment if the replacement is necessary due to a change in the patient's condition or is due to the growth of the patient.

Durable Medical Equipment Limitations: The Plan does not cover the cost of delivery of any Durable Medical Equipment, the setup of deluxe equipment when standard equipment is available and adequate, or the cost of materials used to manufacture equipment.

(B) **Prosthetic Devices**. The Plan covers the fitting and purchase of prosthetic devices that take the place of a natural internal or external part of a participant's or dependent's body (to include but not limited to breast prostheses following a covered mastectomy) or that are needed due to a functional defect of a covered dependent child. The prosthetic device must be ordered by a physician and must be Medically Necessary to relieve or correct a condition caused by an Injury or Illness. The Plan also covers the replacement of a purchased prosthetic device if the replacement is necessary due to a change in the patient's condition or is due to the growth of the patient. Implanted cataract lenses are covered when they perform the function of the human lens and are Medically Necessary because of intraocular surgery.

Prosthetic Devices Limitations: The Plan does not cover delivery charges or routine maintenance related to prosthetic devices. Eyeglasses are not considered prosthetic devices.

(C) **Medical Supplies**. The Plan covers medical supplies for use outside of a Hospital, convalescent/skilled nursing facility, or a rehabilitation facility ordered by a physician including, but not limited to, casts, splints, surgical dressings, ostomy bags and supplies, catheters, and oxygen.

(D) **Oxygen**. The Plan covers oxygen and the administration of oxygen. When the Plan covers the purchase of equipment used to administer oxygen, the Plan also covers necessary maintenance and repairs. Maintenance and repairs can be paid on a per session basis or through an approved maintenance agreement.

(12) **Emergency Room Treatment**. The Plan covers treatment received in an Emergency room in connection with an Injury or Sickness.

Emergency Room Treatment Limitations: Emergency treatment must be rendered within 72 hours of an Injury or within 12 hours of the onset of a sudden and serious Illness.

(13) **Freestanding Surgical Facility Services**.

(14) **Home Health Care**. The Plan covers home health care as shown in the Schedule of Benefits if a treatment plan is established at the time the physician certifies the Medical Necessity of the home health care services. The treatment plan must be filed with Excellus BlueCross BlueShield. The physician may not have any financial relationship with the home health care agency furnishing the services. The physician must be qualified under the law of the state to certify the need for home health care and the treatment plan. It is expected that the physician will see the patient although there is no specified time interval for those visits.

Each four hours of a home health care service is considered a visit. Each home health care visit counts as one-third benefit day of care. For example, 30 home health care visits count as 10 benefit days toward the 365-day benefit maximum.

Nursing and therapy services authorized as part of a home health care plan and performed by a nurse or therapist affiliated with a home health care agency are also covered. Such services are limited to the home health care benefit maximums described in the Schedule of Benefits.

Home Health Care Limitations: Charges are not covered for any care or treatment not outlined by the physician in the treatment plan, or home health care incurred during any period when the participant or dependent is not under the care of a physician. No coverage will be provided for custodial care or for services by a relative of the covered family member or a person who normally resides in the Covered Family Member's home.

Private duty nursing services authorized as part of a home health care plan and performed by a nurse affiliated with a Home Health Care Agency are covered, but

are subject to the home health care benefit maximum described in the Schedule of Benefits.

(15) **Hospice Care**. A participant or dependent diagnosed with a terminal Illness and a life expectancy of six months or less may receive care by a certified Hospice Care Agency up to the limit shown in the Schedule of Benefits. Hospice care consists of services and supplies, including prescription drugs, provided by the hospice to the extent they are otherwise covered by this Plan. Treatment may be furnished in a Hospice Facility or Hospital, or on an outpatient basis in the terminally ill participant's or dependent's home under a home care plan provided by a hospice care agency. Inpatient respite care need not meet the normal Medically Necessary criteria for admissions. Hospice care includes visits for bereavement counseling furnished to the family of the terminally ill family member as described in the Schedule of Benefits. Bereavement counseling may be provided before or after the participant's or dependent's death.

Hospice Care Limitations: The Plan does not cover:

(A) Charges for a physician employed by the Hospice.
(B) Any confinement not required for pain control or other acute or chronic system management.
(C) Services or supplies provided by volunteers or others who do not regularly charge for their services, including pastoral counseling.
(D) Funeral services or arrangements.
(E) Legal or financial counseling or services.
(F) Services, except bereavement counseling, supplied to other family members, other than the terminally ill participant or dependent.
(G) Bereavement counseling in excess of the number of visit maximum indicated in the Schedule of Benefits.
(H) Any expense incurred by a participant or dependent that is listed in the section of this booklet entitled "Plan Exclusions".

(16) **Infertility Treatment**. The Plan covers the treatment of the Sickness or Injury causing infertility. Treatment must be rendered on an outpatient basis and must be Medically Necessary.

Infertility Treatment Limitations: The Plan does not cover any service that provides assistance in achieving a pregnancy. The following procedures and similar procedures intended to achieve a pregnancy are excluded from coverage under this Plan's Medical Expense Benefit; artificial insemination, in-vitro fertilization, in-vivo fertilization, gamete inter-fallopian transfer (GIFT), zygote inter-fallopian transfer (ZIFT) or similar procedures to achieve a pregnancy.

(17) **Inpatient Hospital Admission**. The Plan covers inpatient Hospital expenses and semi-private room and board accommodations. See the Schedule of Benefits for information on coverage of a private room.

With respect to a confinement related to a dental procedure, the Plan does not cover Hospital expenses regardless of whether or not the actual dental procedure is covered.

(18) **Mammograms (Medically Necessary)**. As recommended by the attending physician.

(19) **Maternity Care**. The Plan covers charges in connection with prenatal care, delivery and postpartum care, including inpatient routine nursing care. Maternity care includes, but is not limited to, pre and post-natal office visits, associated diagnostic tests, laboratory tests and x-ray charges, semi-private room, general nursing care, Provider services, anesthesia if Medically Necessary, prescription drugs administered while inpatient, and ancillary services.

The provisions of the Newborns' and Mothers' Health Protection Act of 1996 provide for a minimum length of stay for the birth of a newborn. Benefits payable under this Plan for a maternity-related Hospital stay must not be restricted for the mother or the newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section unless a shorter stay is agreed to by both the mother and her attending physician.

(20) **Mental Illness Treatment**. The Plan covers inpatient confinement for Mental Illness in a Hospital or Behavioral Health Care Facility. Partial Hospitalization is covered when Medically Necessary.

The Plan also covers outpatient treatment, including Emergency visits.

The Plan covers Medically Necessary electro-shock therapy when provided in an outpatient department of a Hospital. Associated expenses for a Hospital operating room and for the anesthesiologist are covered as described in the Schedule of Benefits for those services.

Mental Illness Treatment Limitations: Treatment must be directly related to a Mental Illness (as defined). Benefits are not payable for care primarily directed at raising the level of consciousness, social enhancement, retraining, professional training, or counseling limited to everyday problems of living, marriage counseling, family situational counseling, sex therapy, or support groups. Under no circumstances will benefits be provided for therapy that includes the satisfaction of requirements for professional training.

(21) **Morbid Obesity Treatment**. The Plan covers treatment of obesity as defined by the Excellus BlueCross BlueShield Medical Policy titled "Surgical Management of Obesity".

Morbid Obesity Treatment Limitations: Anything not included or not approved in the written treatment plan is not covered. Prescription appetite or weight control drugs will not be covered under the Health Care Insurance Benefit even when included as part of a written treatment plan. Non-prescription appetite or weight control drugs, dietary supplements, special foods or food supplements, health or weight control centers or resorts and health club memberships, subscriptions to books and exercise equipment also are not covered.

(22) **Newborn Care**. The Plan covers newborn care including nursery charges, charges for routine Provider examinations as described in the Schedule of Benefits, tests, and charges for routine procedures such as circumcision.

(23) **Occupational Therapy.** The Plan covers occupational therapy rendered by a licensed occupational therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily functions within a reasonable period of time.

(24) **Organ and Tissue Transplants**. The plan will provide coverage for all of the benefits otherwise covered in this booklet for organ and bone marrow transplants subject to the following limits:

Care in Approved Transplant Centers. Certain types of organ transplant procedures must be performed in transplant centers certified or otherwise approved by the appropriate regulatory authority for the specific type of transplant procedure being performed. The types of organ transplants that must be performed in certified transplant centers are: bone marrow; liver; heart; lung; heart-lung; kidney and kidney-pancreas. You may contact Excellus BlueCross BlueShield if you wish to obtain a list of certified transplant centers.

No Coverage of Experimental or Investigational Organ Transplants. The plan will not provide coverage for any benefits for an organ transplant we determine to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and therefore are covered by the plan. You may contact us if you have a question concerning whether a particular transplant procedure is covered.

Recipient Benefits. The Plan will provide coverage for a person covered under this plan for all of the benefits provided to the recipient of the organ transplant that are

otherwise covered under the plan when they result from or are directly related to a covered organ or bone marrow transplant.

Coverage for Donor Searches or Screenings. The Plan will not provide coverage for costs relating to searches or screenings for donors of organs.

Costs of Organ Donor. The Plan will provide coverage for the medical services directly related to the donation of an organ for transplantation to a person covered under the plan. The Plan will not provide coverage if you are donating an organ for transplantation to a person not covered under the plan.

(25) **Outpatient Hospital Treatment**.

(26) **Pap Smears (Medically Necessary)**. As recommended by the attending physician.

(27) **Physical Therapy**. The Plan covers physical therapy rendered by a licensed physical therapist. The therapy must be Medically Necessary as outlined in a plan of treatment by the attending physician and expected to restore bodily functions within a reasonable period of time.

Physical Therapy Limitations: Therapy designed to prevent further deterioration is not covered.

(28) **Physician and Health Care Providers**. The Plan covers:

(A) **Office and Inpatient Visits**. The Plan covers non-surgical office and inpatient visit charges by a physician or other Provider for treatment of an Injury or Sickness as described in the Schedule of Benefits. Inpatient or outpatient Provider visits and office consultations by a specialist are also covered.

