I.B.E.W. Local 910 Welfare Fund
25001 Water Street, Watertown, New York 13601
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January 1, 2020

Dear Participant of the Plan for Medicare-Eligible Retirees:

This booklet is a description of the I.B.E.W. Local 910 Welfare Fund Plan for Medicare-Eligible Retirees, in effect on January 1, 2020. 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:

Section I.	Eligibility Requirements
Section II.	Description of Benefits
Section III.	Protected Rights for Continuing Coverage
Section IV.	Qualified Medical Child Support Order
Section V.	Your Rights Under ERISA
Section VI.	Claim Procedure
Section VII.	Protected Health Information
Section VIII.	Technical Details

The Plan is governed by a Board of Trustees of which half represents the former employees and half represents the participating employers. Our role, as Trustees of the Welfare Fund, includes the responsibility for administering the Plan for Medicare-Eligible Retirees.

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. To the extent there is any conflict between the terms of this SPD and the terms of the applicable insurance policy, the insurance policy terms control. 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.

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

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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.**
- **All claim forms must be completely filled in; incomplete claims will be returned.**

Plan Change or Termination

The Trustees reserve the right 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 pensioners and their dependents. It also includes the circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits that a pensioner or dependent might otherwise reasonably expect a plan to provide.

The benefits and eligibility rules applicable to pensioners 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 pensioners and dependents is reserved by the Trustees in accordance with the Restated Agreement and Declaration of Trust. The continuance of benefits for pensioners 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 pensioner or dependent has a vested right or contractual interest in the benefits provided. In addition to the right to terminate benefits of pensioners 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 pensioners and/or dependents and there shall not be any vested right by any pensioner, dependent, or beneficiary nor contractual rights after the disposition of plan assets in connection with the termination of this Plan. The provisions for pensioners' and dependents' coverage shall be reviewed periodically by the Trustees.

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 Fund Plan for Medicare-Eligible Retirees.

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 were made to the personal account plan. A portion of such contributions were credited to a personal account based on your Covered Employment.* The Trustees determined the portion of these contributions that were credited to your personal account before you retired.

Your account grew before your retirement with all the contributions that were made to it. Your account 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 was deposited 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 were made to the Plan for you and the contributions could not be used and/or were insufficient to satisfy the eligibility requirements, such contributions were forfeited and used for Plan administrative costs. Likewise, if there was no activity (for example, payment of benefits) in your account for a consecutive two-year period, the balance in your account was forfeited and used for Plan administrative costs.

**Covered Employment. Covered Employment means work, prior to your retirement, for which your employer was required to contribute to the I.B.E.W. Local 910 Welfare Fund because of a collective bargaining agreement or because your employer had 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, also counted as Covered Employment.*

B. GENERAL ELIGIBILITY REQUIREMENTS

1. I.B.E.W. Local 910 Pensioners. If you are retired under the Local 910 Pension Plan, you will be eligible for coverage under this Plan for Medicare-Eligible Retirees 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:

a. 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

b. 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

c. 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 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.

To qualify for the Health Care Benefit Medicare Supplement Plan, you must also be enrolled in both Parts A and B of Medicare.

Your coverage will continue until the earlier of the following:

- the date you cease making timely self-payment;
- the date the Welfare Plan ceases;
- the date the Plan ceases coverage for the class of covered persons for which you belong;
- the date of your death; or

- the date you choose to end coverage under the Plan and select alternate coverage.

Your eligible dependents will also remain covered, provided:

- you remain eligible for pension benefits under the I.B.E.W. Local 910 Pension Plan; and

- they continue to remain an eligible dependent (as defined in Section C).

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.

Active employees who are receiving a pension benefit from the Local 910 Pension Plan but have not retired from covered employment must satisfy the eligibility requirements for active participants, as outlined in the separate Summary Plan Description for Active Participants. They are not covered as pensioners as long as they are still working.

Loss of Eligibility and Benefits. 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

Eligible dependents are your lawful spouse and your unmarried children (defined below) who are under the age of 26.

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:

- 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.

3. Disabled Dependent Child. If your covered dependent child is totally disabled, coverage may be continued beyond age twenty-five (25). 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 nineteen (19).

