I.B.E.W. Local 910 Welfare Fund
25001 Water Street, Watertown, New York 13601
Telephone: 315-782-5941
Toll Free: 800-801-2201
Facsimile: 315- 782-7343

A Guide To Your Plan Of Benefits

Summary Plan Description **Effective January 1, 2014**

I.B.E.W. Local 910 Welfare Fund

PLAN FOR ACTIVE PARTICIPANTS

I.B.E.W. Local 910 Welfare Fund
25001 Water Street, Watertown, New York 13601
Telephone: 315-782-5941
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January 1, 2014

Dear Participant:

This booklet is a description of the I.B.E.W. Local 910 Welfare Fund as it is in effect on January 1, 2014. There have been some changes in the Plan since the last booklet was written. We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

This booklet has eight sections:

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. Claims Procedure
Section VII. Protected Health Information
Section VIII. Technical Details

The Plan is governed by a Board of Trustees of which half represents the employees and half represents the participating employers. Our role, as Trustees of the Welfare Fund, includes the responsibility for collecting contributions (which are required by an agreement between your employer and Local 910 or between your employer and the Trustees).

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

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

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

Sincerely,

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

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret or extend or change in any way the provisions of insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. This booklet describes the Plan as it exists on January 1, 2014.

CAUTION

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

COMMUNICATIONS

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

NO GUARANTEE OF INCOME TAX CONSEQUENCES

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

GRANDFATHERED PLAN STATUS

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

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

Directory

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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.**

- **Make sure your Death Benefit beneficiary designation is up to date.**

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

Plan Change Or Termination

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

Benefits provided by the Plan:

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

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

Modification Of Benefits & Eligibility Rules

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

The benefits and eligibility rules applicable to employees 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 employees and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for employees 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 Agreement and Declaration of Trust.

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

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

Section I. Eligibility Requirements

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

A. IN GENERAL

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

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

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

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

Those individuals who engage in prohibited employment, as defined under the I.B.E.W. Local 910 Pension Plan, shall forfeit the Plan assets allocated into their then-existing Personal Account Plan to the general treasury of the Fund.

B. GENERAL ELIGIBILITY REQUIREMENTS

1. Active Employees. You will become a participant eligible for benefits on the first of the month following a month during which you work in *covered employment**.

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

You will remain covered until the earliest of the following events:

- the date your account balance is depleted or is insufficient to cover your Health Care Benefit premium for the month. Unless you are self-paying for the Health Care Benefit or the Trustees determine that there is a lack of sufficient covered employment, in that case, active bargaining unit employees will be allowed to run a deficit in their account of up to $1,500.00 [Please note that effective April 1, 2007, an individual may utilize the self-pay benefit as long as they are actively seeking employment through the I.B.E.W. Local Union 910's referral procedures.];

- the date the Welfare Fund ceases;

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

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

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

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

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

  - the date the Plan ceases.

The benefits for pensioners are described in a separate document called the Summary Plan Description for the Retiree-Only Plan. Please contact the Fund Office to receive a copy of this document. Active employees over age 70½ 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 above. They are not covered as pensioners in the Retiree-Only Plan as long as they are still working.

Loss of Eligibility and Benefits. The failure of an individual to cooperate and/or repay the Fund monies alleged by the Fund 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 Fund. The above-referenced loss of eligibility may include the individual's spouse and dependents.

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

domestic violence and/or self-inflicted injuries that are the result of depression or mental illness.

C. ELIGIBLE CLASSES OF DEPENDENTS

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

1. Spouse. The term "spouse" shall mean the person recognized as your husband or wife under the laws of the state of New York. The Plan Manager may require documentation proving a legal marital relationship.

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

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

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

3. Student. Effective July 1, 2011, coverage for a dependent child will no longer cease depending on the dependent's status as a student.

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

- incapable of self-sustaining employment by reason of mental retardation or physical handicap;

- primarily dependent upon you for support and maintenance;
- unmarried, and
- covered under the Plan when reaching age twenty-six (26).

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

5. Health Expense Benefit - Dependents. For the purpose of the Health Expense Benefit, your dependents may include other people, 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.

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

If both husband and wife are employees, their eligible dependent children will be covered as dependents of either the husband or the wife but not as dependents of both.