(B) **Surgery**. The Plan covers surgery, co-surgery, assistant surgery, and Reconstructive Surgery.

Surgery (including multiple surgery or multiple surgical procedures) is defined by the American Medical Association's Current Procedural Terminology (CPT) and by the Healthcare Common Procedure Coding System (HCPCS). All surgical procedures, including multiple surgical procedures, are subject to clinical edits and must fall within standards of practice as defined by the American Medical Association, are subject to review for Medical Necessity, and approval by the appropriate governmental agency. Surgery will include physical complications in all stages of covered surgeries, to include, but not limited to mastectomies,

including lymphedemas. Surgery also includes voluntary termination of pregnancy.

(C) **Treatment of an Injury to the Teeth**. The Plan covers Medically Necessary treatment of an Injury to sound, natural teeth. The Injury must not be caused, directly or indirectly, by biting or chewing, and all treatment must be performed within 12 months of the date of the Injury. Treatment includes replacing natural teeth lost due to such Injury. A sound natural tooth is any tooth that has adequate bone structure, healthy periodontium, and healthy support tissue. A tooth may have been restored in any manner including fillings or a crown but will still be considered a sound and natural tooth as long as the "support" of the tooth remains intact. The above dental services will be covered if they can be identified in the Current Dental Terminology (CDT) developed by the American Dental Association.

(D) **Second Medical Opinions**. The Plan allows coverage for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. The Plan also allows coverage for a second medical opinion concerning any recommendation of a course of treatment for cancer. If a participant or dependent receives a written referral from a participating doctor to a non-participating specialist, In-Network benefits will apply.

(29) **Podiatrist**. The Plan covers charges by a podiatrist for treatment of an Injury, Sickness, or deformity of the feet. The Plan covers the initial fitting and purchase of custom made orthotics if determined to be Medically Necessary for the relief or correction of any condition caused by an Injury or Sickness. Replacements are covered only if necessary due to growth or a change in health.

(30) **Preadmission Testing**. The Plan covers preadmission testing prior to surgery. Tests must be performed within seven days of the planned admission and must be accepted by the Hospital in place of the same post-admission tests. Tests repeated after admission or before surgery are not covered, unless the admission or surgery is deferred solely due to a change in the health of the participant or dependent.

(31) **Preventative Care and Well Care**. The Plan covers:

(A) **Preventative Care for a Child**. The Plan covers routine preventative/well-care visits up to age 19 for a dependent child as described in the Schedule of Benefits.

The Plan will provide coverage for well child care visits in accordance with the schedule recommended by the American Academy of Pediatrics.

(B) **Preventative Care for an Adult**. The Plan covers routine preventative care for an adult over age 50 as recommended by the attending physician. Benefits are limited to the maximums described in the Schedule of Benefits.

(C) **Routine Pap Smear Tests and Pelvic Exams**. The Plan covers charges for routine pap smear test(s) and pelvic exam(s) as described in the Schedule of Benefits.

(D) **Routine Mammography Screening**. The Plan covers charges for routine mammography screenings as recommended by the attending physician as described in the Schedule of Benefits.

(E) **Routine PSA Tests**. The Plan covers charges for routine PSA tests as recommended by the attending physician as described in the Schedule of Benefits.

(F) **Colon Cancer Screening**. The Plan covers a routine screening colonoscopy for Covered Family Members age 50 and over, and every 10 years after a normal colonoscopy. Routine screening colonoscopy may start at an age 10 years younger than a first degree relative with colon cancer (e.g., your father is diagnosed with colon cancer at age 55, colonoscopy could start at age 45).

(32) **Private Duty Nursing**. The Plan covers the services of a private duty registered nurse or licensed practical nurse when the participant or dependent is confined in a Hospital as described in the Schedule of Benefits. The Hospital must not have available the level of nursing care necessary to care for the patient's condition. The Plan will also cover private duty nursing services outside the Hospital, however, the nurse may not be a relative or a person living in the participant's or dependent's home and the Plan will not cover private duty nursing services if the patient is receiving home health care services.

Private Duty Nursing Limitations: Private duty nursing services, both inpatient and outpatient, must be ordered by a physician and the Plan will determine if the private duty nursing services are Medically Necessary for treatment of the medical condition. The nature of the Illness must show that nursing care can only be provided by a person with the education and skills of a nurse. The Plan will not pay for services that consist mainly of providing assistance with the activities of daily living.

(33) **Respiratory Therapy**. The Plan covers respiratory therapy rendered by a licensed respiratory therapist.

(34) **Speech Therapy**. The Plan covers speech therapy rendered by a licensed speech therapist when needed by a participant or dependent due to Injury or Sickness. Speech therapy must be performed to restore speech that was lost due to an Injury or Sickness, be an active treatment for a medical condition resulting in functional defect or be for the correction of a speech impairment resulting from said Injury or Sickness, including previous therapeutic processes.

Speech Therapy Limitations: This Plan does not cover speech therapy services that are educational in any part, or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders. Therapy designed to prevent further deterioration is not covered.

(35) **Substance Abuse Treatment**. The Plan covers inpatient confinement for Substance Abuse in a Hospital or in a Behavioral Health Care Facility. Partial Hospitalization is covered when Medically Necessary.

The Plan also covers outpatient treatment, including Emergency visits.

(36) **Urgent Care Facility Services**.

MEDICAL EXPENSE BENEFITS
SPECIAL CONDITIONS

APPLICATION OF THE DEDUCTIBLE: The deductible as outlined in the Health Care Benefit Schedule of Benefits applies when benefits are being reimbursed under the Major Medical benefits section of the Plan only. No deductible applies to the Basic Benefit section of the Plan. Any applicable Basic benefit will be paid by the Plan first. Major Medical expenses will apply only after all Basic benefits have been paid or exhausted.

The deductible applies to all Major Medical services regardless of whether the participant or dependent chooses to go to an In-Network Provider or an Out-of-Network Provider, except where noted in the Schedule of Benefits. Each participant or dependent must have eligible charges that exceed the deductible before the Plan pays Major Medical expenses for that person. Once a participant or dependent meets the deductible, the Plan pays benefits for Allowable Expenses incurred by the participant or dependent less any applicable coinsurance for the rest of the calendar year. A separate deductible applies to each participant or dependent regardless of the number of his or her disabilities. When any part of a calendar year's deductible is applied against expenses arising during October, November and December, the following calendar year's deductible will be reduced by the same amount.

FAMILY LIMIT ON DEDUCTIBLES: When Major Medical expense deductible amounts for all participant or dependents total the family deductible amount indicated in the Schedule of Benefits, no further deductible will be applied to the family's covered expenses for the rest of that calendar year.

COMMON ACCIDENT DEDUCTIBLE: If two or more family members incur charges as a result of the same accident, only one deductible will be applied to all resulting Injuries of all family members involved in the accident during that calendar year.

COINSURANCE MAXIMUM: During a calendar year, when the coinsurance payable by a participant or dependent equals the coinsurance maximum shown in the Schedule of Benefits, benefits for covered Major Medical expenses will be payable at 100% of the Reasonable and Customary charge or 100% of the Preferred Provider Reimbursement Schedule for the remainder of that calendar year. The deductible will not be applied to the coinsurance maximum.

LIMITATIONS AND EXCLUSIONS: No benefits are payable under the Health Care Benefit for any expenses incurred that result from circumstances outlined in the section of this booklet entitled "Plan Exclusions".

PLAN EXCLUSIONS

The following general exclusions apply to this Plan. Specific Limitations and Exclusions for individual Plan benefits are also described in the Schedule of Benefits or with that benefit in the Detailed Description of Benefits. No payment will be made under this Plan for expenses incurred by a participant or dependent for:

(1) **Acupuncture.**

(2) **Any Other Employment.** The Plan does not cover charges for or in connection with a Sickness, Injury, occupational disease or condition arising out of, or in the course of, any employment for wage, profit, intent of profit, or self-employment, or for which the participant or dependent is or was entitled to receive workers' compensation benefits. This exclusion applies even if the participant's or dependent's right to workers' compensation has been waived, qualified, or not asserted.

(3) **Artificial Insemination.** The Plan does not cover expenses related to artificial insemination, in-vitro fertilization, sperm washing, and for a surrogate mother. However, the expenses for the birth of a child as the result of artificial insemination, in-vitro fertilization, or other approved methods of conception, and the expenses of the child of a surrogate mother if the child has been placed for adoption with the covered participant will be covered. "Placed" means the assumption and retention

of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

(4) **Automobile Insurance, Ineligibility.** The Plan does not cover charges for which the participant or dependent is eligible to receive benefits through mandatory no fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. Excellus BCBS will take into consideration any adjustment option chosen under such part by the participant or dependent. If a participant or dependent is ineligible to receive benefits through mandatory no-fault insurance or uninsured motorist insurance law due to his operation of a motor vehicle while he is intoxicated (DWI), while his ability is impaired (DWAI), or while under the influence (DUI) as defined by applicable state law, or other diagnostic tests indicating the impermissible presence of drugs or alcohol, regardless of whether or not charges are filed, no payment will be made under this plan for charges incurred by that participant or dependent in connection with the resulting Injury.

(5) **Biofeedback.**

(6) **Blood Products.** The Plan will not provide coverage for the cost of blood, blood plasma, other blood products or blood processing or storage charges, when they are available free of charge in the local area, except the Plan will provide coverage for blood required for the treatment of hemophilia when billed by a Facility. When not free in the local area, the plan will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center, or a certified blood bank.

(7) **Civil and Criminal Misconduct.** The Plan does not cover charges for, or in connection with, any Injury or Sickness that arises while committing or attempting to commit an assault, felony, participating in a riot or civil disorder, or any other illegal act. This includes any Injury directly related to substance abuse or incurred while under the influence of alcohol, drugs, or narcotics, including while operating a vehicle.

(8) **Clothing, Orthopedic Shoes.** The Plan does not cover charges for special clothing, including orthopedic shoes, except for Medically Necessary burn garments or lymphedema sleeves.

(9) **Cosmetic Surgery.** The Plan does not cover cosmetic surgery, unless it qualifies as Reconstructive Surgery as defined.