The Plan Manager may require, at reasonable intervals during the two years following the dependent's 19th 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 only, your dependents may include other people as allowed by the Internal Revenue Code, such as your brother, sister or parent. However, you must pay for over one-half of the person's support. 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 pensioner or a dependent at any one time. If conditions so warrant, you may change your status from pensioner to dependent or dependent to pensioner.

If a married couple are both pensioners, 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". The only Special Allocation that applies to this Plan is the "**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 a retired participant and your coverage is terminated because you did not self-pay in a timely manner, you may not reinstate your coverage.

F. SPECIAL ENROLLMENT RIGHTS

This group health plan will permit a dependent of a retiree, if the dependent is eligible but not enrolled for coverage, to enroll for coverage under the terms of this Plan if either of the following conditions are met:

Termination of Medicaid or CHIP Coverage. The dependent is covered under a Medicaid plan or under a State child health insurance plan (CHIP) and the coverage of the dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee 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 dependent becomes eligible for premium assistance through Medicaid or CHIP and the retiree requests coverage under this plan not later than 60 days after the dependent is determined to be eligible for such assistance.

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 procedure for making claims with related limitations and/or exclusions are covered in Section VI. For purposes of this Section, the Health Reimbursement Account Health Expense Benefit is reimbursement coverage. Each of the benefits described in this Section 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 summary of the benefits available under this Plan, the covered persons receiving each benefit, and brief information regarding each benefit. A detailed Schedule of Benefits is also included in this Section II.

Type of Benefit	Covered Persons	Benefit
Health Care Benefit	– Medicare-eligible Pensioners – Medicare-eligible Dependents	Self-insured Medicare Supplemental Benefit
Prescription Drug Benefit	– Medicare-Eligible Pensioners & Their Medicare-Eligible Dependents	The Fund will reimburse Medicare Part D premiums quarterly up to $750.00 per calendar year per family unit.
Health Expense Benefit	– Pensioners – Dependents	Reimbursement from your account for health care expenses.

A. HEALTH CARE BENEFIT

Coverage Options

Medical Benefits consist of the Medicare Health Care Benefit and the Prescription Drug Benefit. To elect coverage, you must complete and return an enrollment form, which will be sent to you by the Fund Office.

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 benefit under any other plan of health care benefits in which you or your spouse are enrolled.

HEALTH CARE BENEFIT
SCHEDULE OF BENEFITS

Applies to: retirees, COBRA beneficiaries, and their dependents. Enrollment in Medicare Part A and Part B is required to receive benefits from this Plan.
Claims must be filed within 180 days after the claim is processed by Medicare or the claim will be denied. Any service that is not covered by Medicare will not be covered under this Medicare Supplement Plan for Retirees.
The following chart illustrates how the Plan fills the major benefit gaps in Medicare Part A and B:

MEDICARE SUPPLEMENT PLAN FOR RETIREES				
SERVICE	**BENEFIT**	**MEDICARE PAYS**	**EXCELLUS BCBS PAYS**	**YOU PAY**
Part A Hospitalizations Semi-private room and board, general nursing, miscellaneous Hospital services and supplies, includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services	First 60 days 61st – 90th day 91st – 150th day Beyond 150 days	All but Part A deductible All but Medicare copayment amount for each day All but Medicare copayment for each day Nothing	Part A deductible Medicare copayment amount for each day Medicare copayment amount for each day 365 lifetime reserve days	Nothing Nothing Nothing Nothing
Post-Hospital Skilled Nursing Care In a facility approved by Medicare, you must have been in a Hospital for at least three consecutive days and enter the facility within 30 days after the Hospital discharge	First 20 days Additional 80 days Beyond 100 days	100% of cost All but Medicare copayment amount for each day Nothing	Nothing Medicare copayment amount for each day Nothing	Nothing Nothing All
Blood		100% of costs except non-replacement fees (blood deductible) for first three pints in each benefit period	Reasonable cost of first three (3) pints in each calendar year	Nothing

Included in the chart below are examples of services covered under the Medicare Supplement Plan for Retirees. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service. Any service not covered by Medicare will not be covered under the Medicare Supplement Plan for Retirees.