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

D. SPECIAL ALLOCATIONS

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

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

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

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

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

2. Financial Activity Allocation. When the Plan's financial activity permits, the Trustees may declare a bonus to be credited to eligible accounts. This will happen no more than once a year. In determining whether or not to declare this bonus and the amount of the bonus, the Trustees will take

into consideration the investment results on the Plan's assets, the expenses of administration of the Plan, the amount of any other allocations and reserve requirements for the future.

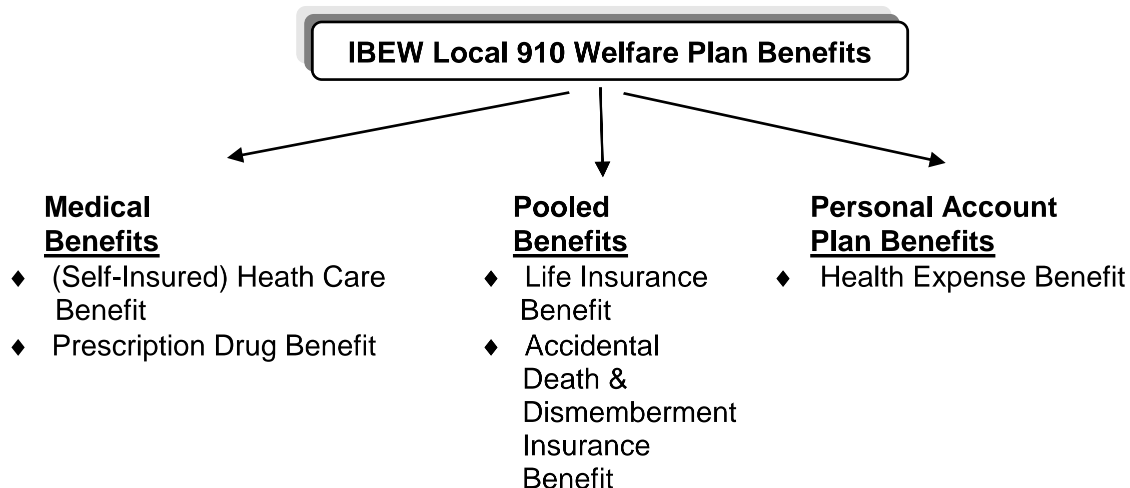
E. REINSTATEMENT AFTER TERMINATION OF ELIGIBILITY

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

Section II. Description Of Benefits

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

The Local 910 Welfare Fund offers the following benefits:



The Personal Account Plan Health Expense Benefit is reimbursement coverage.

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

The following table is intended to give you a quick reference to the benefits available under the Local 910 Welfare Fund. A detailed description of each benefit follows the table.

Type of Benefit	Covered Persons	Benefit
(Self-Insured) Health Care Benefit	– Active Participants & Their Dependents	Self-Insured - Third-Party Administrator – EBS-RMSCO, Inc. See separate booklet regarding the schedule of health care benefits administered by EBS-RMSCO, Inc., or the EBS-RMSCO, Inc. website: www.rsolutionz.com
Prescription Drug Benefit	– Active Participants & Their Dependents	80% * Administered by Sav-Rx. *Medicare-eligible dependents will not be covered by this Plan.
Life Insurance Benefit	– Active Participants	$10,000 – Pooled Benefit Insured by ULLICO
Accidental Death & Dismemberment Insurance Benefit	– Active Participants	Pooled Benefit Insured by ULLICO. Paid in accordance with schedule.
Health Expense Benefit	– Active Participants & Their Dependents	Reimbursement from your account for health care expenses.

Effective April 1, 2009, this group health plan will permit an employee who is eligible, but not enrolled, under the terms of the plan (or a dependent of such an employee if the dependent is eligible but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the Plan if either of the following conditions are met:

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

MEDICAL BENEFITS

Coverage Options

When you are eligible for the Medical Benefits, you will automatically receive coverage for yourself and your eligible dependents, including your spouse and children. Effective January 1, 2014, you will be entitled to waive Fund coverage for yourself if you confirm that you have group coverage sponsored by another employer that provides “minimum value.” An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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

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

You may change your Medical Benefits 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 martial 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.

A. HEALTH CARE BENEFIT

Active participants and dependents are eligible for the self-insured Health Care Benefit. This benefit is administrated by a third-party administrator, EBS-RMSCO, Inc. You should refer to the applicable booklet provided by EBS-RMSCO, Inc. for a schedule of health care benefits for participants and their dependents. You may also visit the EBS-RMSCO, Inc. website: www.rsolutionz.com. If for some reason, you do not have a copy of the EBS-RMSCO, Inc. booklet, please contact the Fund Office.