(10) **Court Mandated Services.** The Plan does not cover charges related to court mandated non-Medically Necessary health services. The Plan will retain the right to cover such services if they are deemed to be Medically Necessary.

(11) **Custodial Care.** The Plan does not cover charges for or in connection with custodial care (except as specifically covered under the hospice benefit or elsewhere in the Plan) sanitariums or rest care.

(12) **Dental Care.** The Plan does not cover for or in connection with treatment of the teeth or periodontium, unless such expenses are incurred for charges made for, or in connection with, dental work due to an Injury to sound, natural teeth. Treatment must be rendered within 12 months of the accident. All the conditions for payment that apply to covered services under the Plan apply to the above covered expenses. Injuries to the teeth and soft tissue as a result of chewing or biting are not considered Injuries.

(13) **Dental Implants.**

(14) **Diagnostic Studies and Therapy.** The Plan does not pay for any Hospital stay, or any portion of a Hospital stay, that is primarily for diagnostic purposes or therapy. This includes, but is not limited to, a Hospital stay, or a portion of a Hospital stay, during which the services are primarily for diagnostic x-rays, laboratory tests, other types of diagnostic studies, or medical evaluation or therapy.

(15) **Disallowed Benefits or Penalties.** The Plan does not cover charges for penalties or disallowed benefits determined by a primary health plan as determined by this Plan's Coordination of Benefits section, Medicare, an HMO or other managed care plan due to failure of the covered person to obtain the proper pre-certification, second opinion, or any other reason including failure to comply with the requirements of the primary care physician network established by the HMO or managed care plan or by voluntarily obtaining services outside the established provider network thereby incurring a reduction or denial of benefits. For any penalty imposed due to failure to adhere to the conditions of the section entitled "Utilization Management and Medical Review".

(16) **Educational and Recreational Therapy.** The Plan does not cover charges for recreational or educational therapy, forms of self-care or self-help training, or marital, family or other counseling or training services unless specifically covered elsewhere under the Plan.

(17) **Employment, School, or Camp Physical Exams.** The Plan does not cover routine exams for the sole purpose of employment, school extracurricular activities, and summer camp physical examinations.

(18) **Excessive Charges.** For charges made which are in excess of Reasonable and Customary charges or the Preferred Provider's Reimbursement Schedule.

(19) **Excluded Treatments.** The Plan does not cover charges incurred for treatment of Sickness or Injury that results directly or indirectly from a treatment, procedure or therapy that is excluded from coverage under this Plan. This exclusion does not apply to charges incurred for maternity or newborn care arising from a non-covered service.

(20) **Experimental or Investigative Drugs.** The Plan does not cover Experimental or Investigative drugs or substances not approved by the Food and Drug Administration or for drugs labeled "Caution - limited by Federal Law to investigational use," including any drug or substance which is Experimental or Investigative.

(21) **Experimental or Investigative Services or Procedures.** The Plan does not cover any and all charges resulting from Experimental or Investigative services and procedures, as defined in the Plan, including, but not limited to, all Experimental organ transplants and Experimental organ implants.

(22) **Eye Examinations and Vision Therapy.** The Plan does not cover eye examinations, contact lenses or glasses (except for aphakic patients and cataract patients who do not receive implants), and soft lens or sclera shells intended for use in the treatment of Sickness or Injury. However, expenses for eye examinations and glasses are covered under the Plan when necessitated by accidental Injury. The Plan will not cover corrective lenses, eye refractions or any other services to determine the need for and/or proper adjustment of corrective lenses. This includes, but is not limited to: astigmatism, modifying or correcting myopia, hyperopia or stigmatic error, and other eye refractions including surgery performed to eliminate the need for corrective lenses. The Plan does not cover vision training for dyslexia and similar procedures, perceptual training and learning disability training. Coverage will only be provided when necessitated by damage to the natural eye as a result of an Injury as stated above, or a Sickness that results in similar damage. Services must restore or rehabilitate any resulting loss of vision.

(23) **Eye/Refractive Surgery.**

(24) **Genetically Engineered Treatment, Gene Therapy and CAR-T Therapy.** This exclusion applies, but is not limited, to all gene therapy drugs (for example, Zolgensma).

The Fund does not cover any charges related to gene therapy and CAR-T therapy, regardless of whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or

investigational. 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, Zolgensma and Luxturna. CAR-T therapy takes cells from the patient's body, genetically alters them outside of the body, then reintroduces them into the body as alternatively-functioning cells. Examples of CAR-T therapies include, but are not limited to, Kymriah and Yescarta.

(25) **Government Hospitals.** The Plan does not cover services rendered in a Hospital owned or operated by the United States Government or any other government unless there is a legal obligation to pay such charges without regard to the existence of any coverage.

(26) **Hazardous Hobbies for Cash or Prize Money.** The Plan does not cover charges incurred for the treatment of a Sickness or Injury that is the result of engaging in a hazardous hobby for cash compensation or prize money. A hobby is considered hazardous if it is an unusual activity characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies include but are not limited to automobile, bicycle and motorcycle racing, skydiving, hang gliding, ATV operation, jet skiing, snowmobiling, skateboarding, or bungee jumping.

(27) **Hearing Aids and Examinations.** The Plan does not cover hearing aids, hearing examinations, or the prescription or fitting of hearing aids.

(28) **Herbal and Homeopathic Remedies.**

(29) **Hypnosis.**

(30) **Inpatient Routine Physical Examinations/Services.** The Plan does not cover routine exams and services rendered in a Hospital during an inpatient confinement (except charges for routine nursery care of newborn child), unless otherwise specified in the Plan.

(31) **Interns and Residents.** The Plan does not cover services rendered and billed by a resident physician or intern while serving in that capacity.

(32) **Licensing.** The Plan does not cover charges for care, services, or supplies rendered which are not within the scope of the professional license of the person providing them.

(33) **Massage Therapy.** The Plan does not cover massage therapy unless it is performed by a licensed Provider, such as a physical therapist or a chiropractor, and is an integral part of a therapy treatment plan that has been approved by the Plan.

(34) **Medicare.** To the extent allowed by Medicare Secondary Payer rules, the Plan does not cover charges to the extent that the participant or dependent is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by Medicare. Any individual who, at any time, was entitled to enroll in all or any portion of the Medicare program but who did not so enroll, will be considered to be entitled to reimbursement in an amount equal to the amount to which he would have been entitled, if any, if he were so enrolled.

(35) **No Coverage.** The Plan does not cover charges that are incurred before a participant or dependent becomes covered by the Plan, after the participant's or dependent's coverage ended, or the Plan has terminated.

(36) **Non-Acute Hospital Care.** The Plan does not pay for a Hospital stay or any portion of a Hospital stay where the participant or dependent received non-acute care. This includes, but is not limited to, a Hospital stay, or a portion of a Hospital stay, in connection with physical checkups, convalescent or custodial care, rest cures, or sanitarium type care.

(37) **Non-Durable Medical Equipment.** The Plan does not cover equipment that does not meet the definition of Durable Medical Equipment, including but not limited to: air conditioners, humidifiers, exercise equipment, etc., and for wigs and artificial hair pieces, human or artificial hair transplants or any drug, prescription or otherwise, used to eliminate baldness.

(38) **Not Legally Required to Pay.** The Plan does not cover charges which would not have been made if no coverage had existed or for which the participant or dependent is not legally required to pay, or payment is unlawful in the jurisdiction where the person resides at the time the expenses are incurred.

(40) **Not Physically Present.** The Plan does not cover charges incurred for room and board for a participant or dependent in any Hospital or facility for any period of time during which that individual was not physically present.

(41) **Nutritional Counseling.** The Plan does not cover nutritional, except for diabetic education.

(42) **Nutritional Supplements.**

(43) **Oral Surgery.** The Plan does not cover oral surgery, except for oral surgery needed due to an accidental Injury to sound, natural teeth if the services are performed within 12 months of the accident.

(44) **Outdated Claims.** The Plan does not cover bills submitted to the Plan after the timely filing limit indicated in the section of this Summary Plan Description entitled "Claim Procedure".

(45) **Over the Counter Medical Drugs and Medical Supplies.** The Plan does not cover any items that can be obtained without a prescription, except for diabetic supplies.

(46) **Patient Charges and Penalties.** The Plan does not cover charges for telephone consultations, charges for failure to keep a scheduled visit, or charges for the completion of claim forms, new patient processing, and late payment, penalty or interest charges caused by the patient's action or inaction.

(47) **Physicals.** The Plan does not cover physicals required as a condition of employment.

(48) **Prescription Drugs.** The Medical Expense Benefit section of the Plan does not cover Prescription drugs (except where noted elsewhere in the Plan). Please refer to the section of this Summary Plan Description entitled "Prescription Drug Benefit" for information regarding prescription coverage.

(49) **Private Duty Nursing Care at Home.** The Plan does not cover private duty nursing services rendered when the patient is receiving home health care services.

(50) **Reimbursements.** The Plan does not cover charges to the extent that the participant or dependent is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public or government program or applicable law, other than the program of Medical Assistance for Needy Persons (Medicaid).

(51) **Reversal of Sterilization Procedures.**

(52) **Routine Care.** The Plan does not cover any service in connection with routine or periodic physicals or routine screening examinations, except for routine services covered as described in the subsection entitled "Medical Expense Benefits.

(53) **Routine Foot Care.** The Plan does not cover routine or palliative foot care such as treatment of corns, calluses, toenails, flat feet, fallen arches, chronic foot strain, reduction of nails, or symptomatic complaints of the feet, except if necessitated due to metabolic conditions such as diabetes.

(54) **Sales taxes.**

(55) **Self-Destruction, Self-Inflicted Injury.** The Plan does not cover any intentionally self-inflicted Sickness or Injury, except for treatment resulting from a medical condition (including behavioral health disorders). The Plan also does not cover charges resulting from insurrection, participation in a riot or in consequence of having participated in an illegal act.

(56) **Services Maintained by the Employer.** The Plan does not cover any service or care furnished by a medical department, clinic, or other similar service maintained by the employer or any participating employer.