MEDICARE SUPPLEMENT PLAN FOR RETIREES	
TYPE OF SERVICE	**BENEFIT** This Plan only pays benefits on the balance remaining after Medicare has already made its payment.
Hospital – Inpatient Care	
- Semi-private room & board (An additional 365 days are available provided there is a 90 day separation between date of discharge & date of readmission)	Paid in full
- Inpatient Mental Illness treatment	Paid in full
- Use of operating, recovery, intensive care, cystoscopic rooms & equipment	Paid in full
- X-ray & laboratory services – including all blood chemistry & pathological services	Paid in full
- Drugs and medications administered while inpatient	Paid in full
- Dressings, ordinary splints and plaster casts	Paid in full
Hospital – Outpatient Care (at the Hospital)	
- Emergency room medical/accidental Injury	Paid in full
- Minor surgical procedures	Paid in full
- Pre-admission testing	Paid in full
- X-rays, laboratory & other diagnostic tests	Paid in full
- Kidney dialysis	Paid in full
- Radiation therapy	Paid in full
- Physical therapy	Paid in full
- Speech therapy	Paid in full
Outpatient Care (other facility care)	
- Skilled nursing facility	Paid in full
- Home health care	Paid in full
- Inpatient Substance Abuse treatment	Paid in full
- Outpatient Substance Abuse treatment	Paid in full
- Hospice Care	Paid in full
Maternity Benefits	
- Delivery	Paid in full
- Routine nursery care (while mother is hospitalized)	Paid in full

Included in the chart below are examples of services covered under the Medicare Supplement Plan for Retirees. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service. Any service not covered by Medicare will not be covered under the Medicare Supplement Plan for Retirees.

MEDICARE SUPPLEMENT PLAN FOR RETIREES	
TYPE OF SERVICE	**BENEFIT** This Plan only pays benefits on the balance remaining after Medicare has already made its payment.
Physician Services	
- Doctor's office visits	Paid in full
- Surgical procedures	Paid in full
- Assistant surgeon	Paid in full
- General anesthesia	Paid in full
- Inpatient Hospital medical visits	Paid in full
- Mental Illness care visits	Paid in full
- Inpatient Hospital consultations	Paid in full
- Maternity care	Paid in full
- Delivery of newborn	Paid in full
- Diagnostic x-rays – out of Hospital	Paid in full
- Radiation therapy – out of Hospital	Paid in full
- Electrocardiographic examinations	Paid in full
- Special examinations & procedures	
• Pap smears	Paid in full
• Hemodialysis	Paid in full
- Second surgical opinions – board certified specialist, initial consultation, intermediate	Paid in full
Emergency Care in a Foreign Country	80% after a $250 calendar year deductible up to a $50,000 lifetime maximum. Emergency care must be Medically Necessary and begin within the first 60 consecutive days of the trip outside the United States.

DEFINITIONS

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.

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, treatment of Mental Illness or Substance Abuse, 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

6. It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

Additionally, the following institution will qualify under this definition:

7. 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 by the Accreditation Association 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. Appropriate for the symptoms and diagnosis or treatment of the participant's or dependent's Injury or Sickness, and

2. Provided for the diagnosis or the direct care and treatment of the participant's or dependent's Injury or Sickness, and

3. Provided in accordance with standards of good medical practice, and

4. Not primarily for the convenience of a participant, dependent, or the Provider, and

5. The most appropriate supply or level of service that can safely be provided to the participant or dependent. When applied to an inpatient hospitalization for the treatment of Mental Illness, Substance Abuse, and admissions to a behavioral health care facility, a convalescent/skilled nursing facility or rehabilitation facility, this further means that the participant or dependent requires acute care as a bed patient due to the nature of the services provided or the participant's or dependent's condition, and the participant or dependent cannot receive safe or adequate care as an outpatient or in another less costly setting.

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.

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.

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.

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.

DETAILED DESCRIPTION OF BENEFITS

The Medicare Supplement Plan for Retirees is intended to supplement Medicare benefits only. You must be enrolled for both Part A and Part B of Medicare in order to be eligible for benefits. Any service or supply that is not covered under Medicare is not covered under the Medicare Supplement Plan for Retirees.

The Plan only makes payment decisions based on the benefits provided. It is the responsibility of the patient and the attending physician to decide whether treatment should be rendered regardless if the services are totally or partially covered, or excluded from coverage under the Plan. The Plan does not and cannot make treatment decisions. The Plan does not select or take any responsibility for the proper or improper performance of any Health Care Provider.