B. PRESCRIPTION DRUG BENEFIT

1. Benefit for Active Participants and Their Eligible Dependents.

Active participants and their eligible dependents will be covered under the Sav-Rx program. Prescription Drug costs will be paid 80% by the Plan , and the participant is responsible for the remaining 20%. Diabetic maintenance supplies are paid at 100%. This applies to prescriptions obtained through the mail order pharmacy and through network pharmacies.* (This benefit is administered by Sav-Rx.)

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

***Medicare-eligible dependents are not covered by this Plan.**

2. Covered Charges. Prescription drug charges will be covered, if:

- the prescription drug is purchased at a participating pharmacy;
- the prescription drug is prescribed by a physician who is licensed to do so;
- the prescription is not more than a 34-day supply (100-day supply for mail order program);
- the prescription is for a drug or device approved by the Food and Drug Administration; and
- diabetic supplies (insulin, insulin syringes and needles, Lancets and Lancet devices, blood glucose monitors, blood, ketone and urine testing strips).

The following items may be covered after receiving prior authorization;

- Desoxyn and Dexedrine are covered when medically necessary; and
- Retin-A after age 26, when medically necessary.

3. Exclusions. Your Plan excludes coverage for the following:

- contraceptive devices;
- durable or disposable medical supplies;
- immunizations;
- legend vitamins;
- medications for cosmetic purposes;
- self-administered injectables;
- replacement scripts, except insulin;
- over the counter (OTC) drugs which are lawfully obtainable without a prescription;

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

POOLED BENEFITS

These insurance benefits are provided out of the Fund's unallocated pooled assets and not out of your Personal Account Plan.

C. LIFE INSURANCE BENEFIT

You will be entitled to the Life Insurance Benefit if you are an Active Employee (as defined on page 4 of your Summary Plan Description) or are covered by a Participating Employer Contribution Agreement.

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

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

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

D. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT

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

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

The Accidental Death & Dismemberment Insurance Benefit is currently insured by the Union Labor Life Insurance Company. Please refer to the certificate of insurance provided by the Union Labor Life Insurance Company for a complete description of this benefit.

PERSONAL ACCOUNT PLAN BENEFITS

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

Those individuals who engage in prohibited employment, as defined under the I.B.E.W. Local 910 Pension Plan, shall forfeit the Plan assets allocated into their then-existing Personal Account Plan to the general treasury of the Fund.

The following benefit is available to you under the Personal Account Plan, if you are eligible.

E. HEALTH EXPENSE BENEFIT

The Health Expense Benefit is available to eligible active employees.

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

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

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

Section III. Protected Rights For Continuing Coverage

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

A. COBRA CONTINUATION COVERAGE

What is COBRA continuation coverage?

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

There are two parts to your coverage under the Plan: (1) your self-insured health care benefits administered by EBS-RMSCO, Inc.; and (2) your health reimbursement (Personal Account Plan) benefits. You, your spouse, and your dependents may elect COBRA continuation coverage for the health care benefits only or for both the health care benefits and the health reimbursement benefits.

Which employees are eligible for COBRA continuation coverage?

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of health care coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff or a loss of eligibility due to reduction of personal account. You may elect COBRA continuation coverage for the health care benefits only or for both the health care benefits and the health reimbursement account benefits. You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Personal Account. You will continue to have access to your Personal Account and to receive reimbursements from your Personal Account so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact your Personal Account can be used to pay the required COBRA premiums for health care benefits. If you lose coverage in this Active's plan because of retirement, you may elect COBRA coverage or coverage under the Retiree-Only Plan. However, election of one type of coverage is rejection of the other.

When is my spouse eligible for COBRA continuation coverage?

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

1. your death;

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

3. divorce or judicial order of legal separation; or

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

If your spouse has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your spouse may elect COBRA continuation coverage for the health care benefits only or for both the health care benefits and the health reimbursement account benefits. In this case, your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Personal Account. Your spouse will continue to have access to your Personal Account 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 Personal Account and to receive reimbursements from your Personal 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. your dependent child's loss of health care coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or a loss of eligibility due to reduction of Personal Account;

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

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

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

If your dependent child has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your dependent child may elect COBRA continuation coverage for the health care benefits only or for both the health care benefits and the health reimbursement account benefits. 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 Personal Account. Your dependent child will continue to have access to your Personal Account and to receive reimbursements from your Personal Account 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 Personal Account and to receive reimbursements from your Personal Account, your dependent child MUST elect COBRA continuation coverage and pay COBRA premiums.