(57) **Services of a Relative.** The Plan does not cover services provided by your immediate family (the patient's Spouse, children, brother, sister, parent of Spouse or other person residing with the patient).

(58) **Services by an Institutional Employee.** The Plan will not cover any service by any health care professional including, but not limited to, a physician or a nurse if the person is an employee of a Hospital, skilled nursing/convalescent facility, home health care agency, hospice organization, Substance Abuse treatment facility, or other health care facility where the participant or dependent receives care.

(59) **Sex Therapy.** The Plan does not cover therapy, supplies, or counseling for transsexuals, sexual dysfunction or other related inadequacies.

(60) **Surrogate Pregnancy.** The Plan does not cover services or supplies related to surrogate's maternity care, including but not limited to, those needed to start the pregnancy, prenatal care, delivery or other obstetrical procedures, and postnatal care. The newborn is covered separately when meeting Plan eligibility and enrollment requirements as a dependent child.

(61) **Temporomandibular Joint Dysfunction (TMJ) Disorder.** The Plan does not cover in connection with dental treatment of the teeth or periodontium, treatment related to Temporomandibular Joint Dysfunction (TMJ). This includes but is not limited to: treatment for clicking or grinding of the temporomandibular joint, soreness of the jaw muscle, stiffness of the jaw, and spasms of the muscles. Hospital and anesthesia charges incurred as a result of dental treatment are not covered.

(62) **Third Party Liability.** The Plan does not cover charges with respect to any Injury or Sickness for which a third party may be legally responsible or liable unless the participant or dependent fully complies with subrogation provisions described in this Summary Plan Description.

(63) **Training.** The Plan does not cover expenses incurred for education or training (except as specifically covered in the Plan).

(64) **Travel.** The Plan does not cover charges incurred for travel, (other than transportation via Medically Necessary ambulance).

(65) **Veteran's Benefits.** The Plan does not cover services or supplies furnished to the participant or dependent by the Veteran's Administration for which there is no charge.

(66) **War.** The Plan does not cover expenses related to war or any act of war (declared or undeclared) including armed aggression, or military or naval service of any country.

(67) **Weight Reduction.** The Plan does not cover charges for weight reduction, diet programs (Weight Watchers, Nutrisystem, etc.) or diet supplements. The Plan will not pay for any surgical procedures intended for weight loss, except in cases of morbid obesity. (See the subsection entitled "Morbid Obesity Treatment" in the section entitled "Medical Expense Benefits" for information on coverage available for the treatment of morbid obesity.)

(68) **Wigs and Hairpieces.**

B. PRESCRIPTION DRUG BENEFIT

1. <u>Benefit for Participants (including eligible retirees) and their Eligible Dependents</u>.

Participants and their eligible dependents will be covered under the Sav-Rx program. Prescription Drug costs will be paid 80% by the Plan, and the participant is responsible for the remaining 20%. This applies to prescriptions obtained through the mail order pharmacy and through network pharmacies. (This benefit is administered by Sav-Rx.) Please note that there is no participant charge for covered diabetic supplies and machines including insulin syringes, and glucagon injections. There is also no participant charge for covered immunizations.

When you become eligible for this benefit, you will receive a prescription drug identification card, a list of participating pharmacies, information regarding the mail order program, instructions and a toll free number for assistance. If you have not yet received this information or you have misplaced it, please contact the Fund Office.

*Medicare eligible dependents are not covered by this Plan unless applicable law requires that coverage be offered to the individual.

2. Covered Charges.

For prescription drug charges to be reimbursable under this Plan:

- the prescription drug must be purchased at a participating pharmacy;
- the prescription drug must be prescribed by a physician who is licensed to do so;
- the prescription cannot be for more than a 34-day supply (100-day supply for mail order program); and
- the prescription drug must be medically necessary for you and approved by the Food and Drug Administration.

The following items may only be covered after receiving prior authorization:

- injectables;
- fertility medications;
- specialty drugs; and
- growth hormone medications.

3. Exclusions.

Your prescription drug plan excludes coverage for the following:

- syringes other than insulin syringes;
- devices/appliances;
- over the counter ("OTC") vitamins;
- OTC prenatal vitamins;
- prescription prenatal vitamins;
- abortifacient;
- OTC non-sedating antihistamine;
- OTC proton pump inhibitor;
- OTC smoking cessation medications;
- transplant medications;
- medications for cosmetic purposes;
- replacement prescriptions, except insulin;
- OTC medications which are lawfully obtainable without a prescription;

- any charge for the administration of prescription Legend Drugs, except for those charges required by law to be covered;
- medications used for experimental indications and/or dosage regimens determined to be experimental;
- gene therapy (for example, Zolgensma) and CAR-T therapy; and
- prescriptions refilled after one year from the order of a physician.

Prescription Drug Benefit for Eligible Pensioners Age 62 through 64 as of December 31, 2018, and their Eligible Dependents

**Eligible Pensioners who, as of December 31, 2018, are age 62 through 64 and covered by this Plan will, along with their Eligible Dependents, continue to have covered prescription drug benefits paid at 100% so long as they remain otherwise eligible for benefits under the Plan; this 100% benefit will end on the Pensioner's 65th birthday.

Sav-Rx Mandatory Generic Program

Except as noted below, if you purchase a brand name prescription medication that has an equivalent generic available, you will be responsible for any applicable coinsurance plus the difference in cost between the brand name medication and the generic medication. The Program applies to generic medications that are rated as equivalent to the brand name medication by the U.S. Food and Drug Administration.

If it is Medically Necessary for you to take the brand name medication as opposed to the equivalent generic medication, you must still pay any applicable coinsurance, however, you are not required to pay the difference in cost between the brand name medication and its generic equivalent. Your physician must submit a Letter of Medical Necessity to Sav-Rx on your behalf to support any claim that a brand name medication is medically necessary for you. The fact though that a physician or health care practitioner may order, recommend, or approve a service, supply or treatment does not itself make it Medically Necessary. Only the Board of Trustees or its designee has the discretion and authority to determine if a service, supply or treatment is Medically Necessary under the Plan.

Participants using a brand name drug prior to July 1, 2018, will be able to continue using that brand name drug without being subject to this Program.

POOLED BENEFITS

These insurance benefits are provided out of the Fund's unallocated pooled assets and not out of your personal account.

C. LIFE INSURANCE BENEFIT

You will be entitled to the Life Insurance Benefit if you are an Active Participant (as described in this Summary Plan Description) or are covered by a Participating Employer Contribution Agreement. (This benefit is not available for retirees.)

This Life Insurance Benefit is insured by the Union Labor Life Insurance Company with premiums being paid directly from pooled assets of the Plan. The Life Insurance Benefit is $10,000. This $10,000 will be paid to your designated beneficiary in the event of your death. Please refer to the certificate provided by the insurance carrier for more details. You can contact the Fund Office for a copy of the insurance certificate and/or any available insurance booklets regarding this benefit.

The beneficiary will be the person or persons designated in writing by you and filed at the Fund Office. You may change your designated beneficiary at any time by completing and submitting the proper form to the Fund Office. A designation or a change of beneficiary received at the Fund Office after your death will not be honored.

Upon receipt of the notice of your death, the Plan Manager will forward a form for the beneficiary to complete in order to claim benefits. If there is no living designated beneficiary at the time of your death, the Life Insurance Benefit is payable to your estate.

D. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT

You will be entitled to the Accidental Death and Dismemberment Insurance Benefit if you are an Active Participant (as described in this Summary Plan Description) or are covered by a Participating Employer Contribution Agreement. (This benefit is not available for retirees.)

If you suffer the loss of life, sight, hand, or foot as a result of an accident and such loss occurs within 90 days of the accident, you will be paid in accordance with the following schedule:

Loss	Benefit
Life	$10,000
Two Hands	$5,000
Two Feet	$5,000
Sight of Two Eyes	$5,000
One Hand and One Foot	$5,000
One Hand and Sight of One Eye	$5,000
One Foot and Sight of One Eye	$5,000
One Hand or One Foot	$2,500
Sight of One Eye	$2,500

The Accidental Death & Dismemberment Insurance 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.

PERSONAL ACCOUNT PLAN BENEFITS

E. HEALTH EXPENSE BENEFIT

The Health Expense Benefit is available to eligible Active Participants.

If you incur health care expenses while you are a participant in the Plan, for yourself, your spouse, or your eligible dependents and these expenses are not covered under the Health Care Benefit or any other insurance, you may apply for a distribution from your account to pay for the uncovered bills.

These expenses may include, but are not limited to expenses incurred for dental care, eye care and hearing aids as allowed by Internal Revenue Code § 213(d) and applicable IRS rules and guidance. They may also include expenses for (1) over-the-counter medicines and drugs, but only if they are purchased with a prescription, and (2) over-the-counter medical devices and supplies, such as crutches or bandages. Please note that you must provide itemized receipts evidencing the purchase of drugs, medicine, or medical care items. For drugs or medicine other than insulin, you must also provide a copy of the prescription, unless the receipt identifies the name of the purchaser (or the name of the person for whom the prescription applies) and an Rx number.

Claims under this benefit may be submitted only if they total at least $100. You may add several bills together in order to reach the $100. However, in the month of December you may submit bills for reimbursement regardless of the amount. Active Participants must maintain a minimum balance of $2,000 in order to use this benefit.

The Health Expense Benefit accounts may not be used to cover premium payments for individual market coverage.

The Health Expense Benefit is designed to help you pay for certain medical costs not covered by this or any other health care or insurance plan. Upon your death, your spouse and/or eligible dependents will be entitled to keep your Health Expense Benefit under the Plan and may use the balance in your account to pay for benefits provided by the Plan on behalf of your spouse and any of your eligible dependents. Upon the death of your spouse/eligible dependents, any balance remaining in the Health Expense Benefit will be forfeited.

Those individuals who are unavailable for Covered Employment for reasons other than retirement under the I.B.E.W. Local 910 Pension Plan, or disability, shall forfeit the Plan assets allocated into their then-existing Personal Account Plan to the general treasury of the Fund. Availability for Covered Employment is determined by the Union.