The Plan will pay benefits for Medically Necessary expenses subject to deductibles, coinsurance, maximums, and any limitations, as shown in the Schedule of Benefits for Retirees and elsewhere in this document. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service. Any service not

covered by Medicare will not be covered under the Medicare Supplement Plan for Retirees, except where noted. Covered services include:

1. **MEDICARE PART A DEDUCTIBLES AND COPAYMENTS**: When you have been hospitalized and have received benefits under Part A of Medicare for that hospitalization, this Plan will pay the following deductibles and copayments, which are left as balances after Medicare has made its payment:

   a. Medicare's Part A deductible in each benefit period;

   b. The copayment amount for the 61st through 90th day of each benefit period;

   c. The copayment amount for the Medicare 60 lifetime reserve Hospital days.

   A benefit period begins when you enter a Hospital. Successive stays in one or more Hospital or skilled nursing facility count as one benefit period unless 60 days or more elapse between the day of discharge and the next admission. When you enter a Hospital after 60 days have elapsed since the last discharge from the Hospital or skilled nursing facility, a new benefit period starts.

   The Medicare Part A deductible amount usually increases each year. The Plan will pay the deductible even though it increases.

2. **ADDITIONAL HOSPITAL DAYS**: During a benefit period, if you have used all your Medicare Hospital days, including your Medicare lifetime reserve days, then the Plan will pay for additional days of inpatient Hospital care in the same benefit period. The Plan will only pay for such additional days if, in the Plan's judgment, it is Medically Necessary for you to be hospitalized. The Plan will not pay for more than 365 of such additional days in your lifetime. The Plan's payment for each such additional day of inpatient care will be limited to:

   a. Those kind of expenses that would have been paid under Medicare, and

   b. Only when you are hospitalized in a short term acute care general Hospital that either qualifies under Medicare or is accredited by the Joint Commission on Accreditation of Health Care Organizations, and

   c. Only when Medicare would have made payment if you had not used all your Medicare days.

3. **BLOOD DEDUCTIBLE UNDER MEDICARE**: The Plan will pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Part A or Part B of Medicare each year, unless the blood is replaced in accordance with federal regulations.

4. **POST-HOSPITAL SKILLED NURSING FACILITY CARE**: When you are confined in a skilled nursing facility following hospitalization and you receive benefits under Part A of Medicare for that confinement, this Plan will pay the copayment amount from the 21st day through the 100th day in each benefit period.

   The copayment amount for skilled nursing facility care under Part A of Medicare usually increases each year. The Plan will pay the copayment even though it increases.

5. **PART B DEDUCTIBLE AND COINSURANCE**: When Medicare pays for a service covered under Part B of Medicare, the Plan will pay the deductible and coinsurance, if any, based on Medicare's allowed amount. If Medicare pays 100% of the allowed amount covered under Part B or Medicare pays nothing for any service, the service will not be reimbursed under this Plan. Under no circumstances will this Plan make any payments for the difference between the Medicare allowed amount and the actual charge for the service.

6. **MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**: The Plan will pay for Emergency care in a foreign country under the following terms and conditions:

   a. 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.

   b. After the eligible participant or dependent satisfies a $250 calendar year deductible, the Plan will pay 80% of billed charges for those expenses for Medically Necessary Emergency Hospital, physician and medical care in a foreign country which would have been covered under Medicare if the participant or dependent had received the care within the United States.

   c. The Emergency care must begin within the first 60 consecutive days of each trip outside the United States.

   d. Payments for Emergency care under this provision are subject to a lifetime maximum of $50,000.

   e. If Medicare pays for any service that is rendered outside the United States, this Plan will only base its payment on the balance left over after Medicare has made its payment.

B. PRESCRIPTION DRUG BENEFIT

Medicare-Eligible Retirees and their Dependents: The Plan will reimburse your Medicare Part D premiums quarterly, up to $750.00 per calendar year per family unit. (This benefit is administered by the Fund.)

C. HEALTH EXPENSE BENEFIT

The Health Expense Benefit is available to eligible pensioners pursuant to the Retiree Health Personal Account Plan. 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. Any reimbursement is subject to Section 213(d) of the Internal Revenue Code and applicable IRS rules and guidance.