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

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

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

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

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

After the Fund Office receives notice of the occurrence of one of the above qualifying events, it will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Fund Office will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverages has terminated.

When must the election be made?

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

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

What type of benefits are available in COBRA continuation coverage?

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

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

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage before January 1, 2015, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health care policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

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

How long does COBRA continuation coverage last?

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

1. the employer no longer provides group health coverage;

2. failure to pay the monthly premium on time;

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

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

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

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

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

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

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

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

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

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

How do I obtain a certificate of creditable coverage?

When your coverage ends prior to January 1, 2015 you and/or your covered dependents are entitled by law to, and will be provided with, a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time you and/or your dependent(s) were covered under the Plan (including, if applicable, COBRA coverage), as well as certain additional information required by law. This certificate may be necessary if you and/or your dependent(s) become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered dependents, a health care policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply to you and/or your covered dependents under the new group health plan or health care policy.

This certificate will be provided to you shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for you and/or your covered dependent(s) has ended. This certificate will also be provided once the Fund Office receives a request for this certificate, provided that the Fund Office receives the request within two years after the later of the date your coverage under this Plan ended or the date your COBRA coverage ended.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered dependents) elect COBRA coverage, another certificate will be sent to you (or to them if COBRA coverage is provided to them only) by first class mail shortly after the COBRA coverage ends for any reason.

Effective January 1, 2015, no group health plan will be permitted to impose a pre-existing condition limitation. Consequently, effective for separations after December 31, 2014, this Fund will no longer provide certificates of creditable coverage.

B. CONTINUATION OF COVERAGE FOR QUALIFIED MILITARY SERVICE

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

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

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

Overview

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

- ♦ The birth of the employee's child or placement of a child with the employee for adoption or foster care;
- ♦ Caring for the employee's parent, spouse, or child with a serious health condition; or
- ♦ Attending to the employee's own serious health condition.
- ♦ During FMLA leave, employers must provide employees continued health plan coverage at the same level that would have been in effect had the employee continued to work.

Interaction of FMLA with COBRA

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

Circumstances under which qualifying event occurs

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

- ♦ The employee (or spouse or dependent child) is covered by the employer's group health plan on the day before the first day of FMLA leave (or became covered during FMLA leave).
- ♦ The employee does not return to work before the FMLA leave ends.
- ♦ The employee (or spouse or dependent child) loses coverage under the group health plan before the end of the maximum coverage period.

Section IV. Qualified Medical Child Support Order

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

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

Section V. Your Rights Under ERISA

As a participant in the I.B.E.W. Local 910 Welfare Fund you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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

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

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

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

  Prior to January 1, 2015, if you have creditable coverage from another plan, you should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. After December 31, 2014, no group health plan will be permitted to impose a preexisting condition limitation regardless of whether you have creditable coverage. Consequently, effective July 1, 2014, this Plan will no longer apply any preexisting condition exclusions, but the Plan will provide the certificate of creditable coverage through December 31, 2014 to reduce any preexisting condition limitation that may be imposed by another group health plan.

♦ **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, U.S. Department of Labor at:

Boston Regional Office
JFK Federal Building
Room 575
Boston, MA 02203
(617) 565-9600

or

The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor at:

200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section VI. Claim Procedure

CLAIM PROCEDURE FOR INSURED BENEFITS

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

CLAIM PROCEDURE FOR THE HEALTH CARE BENEFIT

All medical claims are processed by EBS-RMSCO, Inc., a Third Party Payer. If you have questions regarding the status of a claim, how the claim was processed, or your explanation of benefits, call EBS-RMSCO, Inc. toll free at (866) 616-7225. You may also write to EBS-RMSCO, Inc. at:

EBS-RMSCO, Inc.
115 Continuum Drive
Liverpool, New York 13088

All Health Care claims must be submitted directly to:

EBS-RMSCO, Inc.
115 Continuum Drive
Liverpool, New York 13088

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

PAYMENT OF BENEFITS

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

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

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

HOW TO FILE A CLAIM

When completing a Claims form, be sure that you or your out-of-network provider include:

1. Name of your union – IBEW Local 910.

2. Your name and identification number.

3. The full name of the person receiving treatment.

4. The diagnosis for each date of service.

5. An itemized bill (Note: A “balance forward” statement or canceled check is not acceptable since they provide no information about the medical treatment).