Upon retirement under the IBEW 910 Pension Plan, your individual account coverage under the Active Participant Plan is eliminated. However, please note that the Trustees have established an individual account under the Retiree-Only PAP and your initial account balance in the Retiree-Only PAP will be equal to the balance of your individual account in this Plan immediately before retirement and termination of your Active account. A description of the Retiree-Only PAP can be found in Exhibit "B".

Section III. Protected Rights for Continuing Coverage

In some circumstances, it may be possible for you and/or your dependents to continue coverage under the Welfare Fund even when your coverage would have otherwise terminated.

A. COBRA CONTINUATION COVERAGE

What is COBRA continuation coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. The Fund's COBRA Continuation Coverage is administered by the Fund Office.

There may also be alternative health insurance coverage options for you and your family other than purchasing COBRA coverage from this Plan. When key parts of the health care law take effect in 2014, you will be able to buy coverage through the Health Insurance Marketplace. The Marketplace is designed to help people without employer sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: HealthCare.gov. In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away. Information about the Marketplace can help you see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. In addition to the options available from the Marketplace, you may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which you are eligible (such as a spouse's plan). Even if the other plan generally does not accept late enrollees, you may still qualify if you request enrollment within 30 days. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. The Active Participant PAP may not be used to purchase coverage on the Marketplace.

There are two parts to your coverage under the Plan: (1) your self-insured Health Care Benefits administered by Excellus BlueCross BlueShield; and (2) your health reimbursement (Health Expense Benefit (personal account plan)) benefits. You, your spouse, and your dependents may elect COBRA continuation coverage for the Health Care Benefits only or for both the Health Care Benefits and the health reimbursement Health Expense Benefit.

No Personal Account Plan will be available for an individual under COBRA if that individual has been credited with a Personal Account Plan, as a participant or beneficiary, under the Retiree PAP Plan.

Which participants are eligible for COBRA continuation coverage?

For individuals covered by the Plan as participants, COBRA continuation coverage may be elected upon loss of health care coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the participant no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff. You may elect COBRA continuation coverage for the Health Care Benefit only or for both the Health Care Benefit and the Health Expense Benefit. You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Health Expense Benefit. You will continue to have access to your Health Expense Benefit and to receive reimbursements from your Health Expense Benefit subject to the terms of the Plan, and so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact your Health Expense Benefit can be used to pay the required COBRA premiums for the Health Care Benefit. If you lose coverage in this plan because of being a Medicare-Eligible Retiree, you may elect COBRA coverage or coverage under the Plan for Medicare-Eligible Retirees. However, election of one type of coverage is rejection of the other.

When is my spouse eligible for COBRA continuation coverage?

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

1. your death;

2. your spouse's loss of health care coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff;

3. divorce or judicial order of legal separation; or

4. your enrollment in Part A or Part B of Medicare.

If your spouse has a COBRA Qualifying Event as a result of your death, because you have terminated Covered Employment or because of a reduction of your hours of Covered Employment, your spouse may elect COBRA continuation coverage for the Health Care Benefit only or for both the Health Care Benefit and the Health Expense Benefit. In this case, your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Health Expense Benefit. Your spouse will continue to have access to your Health Expense Benefit subject to the terms of the Plan, and so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your spouse has a COBRA Qualifying Event as a result of divorce or judicial order of legal separation, to continue to have access to your Health Expense Benefit and to receive reimbursements from your Health Expense Benefit account, your spouse MUST elect COBRA continuation coverage and pay COBRA premiums.

If you lose coverage and are credited with a Personal Account Plan under the Retiree PAP Plan (as set forth above), your spouse will have the right to have access to your Personal Account Plan under the Retiree PAP Plan, provided that the rules of the Retiree PAP Plan concerning spousal coverage (including, if applicable, those with respect to COBRA) are complied with.

When does my dependent child become eligible for COBRA continuation coverage?

Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

1. your death;

2. your dependent child's loss of health care coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff;

3. divorce or judicial order of legal separation of the child's parents;

4. your enrollment in Part A or Part B of Medicare; or

5. the child ceases to qualify as an "eligible dependent" as described in Section 1. C.

If your dependent child has a COBRA Qualifying Event as a result of your death, because you have terminated Covered Employment or because of a reduction of your hours of Covered Employment, your dependent child may elect COBRA continuation coverage for the Health Care Benefit only or for both the Health Care Benefit and the Health Expense Benefit. In this case, your dependent child is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Health Expense Benefit. Your dependent child will continue to

have access to your Health Expense Benefit and to receive reimbursements from your Health Expense Benefit subject to the terms of the Plan, and so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your dependent child has a COBRA Qualifying Event as a result of your divorce or judicial order of legal separation or because your child ceases to qualify as an "eligible" dependent, to continue to have access to your Health Expense Benefit and to receive reimbursements from your Health Expense Benefit, your dependent child MUST elect COBRA continuation coverage and pay COBRA premiums.

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

If you lose coverage and are credited with a Personal Account Plan under the Retiree PAP Plan (as set forth above), your eligible dependent child will have the right to have access to your Personal Account Plan under the Retiree PAP Plan, provided that the rules of the Retiree PAP Plan concerning dependent child coverage (including, if applicable, those with respect to COBRA) are complied with.

How is a person eligible for COBRA continuation coverage notified of his or her eligibility?

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B Medicare. The Trustees have determined that because participants frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent or of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Fund Office within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, you have the responsibility to inform the Fund in the event that the Social Security Administration has determined you or one of your qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

After the Fund Office receives notice of the occurrence of one of the above qualifying events, it will notify each eligible individual whether he or she has the 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 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverages has terminated.

When must the election be made?

The participant, spouse and dependent children each has independent election rights. Covered participants may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Fund Office that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form, if mailed, is post-marked no later than the due date. If the election is hand-delivered, the date of delivery must be on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the election is hand-delivered, your COBRA continuation will begin on the date of delivery.

You may elect COBRA continuation coverage for the Health Care Benefit only or for both the Health Care Benefit and the Health Expense Benefit. You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Health Expense Benefit. You will continue to have access to your Health Expense Benefit and to receive reimbursements from your Health Expense Benefit so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact your Health Expense Benefit can be used to pay the required COBRA premiums for health care benefits.

What type of benefits are available in COBRA continuation coverage?

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no Life Insurance or Disability benefits or Accidental Death & Dismemberment benefits or other non-health benefits will be included.

What are the consequences of failing to elect or waiving COBRA continuation coverage?

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under Federal law. Finally,

you should take into account that you have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How long does COBRA continuation coverage last?

If the election is due to termination of your employment or a reduction in hours worked or a loss of eligibility due to reduction in Health Care Benefit, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. the employer no longer provides group health coverage;

2. failure to pay the monthly premium on time;

3. the individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions;

4. the individual enrolls in Part A or Part B of Medicare; or

5. circumstances are such that the individual's participation could be canceled if the individual were an active participant.

If any of these events occur, the Fund Office will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the participant, spouse or dependent child may have under the Plan to elect alternate coverage.

What is the cost of COBRA continuation coverage and how is the cost computed?

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan.

Is there anything else I should know about COBRA continuation coverage?

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Plan Manager.

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

In order to protect your family's rights, you should keep the Plan Manager informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Manager.

B. CONTINUATION OF COVERAGE FOR QUALIFIED MILITARY SERVICE

If you leave employment for full-time Qualified Military Service, as defined by Federal law, you and your eligible dependents are permitted to elect to continue health coverage under the Plan, subject to certain limitations under Federal law. This coverage, subject to the rules of the Plan, may last for up to 24 months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the 24 month period if you enter Qualified Military Service and are discharged earlier and fail to make timely application for re-employment upon discharge.

If you elect such continuation, you will not be required to pay any premium for the first 30 days of coverage. Thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan, which will be based on the average cost that the Plan incurs annually per participant plus a two percent (2%) administrative charge.

C. CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT

Overview

The Family and Medical Leave Act (FMLA) requires that employers permit participants to take up to 12 weeks of unpaid leave during any 12-month period for any one of the following reasons:

- The birth of the participant's child or placement of a child with the participant for adoption or foster care;
- Caring for the participant's parent, spouse, or child with a serious health condition; or

- Attending to the participant's own serious health condition.

- During FMLA leave, employers must provide participants continued health plan coverage at the same level that would have been in effect had the participant continued to work.

Interaction of FMLA with COBRA

A COBRA qualifying event (i.e., reduction in hours or termination of employment) will *not* occur if a participant takes FMLA leave. In addition, a participant's failure to pay premiums or an election to discontinue coverage while on FMLA leave is *not* A COBRA qualifying event.

Circumstances Under Which Qualifying Event Occurs

The IRS proposed rules published in 1999 specify the circumstances in which a qualifying event occurs if a participant does not return from leave within the 12-week period. Under the rules, a qualifying event generally occurs if the event meets the following three conditions:

- The participant (or spouse or dependent child) is covered by the employer's group health plan on the day before the first day of FMLA leave (or became covered during FMLA leave).

- The participant does not return to work before the FMLA leave ends.

- The participant (or spouse or dependent child) loses coverage under the group health plan before the end of the maximum coverage period.

Section IV. Qualified Medical Child Support Order

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled "alternate recipients." Both you and your beneficiaries can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Manager.

Upon receipt of a medical child support order, the Plan Manager will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a participant under the Welfare Fund and will receive copies of summary plan descriptions, summary

annual reports, and summaries of any amendments made to the Plan according to current ERISA requirements.

Section V. Your Rights Under ERISA

As a participant in the I.B.E.W. Local 910 Welfare Fund 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 plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

  Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- **Continue Group Health Plan Coverage.** Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the participant benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

Assistance with Your Questions. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) in your area, listed in your telephone directory, or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone numbers of the Regional and District EBSA Offices are available through EBSA's website). The information contained in this Section is subject to change based upon future guidance that may be issued by the Internal Revenue Service or Department of Labor.

Section VI. Claim Procedure

CLAIM PROCEDURE FOR INSURED BENEFITS

Please read your insurance carrier's booklet or certificate of insurance for the claim procedures for the insured benefits provided under the Welfare Fund.