These expenses may include, but are not limited to expenses incurred for dental care, eye care, and hearing aids. 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 and 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. Retirees are not required to maintain a minimum balance in order to use this benefit. The Retiree Personal Account Plan "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.

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

If you return to employment with any employer who is obligated to make contributions to the I.B.E.W. Local 910 Welfare Fund, your participation under the 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.

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.

Section III. Protected Rights for Continuing Coverage

In some circumstances, it may be possible for your dependents to continue coverage under this Plan even when your coverage would have otherwise terminated. This section contains important information about your family's right to COBRA Continuation Coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances where coverage would otherwise end. The section generally explains COBRA Continuation Coverage, when it may become available to your family, and what you need to do to protect the right to receive it. Please read this information carefully.

When is COBRA Continuation Coverage Available?

COBRA Continuation Coverage is a continuation of the Plan for Retirees coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event is properly provided to the Plan Manager, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." Your spouse and your dependent children (including any child covered pursuant to a Qualified Medical Child Support Order ("QMCSO")) could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for such coverage.

There may also be alternative health insurance coverage options for your family other than purchasing COBRA coverage from this Plan. The Affordable Care Act Health Insurance 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 than COBRA coverage, there is a new kind of tax credit that lowers monthly premiums right away. Information about the Marketplace can help a person see what their premium, deductibles, and out-of-pocket costs will be before they make a decision to enroll. Being eligible for COBRA does not limit eligibility for coverage for a tax credit through the Marketplace. However, please note that an HRA balance will disqualify you from eligibility for tax credits. In addition to the options available from the Marketplace, a person may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which they are eligible (such as a spouse's plan). Even if the other plan generally does not accept late enrollees, they may still qualify if they

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.

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; or

2. divorce or judicial order of legal separation.

If your spouse has a COBRA Qualifying Event as a result of your death, 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.

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

3. the child ceases to qualify as an "eligible dependent" under this Plan.

If your dependent child has a COBRA Qualifying Event as a result of your death, 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.

You Must Give Notice of a Qualifying Event.

You or your qualified beneficiaries must inform the Plan Manager of your death, divorce, judicial order of legal separation, or your child's loss of status as an eligible dependent. To do this, you or your qualified beneficiaries must use the Fund's "Participant's Notice to Plan Manager" form, which can be obtained from the Fund Office. 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 Plan Manager within the time limits may result in your ineligibility for COBRA continuation coverage. The notice should be sent to:

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

After the Plan Manager receives notice of the occurrence of one of the above qualifying events, the Fund 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 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 coverage has terminated. You can also request this information at any time by contacting the Plan Manager at the above address.

How is COBRA Continuation Coverage Elected?

Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the COBRA Election Notice will lose his or her right to elect COBRA Continuation Coverage.**

If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. However, the qualified beneficiary may change his or her election within the 60-day period described above as long as the completed COBRA Election Form is received by the Plan

Manager on or before the due date. If the qualified beneficiary changes his or her mind after first rejecting COBRA continuation coverage, the qualified beneficiary's COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the election is hand-delivered, the qualified beneficiary's COBRA continuation coverage will begin on the date of delivery.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to, and is actually enrolled in, Medicare benefits or becomes covered under another group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Please note that if the qualified beneficiary is enrolled in Medicare and elects COBRA Continuation Coverage at a time when he or she is not actively employed, COBRA Continuation Coverage will be secondary to Medicare.

If the qualified beneficiary elects COBRA Continuation Coverage, the qualified beneficiary will be entitled to the same health coverage that he or she had when the event occurred that caused his or her health coverage under the Plan to end. The qualified beneficiary will be required to pay for the full cost of such coverage. In addition, if there is a change in the health coverage provided by the Plan to similarly-situated active participants and their families, the same change will be made to the qualified beneficiary's COBRA Continuation Coverage.

How is the COBRA Continuation Coverage Premium Paid?

The amount that your covered spouse and/or dependent children will be required to pay for COBRA Continuation Coverage will be payable monthly. The Plan charges the full cost of coverage for similarly situated participants and beneficiaries who have not lost coverage under the Plan, plus an additional 2% (for a total charge of 102%).