6. If charges are due to an accident, note the date of the accident and a brief description of the circumstances.

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 UNDER THE PRESCRIPTION DRUG BENEFIT

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

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

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

CLAIM PROCEDURE UNDER THE HEALTH EXPENSE BENEFIT

Application for Health Expense Benefits must be made in writing on forms that may be obtained from the Fund Office.

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

Plan 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

Health Care Benefits (Administered by EBS-RMSCO), Health Expense Benefits and Prescription Drug Benefits (Administered by Sav-Rx).

For these medical claims, the rules that apply to denied claims depend on the type of claim. There are generally four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a Pre-Service Claim involving an ongoing course of treatment and care made concurrently with the treatment itself. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant. Pre-Service, Urgent, and Concurrent claims are not Post-Service claims.

Post-Service Claims: For claims not requiring pre-approval, i.e., Post-Service Claims, you will be notified of any adverse benefit determination (by the plan or by the third-party administrator) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the plan's (or the third-party administrator's) control if, before the end of the initial 30-day period, the plan (or the third party administrator) notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the

extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. (Note: The Personal Account Plan Health Expense Benefit under this plan does not require pre-approval as a condition of receipt of benefits. Thus, all claims for this benefit are Post-service Claims.)

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

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

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

Prescription Drug Benefit

Claim forms are not needed to obtain prescription benefits. To request prescription benefits you simply present your card and prescription to the pharmacist. That request is not considered a "claim" under these procedures. However, if your request is denied in whole or in part, you may file

a claim for benefits by submitting your paid receipts for the prescription drug, along with a completed claim form, to Sav-Rx at the following address:

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

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

Life Insurance, and Accidental Death & Dismemberment Insurance Benefits

If your claim for Life Insurance, and Accidental Death & Dismemberment Insurance Benefits is denied in whole or in part for any reason, then within 90 days after the insurance company receives your claim, the insurance company will send you written notice of its decision, unless special circumstances require an extension, in which case the insurance company will send you written notice of the decision no later than 180 days after the insurance company receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the insurance company expects to render the benefit determination.

Content of Notification of Initial Adverse Benefit Determination

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

1. The specific reasons for the adverse determination;

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

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

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

5. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request;

6. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

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

Appeals of Adverse Benefit Determinations

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

If you are not satisfied with the reason or reasons for your adverse benefit determination, you may appeal the determination. To appeal an adverse determination of a Health Care benefit, you must first appeal to EBS-RMSCO, Inc. 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 EBS-RMSCO, Inc.(for Pre-Service claims), within 180 days of the first-level denial. To appeal an adverse determination of a Prescription Drug Benefit, or a Disability Income benefit, you must write to the Trustees within 180 days after you receive this Plan's initial adverse benefit determination. Notwithstanding anything in this paragraph to the contrary, for Concurrent Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will be afforded a reasonable period of time to appeal. To appeal an adverse benefit determination of a Life Insurance, or Accidental Death & Dismemberment Insurance Benefit claim, you (or your beneficiary) must write to the insurance company within 60 days after you (or your beneficiary) receive the insurance company's initial determination.

Special Rule Regarding Urgent Care Claims: If Urgent Care Claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan (or the third-party administrator, as applicable) by telephone, facsimile, or other similarly expeditious method. Further, if the appeal involves an Urgent Care Claim, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

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

In addition, all other appeals must adhere to the following criteria: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical

judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Determinations on Appeal

Time Frames

Pre-Service Claims for Health Care Benefits: These medical claims are subject to a two-level appeal process, as noted above. At the first level of appeal, EBS-RMSCO, Inc., 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 EBS-RMSCO, Inc., EBS-RMSCO, Inc. 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: EBS-RMSCO, Inc. will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

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

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

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

Content of Adverse Benefit Determination on Review

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

1. The specific reasons for the adverse benefit determination;

2. Reference to specific plan provisions on which the determination is based;

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

4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The Trustees' Decision is Final and Binding

The Trustee's (or other designee's) final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the plan.