CLAIM PROCEDURE FOR THE HEALTH CARE BENEFIT

All medical claims are processed by Excellus BlueCross BlueShield, a Third Party Payer. If you have questions regarding the status of a claim, how the claim was processed, or your explanation of benefits, call Excellus BlueCross BlueShield (Customer Care) toll free at (800) 499-1275 (or 800-662-1220 for TTY). You may also write to Excellus BlueCross BlueShield at:

Excellus BlueCross BlueShield
PO Box 21146
Eagan, MN 55121

All Health Care claims must be submitted directly to:

Excellus BlueCross BlueShield
PO Box 21146
Eagan, MN 55121

(The billing address is on the back of your insurance card.)

Either the Provider or the participant or dependent must submit a claim form before reimbursement for an eligible expense can be paid. Claim forms are available from the Fund Office.

Claims must be submitted no later than **120 days** after the date the claim is incurred. Claims that are not filed within this time period will be denied. When submitting a claim form, include:

(1) The participant's name, and

(2) The participant's Social Security Number or the participant's Alternative Identification Number, and

(3) The full name of the participant or dependent receiving treatment, and

(4) An itemized bill reflecting a diagnosis, and

(5) When the claim is the result of an accident, note the time and date of the accident and include a one or two sentence description of the circumstances.

(6) When a participant or dependent is covered under more than one health plan, and medical coverage under the other plan is, or could be, primary, submit the claim to the other plan first. Then, submit a copy of the "explanation of benefits" from the other plan when submitting the claim to Excellus BCBS.

Payment for services provided by an In-Network Provider will be made directly to the provider. If you receive services from an Out-of-Network Provider, Excellus Blue Cross BlueShield reserves the right to pay either you or the provider. Submit claim forms to Excellus BlueCross BlueShield at:

Excellus BlueCross BlueShield
P.O. Box 21146
Eagan, MN 55121

PAYMENT OF BENEFITS

How Excellus BlueCross BlueShield pays medical expenses payable under your Plan is determined by whether you received treatment in or out of the Plan's Preferred Provider Network(s). To obtain a list of the Plan's Preferred Providers, you may contact the Fund Office or go to Excellus BlueCross BlueShield's website at www.excellusbcbs.com/IBEW910.

If you or your Dependent(s) receive treatment from a member of this Plan's Preferred Provider Network(s), Excellus BlueCross Blue Shield, will make payment directly to the Provider. Please do not pay your bill at the time of service. These providers have agreed to accept a lower fee. Therefore, the percentage that you may be required to pay will be the percentage of a lower fee – a savings to both you and the Plan. You **do not** have to submit claims.

If you or your Dependent(s) receive treatment from a Non-Preferred Provider, Excellus BlueCross BlueShield will pay expenses payable under this Plan for which you have proof of service. Proof of service must be furnished by you or your out-of-network provider via the claims procedure as follows.

The Trustees will have the right and opportunity to examine any claimant (while living) when and so often as it may reasonably require and, also, the right and opportunity to make an autopsy where it is not forbidden by law.

CLAIM PROCEDURE UNDER THE PRESCRIPTION DRUG BENEFIT

The prescription drug benefit is administered by Sav-Rx. If you need assistance, or wish a claim form, please call the Member Services phone number 1-866-233-4239, found on the back of your identification card. You may obtain claim forms by logging on to the Sav-Rx website, **www.savrx.com**. You may also obtain paper claim forms by writing to:

Sav-Rx
P.O. Box 8
Fremont, NE 68026

You may file for secondary coverage for any eligible dependent who purchases a covered medication. You will need to complete the Sav-Rx claim form, and attach any pharmacy receipts or explanation of benefits. Be sure to provide all information that is requested, including the quantity and days' supply. You may write any requested information directly on the claim form if it is missing from the receipt. Your claim will be denied if requested information is not supplied.

CLAIM PROCEDURE UNDER THE HEALTH EXPENSE BENEFIT

Application for Health Expense Benefits must be made within one calendar year of the expense being incurred. The Application must be in writing on forms that may be obtained from the Fund Office.

Time deadlines for filing, if any, are indicated under the particular Benefit description in Part A. of this booklet.

Fund Office Claim Payment Procedure

It is the policy of the I.B.E.W. Local 910 Welfare Plan to issue payments for all claims that are administered by the Fund Office within a period of 30 days from the date of receipt by the Fund Office to the extent administratively feasible.

For all claims, the following will be required:

1. Obtain an appropriate claim form(s) from the Fund Office.

2. Complete your portion of the form(s). Be sure that the participant's signature and the participant's social security number are in the proper spaces.

3. Upon completion of the claim form(s), attach all itemized bills and return it to the Fund Office.

An expense is considered to be incurred on the date the service or treatment is received or a purchase is made, rather than on the date the bill is received.

CLAIM REVIEW AND APPEAL PROCEDURES

Initial Decisions

Time Frames

Health Care Benefits (Administered by Excellus Blue Cross Blue Shield), Health Expense Benefits, and Prescription Drug Benefits (Administered by Sav-Rx).

For these medical claims, the rules that apply to denied claims depend on the type of claim. There are generally four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods

for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a Pre-Service Claim involving an ongoing course of treatment and care made concurrently with the treatment itself. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant. Pre-Service, Urgent, and Concurrent claims are not Post-Service claims.

Post-Service Claims: For claims not requiring pre-approval, i.e., Post-Service Claims, you will be notified of any adverse benefit determination (by the plan or by the third--party administrator) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the plan's (or the third-party administrator's) control if, before the end of the initial 30-day period, the plan (or the third-party administrator) 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 45 days from receipt of the notice to provide it. (Note: The Health Expense Benefit under this plan does not require pre-approval as a condition of receipt of benefits. Thus, all claims for this benefit are Post-service Claims.)

Pre-Service Claims: The receipt of some medical benefits (Health Care and Prescription Drug Benefits) may be conditioned on advance approval from the third-party administrator or prescription benefits manager (PBM). Claims for such benefits are considered Pre-service Claims, as defined above. For Pre-service Claims, the following rules apply. Generally, you will be notified of the third-party administrator's or prescription benefits manager's determination (whether adverse or not), within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the third-party administrator's or prescription benefits manager's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the third-party administrator's or prescription benefits manager 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 45 days from receipt of the notice to provide the specified information. If the claim is improperly filed, the third-party administrator or prescription benefits manager will provide notice of the failure within 5 days.

Urgent Care Claims: The rules are slightly different for Pre-Service Claims involving urgent care, i.e., Urgent Care Claims. For such 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 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 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 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 3 days of the oral notification.

Concurrent Care Claims: With regard to Concurrent Care claims, if the third-party administrator 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 third-party administrator 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 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatments.

Prescription Drug Benefit

Claim forms are not needed to obtain prescription benefits. To request prescription benefits you simply present your card and prescription to the pharmacist. That request is not considered a "claim" under these procedures. However, if your request is denied in whole or in part, you may file a claim for benefits by submitting your paid receipts for the prescription drug, along with a completed claim form, to Sav-Rx at the following address:

P.O. Box 8
Fremont, NE 68026
Telephone: (866) 233-4239
www.savrx.com

If Sav-Rx denies your claim, the rules regarding post-service claims apply. If you need a claim form, or have any questions regarding these procedures, please call the Fund Office at (315) 782-5941.

Life Insurance, and Accidental Death & Dismemberment Insurance Benefits

If your claim for Life Insurance and Accidental Death & Dismemberment Insurance Benefits is denied in whole or in part for any reason, then within 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 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.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;

2. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. 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;

4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;

5. 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;

6. If the adverse benefit determination is based on medical necessity or experimental treatment, 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

7. In the case of an adverse determination involving the claim for urgent care, a description of the expedited review process applicable to such claims.

Appeals of Adverse Benefit Determinations

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in this Plan; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If you are not satisfied with the reason or reasons for your adverse benefit determination, you may appeal the determination. To appeal an adverse determination of a Health Care benefit, you must first appeal to Excellus BlueCross BlueShield within 180 days after you receive the initial adverse benefit determination. For Health Care Benefit claims other than Urgent Care claims, the Plan

employs a two-level appeal process. If you have your first level appeal of a Health Care Benefit claim denied, to appeal to the second level of appeal, you must appeal to the Board of Trustees (for Post-Service claims), and to Excellus BlueCross BlueShield (for Pre-Service claims), within 180 days of the first-level denial. To appeal an adverse determination of a Prescription Drug Benefit, you must write to the Trustees within 180 days after you receive this Plan's initial adverse benefit determination. Notwithstanding anything in this paragraph to the contrary, for Concurrent Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will be afforded a reasonable period of time to appeal. To appeal an adverse benefit determination of a Life Insurance or Accidental Death & Dismemberment Insurance Benefit claim, you (or your beneficiary) must follow the appeal procedures of the insurance carrier. For a copy of the applicable policy, please contact the Fund Office.

Special Rule Regarding Urgent Care Claims: 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 Plan (or the third-party administrator, as applicable) by telephone, facsimile, or other similarly expeditious method. Further, if the appeal involves an Urgent Care Claim, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

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 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 to someone unless they are sure he or she is your chosen representative.

In addition, all other appeals, except life insurance and Accidental Death and Dismemberment Insurance benefits, must adhere to the following criteria: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Determinations on Appeal

Time Frames

Pre-Service Claims for Health Care Benefits: These medical claims are subject to a two-level appeal process, as noted above. At the first level of appeal, Excellus BlueCross BlueShield, 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 15 days after receipt of the request for review. If your first-level of appeal is denied and you appeal at the second level to Excellus BlueCross BlueShield will also notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Urgent Care Claims: Excellus BlueCross BlueShield will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

Post-Service Claims for Health Care Benefits: These medical claims are subject to a two-level appeal process, as noted above. At the first level of appeal, Excellus BlueCross BlueShield will notify you of its determination on appeal within 30 days of receipt of the appeal. If your first-level appeal is denied and you appeal to the second level to the Board of Trustees, the Board of Trustees will also notify you of its determination on appeal within 30 days of receipt of the appeal.

Life Insurance and Accidental Death & Dismemberment Insurance Claims: Appeals of adverse Life Insurance and Accidental Death & Dismemberment Insurance determinations must be determined by the insurance company within 60 days (plus a possible 60-day extension, if necessary).