The Fund Office will notify the qualified beneficiary of the cost of the coverage and of any monthly COBRA premium charges at the time the qualified beneficiary receives his or her notice of entitlement to COBRA Continuation Coverage. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Your first payment for COBRA Continuation Coverage does not have to be sent with the COBRA election form. However, the first payment must be made no later than 45 days after the date of the COBRA election. (This is the date that the Election Notice is post-marked, if mailed). Coverage will not be effective until payment is received. **Failure to make the first payment for COBRA Continuation Coverage in full within 45 days after the date of the COBRA election will result in the loss of all COBRA Continuation Coverage rights under the Plan. Once COBRA Continuation rights are terminated, they cannot be reinstated.**

After the first payment is received, payments are due on the first day of each month. There will then be a grace period of 30 days in which to make the payment. Please note that the qualified beneficiary's coverage will be suspended and claims will not be paid until a payment is made to the Fund Office. However, once payment is received, your coverage will be reinstated retroactive to the first day of the month.

If payment of the applicable COBRA Continuation Coverage premium is not made by the end of the applicable grace period, COBRA Continuation Coverage will terminate. Once COBRA Continuation rights are terminated, they cannot be reinstated.

What is the Duration of COBRA Continuation Coverage?

COBRA Continuation Coverage is available for your eligible spouse and dependent children as follows:

COBRA Continuation Coverage is available if coverage would otherwise be lost because:	For up to:
Your dependent child ceases to be eligible for coverage under the Plan	36 months from the date the child becomes ineligible under the terms of the Plan
You divorce or legally separate by Court Order from your spouse	36 months for your spouse and eligible dependent children from the date of divorce or legal separation
You die	36 months for your spouse and eligible dependent children from the date of your death

What Happens When COBRA Continuation Coverage Ends?

Once COBRA Continuation Coverage has been elected, it may be terminated prior to the exhaustion of the 36-month COBRA Continuation Coverage period as a result of the occurrence of any of the following events:

- The premium for coverage is not paid in a timely manner;
- The Plan ceases to provide group health coverage for any retirees;
- After electing COBRA Continuation Coverage, the qualified beneficiary becomes covered by another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have; and/or
- After electing COBRA Continuation Coverage, the qualified beneficiary enrolls in Medicare.

Keep the Plan Informed of Address Changes.

To protect your and your family's rights, the qualified beneficiary should keep the Plan Manager informed of any changes to his or her address and the addresses of family members. The qualified beneficiary should keep a copy, for his or her records, of any notices sent to the Plan Manager. The qualified beneficiary should send all notices to the Plan Manager at the address listed in the ***You Must Give Notice of a Qualifying Event*** paragraph above.

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

- **Receive Information About Your Plan and Benefits.** Examine, without charge, at the 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

  Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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 THE HEALTH CARE BENEFIT

All medical claims are processed by Excellus BlueCross BlueShield, a third-party administrator. 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 telephone number: 1-800-499-1275 or 1-800-662-1220 for TTY, , website: www.excellusbcbs.com/IBEW 910. You may also write to Excellus BlueCross BlueShield at:

Excellus BlueCross BlueShield
PO Box 21146
Eagan, MN 55121

HOW TO FILE A CLAIM

All claims must be submitted to Medicare first. Once Medicare has made its payment, then the claim may be submitted to Excellus BCBS. (The billing address is on the back of your insurance card.) Either the Provider or the participant or dependent must submit a claim form along with the "Explanation of Medicare Benefits" before reimbursement for an eligible expense can be paid. Claim forms are available at www.excellusbcbs.com/ibew910.

Claims must be submitted no later than 180 days after Medicare processes the claim. 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 participants 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. The "Explanation of Medicare Benefits" indicating what payment Medicare has made on the expenses, and

6. 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; and

7. When a participant or dependent is covered under another health plan besides Medicare and this Plan, and medical coverage under that other plan 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 BCBS reserves the right to pay either you or the provider.

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 excellusbcbs.com/IBEW910.

Submit claim forms to Excellus BCBS at:

Excellus BCBS
P.O. Box 21146
Eagan, MN 55121

Payments will be made to the provider unless the bills are marked "paid". When submitting claims, if you would like some payments to go directly to your health care provider and some to be paid directly to you, make separate submissions indicating where payment should be made.