Any legal action against this plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

Please note that filing a lawsuit without exhausting the Fund's appeals procedures could limit your right to appeal or cause you to lose benefits to which you would otherwise be entitled.

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 Insurance Fund provides a coordination of benefits provision. The provision affects all your health care benefits.

If you or your dependent is also covered under another plan or policy, the total amount received from all plans will never be more than 100% of "Allowable Expenses". Benefits are reduced 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 "first" plan. The method of determining which plan is "first" is:

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

2. The plan that covers the patient as a current employee is the first 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 first plan. If the parents have the same birthday, the plan that covered the parent longer shall be the first plan. If the other plan does not use the birthday rule, then the plan that covers the father as a current employee is the first plan, unless the first plan is already determined by 1. or 2.

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

a) The plan which covers the parent, who has not remarried, with custody of the dependent, is the first 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 first 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 first 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 first plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the first 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 greater part of a charge covered by this Plan and another plan(s) than that which when added to the part(s) payable by the other plan(s) equals 100% of such charge.

COORDINATION OF BENEFITS WITH MEDICARE

In general, if you are covered by this Plan as an active participant and this Plan is receiving employer contributions on your behalf, then this Plan will be primary and Medicare will be secondary, to the extent you are also entitled to coverage under Medicare. However, not withstanding this general rule, this Plan will NOT be primary for any individuals (including eligible active employees) who:

- work for an employer that does not have 20 or more employees (including plan participants and employees who are not eligible for coverage under this Plan) for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year; or

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

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

renal disease before age 65, Medicare will be primary after the coordination period described in the regulations of the Department of Health and Human Services.

RECOVERY OF OVERPAYMENTS AND MISTAKEN PAYMENTS

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

CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all employees 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 employees 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 advise the Fund of that fact. By law, the Fund automatically acquires any and all rights, which you may have against the third party.

In addition to its subrogation rights, the Fund has the rights to be reimbursed for payments made on your behalf under these circumstances. The Fund 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, are taken out of the payment. The Trustees may, in their sole discretion, require the execution of this Fund's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Fund pays you any benefits related to such expenses. The Plan's Subrogation Agreement must be signed by you and your attorneys and received at the Fund Office on the earlier of either (1) one year from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Subrogation Agreement to be signed or no Benefits will be paid by the Plan for the expenses related to that accident. You must also notify the Fund before you retain another attorney or an additional attorney since that attorney must also execute the form. In no event shall the failure of the Trustees to require execution of the lien forms diminish or be considered a waiver of the Fund's rights of subrogation and reimbursement. 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. In enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not limited by any determination of the trier of fact as to the causal relationship between the injuries giving rise to these expenses and the liability of the third party if evidence exists which, in the opinion of the Trustees, supports causation.

RIGHTS OF FUTURE SUBROGATION AND REIMBURSEMENT

In addition to satisfaction of the existing lien from any recovery by the participant and/or dependent, the Fund is also entitled to a future credit for future related plan expenses equal to the net monies received by the participant and/or dependent. As such, the participant and/or the dependent must spend the net recovery on related plan expenses until the amount of said net recovery is exhausted. It is only at that point that the participant's and/or dependent's further related plan benefits will again be the responsibility of the Fund pursuant to the terms of the Plan. The Fund Office will determine the net monies available for a future credit.

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.

FAILURE TO DISCLOSE

If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Fund for the reimbursement owed to this Fund by the third party as well as for the Plan's attorney's fees and costs incurred in recovering that amount. This Fund

may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you. The reimbursement owed to the Plan may also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with overpayments and mistaken payments.

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.

We are required by law to maintain the privacy of your protected health information.

A. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR.

The Plan shall disclose protected health information to the Plan Sponsor only to the extent necessary for the Plan Sponsor to perform the following Plan administrative functions:

1. Review Benefit claims in regards to a claim denial, complaint or an Appeal; and

2. To proceed under the Appeal Process under the Plan which is described in Section VI.

B. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PLAN SPONSOR.