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 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 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 reasons for the adverse benefit determination;

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;

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; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment or 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 upon request.

Disability Claims and Appeals

The following also applies to any benefit determination conditioned on a finding of disability by the Plan. These rules do not apply to a determination conditioned on a finding of disability by a party other than the Plan (for example, the Social Security Administration).

1. Adverse benefit determination notices will also include the following:

    a. Discussion of the decision including, if applicable, an explanation of the basis for disagreeing with or not following:

        (i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

        (ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

        (iii) A Social Security Administration disability determination regarding the claimant, presented by the claimant to the Plan.

b. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

c. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

d. For appeal determinations, any contractual limitations period for filing a civil action and the calendar date deadline for doing so.

2. Before the Plan issues an adverse benefit determination on appeal, the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Trustees, or their designee, (or at the direction of the Trustees or their designee) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

3. Before the Plan issues an adverse benefit determination on appeal based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale. Such rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

4. The term ''adverse benefit determination'' also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term ''rescission'' means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

5. To the extent required by applicable law, any notices will be provided in a culturally and linguistically appropriate manner.

6. To the extent the Plan violates any applicable claims and appeals procedures, a participant may request a written explanation of the violation from the Plan. The Plan will respond within ten days.

The Trustees' Decision is Final and Binding

The Trustee's (or other 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 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address. Please note that filing a lawsuit without exhausting the Fund's appeals procedures could limit your right to appeal or cause you to lose benefits to which you would otherwise be entitled. You may not assign, convey, or in any way transfer your right to bring a legal action against the Plan or its Trustees, to anyone else.

The Trustees are responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees have exclusive authority and discretion: to determine whether an individual is eligible for any benefits under the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to determine or find facts that are relevant to any claim for benefits from the Plan; to interpret all of this SPD's provisions; to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting this Plan; to interpret all the provisions of any other document or instrument involving or impacting the Plan; and, to interpret all of the terms used in this booklet and in all of the other previously-mentioned agreements, documents, and instruments.

All such interpretations and determinations made by the Trustees, or their designee shall be final and binding upon any individual claiming benefits under the Plan and upon all Participants, all Employers, the Union, and any party who has executed any agreement with the Trustees or the Union; will be given deference in all courts of law, to the greatest extent allowed by applicable law; and will not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation. **Benefits under this Plan will be paid only if the Trustees decide in their discretion that you are entitled to them.**

INCOMPETENCE

In the event it is determined that a claimant is unable to care for his or her affairs because of illness, accident, or incapacity, either mental or physical, payments due may, unless the claim has been made therefore by a duly appointed guardian, committee, or other legal representatives, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant, as the Trustees will determine in their sole discretion.

COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be

sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulas, methods and procedures as they consider advisable.

CLAIM REPRESENTATIONS

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information, or proof submitted, as well as any benefit payments made in error.

COORDINATION OF BENEFITS WITH OTHER HEALTH INSURANCE

Many times, a married couple are each covered by more than one health care plan. As a result, two or more plans are paying for the same expense. To avoid this costly problem, this Fund provides a coordination of benefits provision. The provision affects all your health care benefits.

If you or your dependent is also covered under another plan or policy, the total amount received from all plans will never be more than 100% of "Allowable Expenses". Benefits are reduced to the extent necessary to prevent any person from making a profit on his coverage.

In coordinating benefits for multiple Coverage, the "primary" Plan pays first and the "secondary" Plan pays next to make up the difference, but the total benefits paid by both the primary and the secondary Plans will not exceed 100% of the Allowable Expenses incurred. In addition, no Plan will pay more benefits than it would normally provide without this special coordinating provision.

A "plan" is considered to be any group plan providing health care coverages on an insured or uninsured basis. This includes group BlueCross, BlueShield, labor-management trusteed governmental programs, No-fault auto insurance, or any other policy.

In the event the covered person has coverage under another employer-sponsored plan that provides health care benefits, there will be coordination of benefits regarding the health care reimbursement of this Plan.

This coordination will apply in the event a covered expense is incurred under this Plan, which also is covered under other programs. A determination will be made as to which plan is the "primary" plan. The method of determining which plan is "primary" is:

1. If the other plan does not have a coordination of benefits provision with regard the particular expense, it is the primary plan regardless of the following rules for such determination.

2. The plan that covers the patient as a current participant is the primary plan, regardless of the coordination of benefits provisions or other terms of another plan.

3. If the patient is a dependent child of parents not separated or divorced, then the plan covering the parent whose birth date falls earlier in the calendar year is the primary plan. If the parents have the same birthday, the plan that covered the parent longer shall be the primary plan. If the other plan does not use the birthday rule, then the plan that covers the father as a current participant is the primary plan, unless the primary plan is already determined by 1. or 2.

   When the parents of such dependent are separated or divorced, then the following rules apply:

   a) The plan which covers the parent, who has not remarried, with custody of the dependent, is the primary plan.

   b) If the parent of the dependent has remarried, the plan which covers the dependent as a dependent of the parent (or step parent) with custody is the primary plan.

   c) If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the dependent, the plan which covers the dependent as a dependent of the parent with such financial responsibility is the primary plan.

4. If the other plan has a provision that it is always secondary, then this Plan will be secondary in coordination with such plan, except as stated above.

5. If none of the above criteria establishes which plan is the primary plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the primary plan.

COORDINATION OF BENEFITS WITH MEDICARE

In general, this Plan pays benefits consistent with applicable Medicare Secondary Payer rules. If you are covered by this Plan as an Active Participant and this Plan is receiving employer contributions on your behalf, then this Plan will be primary and Medicare will be secondary, to the extent you are also entitled to coverage under Medicare. However, notwithstanding this general rule, this Plan will NOT be primary for any individuals (including eligible Active Participants) who:

- are age 65 and over and who have end stage renal disease and are, or would upon proper application be, entitled to benefit s under the Medicare End Stage Renal Disease Program.

However, this Plan will be primary and Medicare will be secondary for 30 months for eligible individuals under age 65 who have Medicare solely because of permanent kidney failure. Thereafter, Medicare will be primary. If you are age 65 and older with end stage renal disease, Medicare will be primary in accordance with applicable law. If you began to suffer from end stage renal disease before age 65, Medicare will be primary after the coordination period described in the regulations of the Department of Health and Human Services.

RECOVERY OF OVERPAYMENTS AND MISTAKEN PAYMENTS

In the event that you or a third party are paid benefits from the Fund in an improper amount or otherwise receive Fund assets not in compliance with the Plan (hereinafter "overpayments" or "mistaken payments"), the Fund has the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to you or to a third party. You, the third party, or the individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Fund with interest at 18% per year. This recovery may be made by reducing other benefit payments made to or on behalf of you or your dependents by commencing a legal action or by any other method the Trustees determine to be appropriate. You, the third party, or other individual or entity shall reimburse the Fund for attorney's fees, paralegal fees, court costs, disbursements and any expenses incurred by the Fund in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all participants and their covered dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all participants and covered dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or Injury or is otherwise responsible for your medical bills. The Trustees, in their sole discretion, may determine to not provide benefits under the Plan, for any participant who may have a third party responsible for the payment of benefits until a determination is made by the proper and final decision maker regarding the third party's responsibility to the participant. The rules in this section govern how the Fund pays benefits, if at all, in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Fund to pay your covered expenses until your dispute with the third party is resolved.

Second, the rules protect this Fund from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Fund must be reimbursed for the relevant benefits it has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

RIGHTS OF SUBROGATION AND REIMBURSEMENT

If you incur covered expenses for which a third party may be liable, you are required to so advise the Fund Office. By law, the Plan automatically acquires any and all rights which you may have against the third party.

The Trustees may, in their sole discretion, require the execution of this Plan's Reimbursement and Subrogation Agreement ("Agreement") by you (or your authorized representative, if you are a minor or you cannot sign) before this Plan pays you any benefits related to such expenses. The Plan's Agreement must be signed and returned to the Fund Office within forty-five (45) days of the date of the cover letter forwarding the Agreement. If the Trustees have required execution of the Plan's Agreement, no benefits will be provided unless you, your Spouse (if any) and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney, since that attorney must also execute the Agreement.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE REIMBURSEMENT AND SUBROGATION AGREEMENTS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHT OF SUBROGATION AND REIMBURSEMENT.

At the Plan's request, you must complete a form(s) which includes, but is not limited to the following information:

1. The details of your Accident or injury;

2. The name and the address of the person you claim caused the Accident or injury as well as the name and address of that person's insurance company and attorney; and

3. The name and address of your attorney.

You must also:

1. Sign the Fund's Agreement;

2. Have your attorney sign the Agreement and return it to the Fund Office before any benefits are paid;

3. Provide the Fund Office with quarterly reports regarding status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and

4. Promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Plan is a continuing one.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payment made on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party before any other expenses, including attorneys' fees and costs, are taken out of the payment regardless of how you or the Court characterize the nature of the recovery.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole". The Plan's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine. The Plan has no responsibility to contribute to the payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees have the right to disregard any findings, determinations, conclusions, or judgments regarding a third party action relating to your obligation to reimburse the Fund. The Trustees have the right to independently determine whether reimbursement is required and/or how the Fund receives the appropriate reimbursement or credit, including reduction of future benefits for you, your Spouse or dependents.

ASSIGNMENT OF CLAIM

You may not assign any rights or causes of action that you may have against any third-party tortfeasor without the express written consent of the Plan.

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Fund. If this Fund recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

Right of Future Subrogation and Reimbursement

In addition to satisfaction of the existing lien from any recovery by you, the Plan is also entitled to a future credit for future related expenses equal to the net proceeds received by you.

"Net proceeds" shall be defined as the amount of your total recovery and/or judgment less payment in full of the amount of the Fund's lien, less payment of your attorneys' fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses

arising out of or related to the injuries which were the subject of the third party action and which would have otherwise been covered by the Plan until the amount of said proceeds is exhausted.

It is only at that point that your further related Plan benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Administrator will determine the net proceeds available for a future credit.