If your union's name is not indicated on the claim, the claim will be returned to you or the provider for that information.

Send completed claim forms and bills to the appropriate address shown on the back of your identification card.

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 FOR THE PRESCRIPTION DRUG BENEFIT

The Plan will reimburse your Medicare Part D premiums quarterly, up to $750.00 per calendar year upon submission to the Fund Office of proof of your Medicare Part D premiums in a form satisfactory to the Fund.

CLAIM PROCEDURE FOR THE HEALTH EXPENSE BENEFIT

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

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.

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

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.

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 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 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. 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.

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.

All other appeals must be submitted to the Trustees within 180 days of your receipt of the adverse benefit determination.

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.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of

charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, all other appeals 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: 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, 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: 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.

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 Trustees' (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. You may not assign, convey, or in any way transfer your right to bring legal action against the Plan, or its Trustees, to anyone else.

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.

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 booklets 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 of 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 Employees, 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, both husband and wife are 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, your Retiree-Only Plan 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 only to the extent necessary to prevent any person from making a profit on his coverage. "Allowable

Expenses" are any necessary and reasonable expenses for medical services, treatment, or supplies, covered by one of the plans under which you or your dependents are covered.

A "plan" is considered to be any group plan providing health care coverages on an insured or uninsured basis. This includes group Blue Cross, Blue Shield, 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 employee 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 birthday rule stated in this plan shall govern unless the primary plan is already determined by 1 or 2 above.

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.

If this Plan is the second plan, it will pay its benefits as if there were no other such plan, except that this Plan will pay not more than 100% of the charge when the amount covered by this Plan and another plan(s) are added to the part(s) together.

COORDINATION OF BENEFITS WITH MEDICARE

Medicare is your primary plan. If there are covered charges remaining unpaid (that is, after Medicare has paid or would have paid), you will be reimbursed by this Plan up to the amount payable under the terms of this Plan. However, the total amount received from Medicare and the plan will never be more than 100% of your "allowable expenses". "Allowable Expenses" means any necessary, reasonable and customary item of expense for medical care and treatment of the type and kind covered under this plan.

When you become eligible for Medicare, you will be considered to be insured under Part A. and B. Medicare. This is regardless of whether or not you have registered for Part A. or enrolled for Part B. We suggest, therefore, that at least 3 months before you reach age 65 or 3 months before you receive your 24th Social Security disability pension payment, you contact your local Social Security Office. This is necessary in order to insure that as soon as you are eligible, you are adequately covered by Medicare, which includes both Part A. for Hospital coverage and Part B. for Medical expenses.

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 THE 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:

1. 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);

2. coordination of benefits;

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

4. subrogation of health benefit claims;

5. COBRA contributions;

6. risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. billing, collection activities and related health care data processing;

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

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

10. medical necessity reviews or reviews of appropriateness of care or justification of charges;

11. utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

12. 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

13. reimbursement to the plan.

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

1. quality assessment;

2. 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;

3. rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

5. 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;

6. business management and general administrative activities of the Plan, including, but not limited to:

    a. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements

7. resolution of internal grievances; and

8. 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:

1. 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;

2. 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;

3. 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;

4. report to Plan any security incident of which it becomes aware concerning electronic protected health information; and

5. appoint Mark A. Capone as the HIPAA Security Official.

Section VIII. Technical Details

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

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

1. PLAN NAME: I.B.E.W. Local 910 Welfare Fund Plan for Medicare Retirees.

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:** Self-insured.

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

16. **THIRD-PARTY ADMINISTRATOR:** Excellus BlueCross BlueShield, Attn: Group Claims, P.O. Box21146, Eagan, MN 55121, 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

Leo J. Villeneuve
S & L Electric, Inc.
Route #1
Colton, NY 13625

Joel J. Bovee
J&R Electric, Inc.
15685 County Route 91, PO Box 767
Pierrepont Manor, NY 13674

Curtis M. Hammond
PO Box 383
Ogdensburg, NY 13669

Union

Andrew VanTassel
603 Main Street
Morristown, NY 13664

Steven P. Young
c/o IBEW Local 910
25001 Water Street
Watertown, NY 13601

John T. O'Driscoll
IBEW Local 910
25001 Water Street
Watertown, NY 13601