The Plan Sponsor shall use and/or disclose protected health information only to the extent necessary to perform the following Plan Administration functions, which it performs on behalf of the Plan:

1. Address changes;

2. Eligibility/benefit;

3. Student status;

4. Provider lookup;

5. Billing;

6. New enrollment;

7. Reinstatements;

8. Order I.D. cards;

9. Add dependent;

10. Terminations eligibility; Benefit claims;

11. Monitor personal account balances for the purpose of paying health premiums; and

12. Contact service providers for the purpose of verifying service dates co-pays.

C. PLAN SPONSOR CERTIFICATION.

The Plan agrees that it will only disclose protected health information to the Plan Sponsor (which is the Board of Trustees), subject to the following:

1. Prohibition on Unauthorized Use or Disclosure of Protected Health Information.

The Plan Sponsor will not use or disclose any protected health information received from the Plan, except as permitted in these provisions or required by law. When used in this Section, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

2. Subcontractors and Agents.

The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide protected health information to agree to written contractual provisions that impose at least the same obligations to protect protected health information as are imposed on the Plan Sponsor.

3. Permitted Purposes.

The Plan Sponsor will not use or disclose protected health information for employment-related actions and decisions or in connection with any other of Plan Sponsor's benefits or employee benefit plans.

4. Reporting.

The Plan Sponsor will report to the Plan any impermissible or improper use or disclosure of protected health information not authorized by the plan documents.

5. Access to Protected Health Information.

The Plan Sponsor will make protected health information available to the Plan to permit Participants to inspect and copy their protected health information contained in the designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits.

6. Correction of Protected Health Information.

The Plan Sponsor will make a Participant's protected health information available to the Plan to permit Participants to amend or correct protected health information contained in the designated record set that is inaccurate or incomplete and the Plan Sponsor will incorporate amendments provided by the Plan

7. **Accounting of Protected Health Information.**

The Plan Sponsor will make a Participant's protected health information available to permit the Plan to provide an accounting of disclosures.

8. **Disclosure to Government Agencies.**

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of protected health information available to the Plan and to the U.S. Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA.

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Fund will be required to operate. For example, where such laws have been enacted, the Fund will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

9. **Return or Destruction of Health Information.**

When the protected health information is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all protected health information that the Plan Sponsor received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the protected health information. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

10. **Minimum Necessary Requests.**

The Plan Sponsor will use best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested.

D. ADEQUATE SEPARATION.

The Plan Sponsor represents that adequate separation exists between the Plan and Plan Sponsor so that protected health information will be used only for plan administration. The following employees or persons under the control of the Plan Sponsor have access to Participants' protected health information for the purposes set forth above:

John Love, Plan Manager

E. REPORTS OF NON-COMPLIANCE.

Anyone who suspects an improper use or disclosure of protected health information may report the occurrence to the Plan's Privacy Official at the I.B.E.W. Local 910 Welfare Fund Office at (315) 782-5941. You may also file a complaint with the Secretary of the U.S. Department of

Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Section VIII. Technical Details

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

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

2. **EDITION DATE:** This summary plan description is produced as of January 1, 2014.

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. John Love, 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:** Some benefits are insured; some are self-insured.

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

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

14. **PARTICIPATING EMPLOYERS:** You may receive from the Plan Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the

Plan. If so, you may also request the employer's address.

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

16. **THIRD-PARTY ADMINISTRATOR:** EBS-RMSCO, Inc., Attn: Group Claims, P.O. Box 6309, Syracuse New York 13217-6309, telephone number: (315) 448-9070, toll free number: (800) 889-4520, website: www.rsolutionz.com.

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.

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

19. **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.

20. **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, 2014.

Employer

Leo J. Villeneuve
Route #1
Colton, NY 13625

James A. Williams
6184 State Hwy. 56
Potsdam, NY 13676

Curtis M. Hammond
PO Box 383
Ogdensburg, NY 13669

Employee

Andrew VanTassel
603 Main Street
Morristown, NY 13664

Elizabeth Cassada
15662 US Route 11
Watertown, NY 13601

John T. O'Driscoll
25001 Water St.
Watertown, NY 13601

EXHIBIT A

Special Provisions Involving Welfare and Annuity Funds Contributions

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

The contractor shall contribute the respective amounts specified in Article 9 of the Collective Bargaining Agreement to the Welfare Fund and Annuity Fund and those contributions shall be aggregated and allocated according to the following formula regarding a participant's account balance in the IBEW Local 910 Welfare Fund. The method used to determine a participant's account balance requirement will be dictated by the participant's status, either family or individual. Opted out participants will be classified as individuals for this determination.

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

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

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

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

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