Failure to Cooperate with Plan

You will be personally liable to the Plan for reimbursement owed to the Plan as well as for the Plan's attorney's fees and costs and we will discontinue your benefits if any of the following occurs:

1. You fail to tell the Plan that you have a claim against a third party;

2. You fail to assign your claim against the third party to this Plan when required to do so;

3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;

4. You fail to require any attorney you subsequently retain to sign the Plan's Reimbursement and Subrogation Agreement;

5. You and/or your attorney fail to reimburse the Plan;

6. You fail to provide the Plan with medical or other authorization to obtain the necessary information; or

7. You or your attorneys fail to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount you owe from any future claims submitted by you as well as by your dependents and beneficiaries and/or will discontinue benefits to you, your dependents and beneficiaries, or, if necessary, take legal action against you. The Plan may also recover the amount you owe from your Personal Account Plan. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien.

Section VII. Protected Health Information

This Section describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

A Federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your Protected Health Information ("PHI") effective April 14, 2004. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which will be distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official, Mark A. Capone.

This Plan and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the I.B.E.W. Local 910 Welfare Fund), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

(a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a Participant's claim);

(b) coordination of benefits;

(c) adjudication of health benefit claims (including appeals and other payment disputes);

(d) subrogation of health benefit claims;

(e) COBRA contributions;

(f) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) billing, collection activities and related health care data processing;

(h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m) reimbursement to the plan.

"Health Care Operations" include, but are not limited to, the following activities:

(a) quality assessment;

(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

(d) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(e) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(f) business management and general administrative activities of the Plan, including, but not limited to:

(1) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements

(g) resolution of internal grievances; and

(h) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the I.B.E.W. Local 910 Welfare Fund who assist in the Plan's administration and the Board of Trustees of the I.B.E.W. Local 910 Welfare Fund will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not to use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not to use or disclose the information for employment related actions and decisions unless authorized by you; (d) not to use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

If a breach of your unsecured health information (PHI) occurs, the Plan will notify you.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact Mark A. Capone, the Fund's Privacy Official, if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

The Plan Sponsor will:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information;

(d) report to Plan any security incident of which it becomes aware concerning electronic protected health information; and

(e) appoint Mark A. Capone as the HIPAA Security Official.

Section VIII. Technical Details

(As required by the Employee Retirement Income Security Act of 1974)

1. **PLAN NAME:** I.B.E.W. Local 910 Welfare Fund.

2. **EDITION DATE:** This summary plan description is produced as of January 1, 2020.

3. **PLAN SPONSOR:** Board of Trustees of I.B.E.W. Local 910 Welfare Fund.

4. **PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 16-6053626.

5. **PLAN NUMBER:** 501 (assigned by Federal government)

6. **TYPE OF PLAN:** Welfare Plan

7. **PLAN YEAR ENDS:** June 30.

8. **PLAN ADMINISTRATOR:** Board of Trustees of the I.B.E.W. Local 910 Welfare Fund, 25001 Water Street, Watertown, New York 13601.

9. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Mr. Mark A. Capone, Plan Manager, 25001 Water Street, Watertown, New York 13601.

   In addition to the person designated as agent of service of legal process, service of legal process may also be made upon any Plan Trustee.

10. **TYPE OF PLAN ADMINISTRATION:** Direct employees of the Board of Trustees.

11. **TYPE OF FUNDING:** As further described in this SPD, some benefits are insured; some are self-insured.

12. **SOURCES OF CONTRIBUTIONS TO PLAN:** Employers required to contribute to the I.B.E.W. Local 910 Welfare Fund, certain benefit funds with whom this Fund has reciprocal agreements, and, in certain circumstances, participants.

13. **COLLECTIVE BARGAINING AGREEMENTS:** This Plan is maintained in accordance with collective bargaining agreements. A copy of these agreements may be obtained by you upon written request to the Plan Manager and is available for examination by you at the Fund Office.

14. PARTICIPATING EMPLOYERS: You may receive from the Plan Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address. A complete list of the employers sponsoring the Plan may be obtained by you upon written request to the Plan Manager, and is also available for your inspection at the Fund Office.

15. PLAN BENEFITS PROVIDED BY: The I.B.E.W. Local 910 Welfare Fund and the Union Labor Life Insurance Company.

16. THIRD-PARTY ADMINISTRATOR: Excellus BlueCross BlueShield, Attn: Group Claims, P.O. Box 21146, Eagan, MN 55121-14692, Customer Care telephone number: 1-800-499-1275 or 1-800-662-1220 for TTY, website: www.excellusbcbs.com/IBEW910.

17. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: See Sections I. & II. of this booklet.

18. HOW TO FILE A CLAIM: See Section VI. of this booklet.

19. REVIEW OF CLAIM DENIAL: See Section VI. of this booklet.

20. NO INSURANCE UNDER THE PGBC: Since this Plan is not a defined benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

21. TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees. The following are the individual Trustees that make up the Board as of January 1, 2020.

Employer	***Union***
Leo J. Villeneuve S & L Electric, Inc. Route #1 Colton, NY 13625	Andrew VanTassel 603 Main Street Morristown, NY 13664
Joel J. Bovee J&R Electric, Inc. 15685 County Route 91, PO Box 767 Pierrepont Manor, NY 13674	Steven P. Young c/o IBEW Local 910 25001 Water Street Watertown, NY 13601
Curtis M. Hammond PO Box 383 Ogdensburg, NY 13669	John T. O'Driscoll IBEW Local 910 25001 Water Street Watertown, NY 13601

EXHIBIT A

Special Provisions Involving I.B.E.W. Local 910 Welfare and I.B.E.W. Local 910 Annuity Funds Contributions

Notwithstanding any other provisions in the parties' Collective Bargaining Agreement to the contrary, the parties agree that the I.B.E.W. Local 910 Welfare Fund ("Welfare Fund") and I.B.E.W. Local 910 Annuity Fund ("Annuity Fund") employer contributions shall be tendered to the Fund Office in the aggregate amount specified in this Collective Bargaining Agreement. The Plan Manager at the Fund Office shall then allocate the aggregate contributions into the Welfare Fund and Annuity Fund based upon the below-referenced rationale. The aforementioned allocation shall occur while such aggregate employer contribution is being held by the Plan Manager in escrow pending such allocation, the employer contribution does not become a Plan asset of the Welfare Fund and/or the Annuity Fund until such allocation is made by the Plan Manager. The parties agree that in the event either the Boards of Trustees of the Welfare Fund and/or the Annuity Fund elect not to participate in the aforementioned allocation process, then the contributions provided for in the Collective Bargaining Agreement shall be tendered to and received by the Welfare and Annuity Funds without such allocation as described herein.

The contractor shall contribute the respective amounts specified in the Collective Bargaining Agreement to the Welfare Fund and Annuity Fund and those contributions shall be aggregated and allocated according to the following formula regarding a participant's account balance in the IBEW Local 910 Welfare Fund. The method used to determine a participant's account balance requirement will be dictated by the participant's status, either family or individual. Opted out participants will be classified as individuals for this determination.

Tier A: For family participants with an account balance of less than one year of family premiums, or individual participants with an account balance of less than one year of individual premiums, 85% of the Annuity Fund contribution shall be distributed to the Welfare Fund in addition to the established Welfare Fund contribution.

Tier B: For family participants with an account balance greater than one year but less than three years of family premiums, or individual participants with an account balance greater than one year but less than three years of individual premiums, the established contributions for the Welfare Fund and Annuity Fund shall apply.

Tier C: For family participants with an account balance greater than three years but less than five years of family premiums, or individual participants with an account balance greater than three years but less than five years of individual premiums, 35% of the Welfare Fund contribution shall be distributed to the Annuity Fund in addition to the established Annuity Fund contribution.

Tier D: For family participants with an account balance greater than five years of family premiums, or individual participants with an account balance greater than five years of individual premiums, 85% of the Welfare Fund contribution shall be distributed to the Annuity Fund in addition to the established Annuity Fund contribution.

The Boards of Trustees of the Welfare and/or Annuity Funds have the right to not participate in the aforementioned allocation protocol and in its place allocate into the appropriate Funds the employer contributions required notwithstanding the aforementioned allocation protocol.

Exhibit B
Retiree Health Personal Account Plan

A retiree's PAP balance is transferred from the Active Participant PAP to this Retiree PAP Plan upon retirement under the I.B.E.W. Local 910 Pension Plan. The Retiree PAP will be administered under the rules set forth above in the Summary Plan Description to the extent not modified by this Exhibit. No benefit in this Plan is "vested" in any participant.

Once you become a participant in the Retiree PAP Plan, you may use your account for the reimbursement of eligible health care expenses incurred by you, your spouse, or your eligible dependents. Eligible health care expenses include those expenses defined in Section 213(d) of the Internal Revenue Code (as described in IRS Publication 502) as approved by the Trustees. You can find a copy of this publication on www.irs.gov. The Retiree PAP may be utilized to purchase group or individual health insurance premiums.

No more will be paid out to you (or your beneficiary) under this Plan than has come into your PAP. Under no circumstances may any money be drawn from your account once the level of your account has reached zero.

Your eligible dependents are the same as those listed in the Summary Plan Description.

You may opt-out of the Retiree PAP at any time. However, if you opt-out, you will permanently forfeit your account balance.

Upon their loss of eligibility for benefits, your dependent children will be able to continue coverage under this PAP Plan for up to 36 months by electing COBRA Continuation Coverage and paying a COBRA premium. If you divorce, your spouse will also have the ability to purchase COBRA Continuation Coverage for up to 36 months.

If you die and still have a balance in your Retiree PAP, your spouse and other eligible dependents may continue to apply for reimbursement of eligible health care expenses until your account is exhausted. If you die and do not have a spouse or any other eligible dependents, any balance remaining in your Retiree PAP will be forfeited.

If you return to Covered Employment, your participation under the Retiree Personal Account Plan will be immediately terminated and your account balance will be transferred to the Active Participant PAP Plan. YOU MUST NOTIFY THE FUND IN ADVANCE OF ANY RETURN TO COVERED EMPLOYMENT.