

ELECTRICAL WORKERS LOCAL #86



HEALTH AND WELFARE BENEFITS PLAN FOR RETIREES 65 AND OVER

June, 2004

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**ELECTRICAL WORKERS LOCAL #86
HEALTH AND WELFARE
BENEFITS PLAN
FOR RETIREES 65 AND OVER**

Dear Retirees:

This booklet gives you a summary of the benefits available to retired members age 65 and over and to their spouses age 65 and over.

Please contact the Plan office at 585-235-1515 or 888-511-7393 if you have any questions regarding coverages or claim forms.

These pages are an outline of the Plan in layman's terms. The terms and conditions of any insurance policies, other contracts, or other descriptions of the benefits of this Plan that the Plan may acquire to provide benefits hereunder, will prevail in the case of any difference between these pages and those documents.

PLAN TRUSTEES

June 1, 2004

- Name: William R. Auble
Business Manager
I.B.E.W. Local No. 86
- Address: 2300 E. River Road
Rochester, New York 14623
- Name: Edward Colombo
Cashette Electric Inc.
- Address: 311 E. Chestnut
East Rochester, New York 14445
- Name: Clark Culver*
Assistant Business Manager
I.B.E.W. Local No. 86
- Address: 2300 E. River Road
Rochester, New York 14623
- Name: James G. Hynes
Member Local No. 86
- Address: 2300 E. River Road
Rochester, New York 14623
- Name: Shaun M. O'Brien
Member Local No. 86
- Address: 2300 E. River Road
Rochester, New York 14623
- Name: Robert Reed*
R.C. Daniel Inc.
- Address: P.O. Box 33
Geneva, New York 14456
- Name: Victor E. Salerno
O'Connell Electric Company
- Address: 830 Phillips Road
Victor, New York 14564
- Name: Carl Swetman
Rochester, New York Chapter N.E.C.A. Inc.
- Address: 100 Metro Park, #102
Rochester, New York 14623

PLAN TRUSTEES

As of October 13, 2004

Name: Robert F. Baker
Member Local No. 86

Address: 64 Presque Street
Rochester, New York 14609

Name: Daniel Conte
Business Manager
I.B.E.W. Local No. 86

Address: 2300 E. River Road
Rochester, New York 14623

Name: Clark Culver*
Assistant Business Manager
I.B.E.W. Local No. 86

Address: 2300 E. River Road
Rochester, New York 14623

Name: James G. Hynes
Member Local No. 86

Address: 2300 E. River Road
Rochester, New York 14623

Name: Robert Reed*
R.C. Daniel Inc.

Address: P.O. Box 33
Geneva, New York 14456

Name: Carl Roth
Cashette Electric Inc.

Address: 311 E. Chestnut
East Rochester, New York 14445

Name: Victor E. Salerno
O'Connell Electric Company

Address: 830 Phillips Road
Victor, New York 14564

Name: Carl Swetman
Rochester, New York Chapter N.E.C.A. Inc.

Address: 100 Metro Park, #102
Rochester, New York 14623

* Messrs Culver and Reed became Trustees on January 1, 2001 when the Health and Welfare Fund at I.B.E.W. Local No. 840 was merged into the Health and Welfare Fund of I.B.E.W. Local No. 86. They will serve as Trustees until December 31, 2004.

The Plan is established by the Trustees of the Electrical Workers Local #86 Health and Welfare Plan for Active Members in order to enable Retirees to purchase certain health and welfare benefits that are supplemental to the benefits available under Medicare. The Health and Welfare Plan for Active Members is established by Section 5.02 of the Collective Bargaining Agreement between the Rochester N.Y. Chapter, N.E.C.A. and Local No. 86 I.B.E.W. A copy of such Collective Bargaining Agreement may be obtained from the Plan Administrator.

How You Can Do Your Part

The benefits for medical care described in this booklet have been designed to help pay the bills which accompany sickness or injury.

Like any good tool, this Plan must be used properly if it is to endure. For the Plan to work successfully, it is important that its cost be kept reasonable and, of course, the cost is governed by the claims submitted by you and your fellow retirees.

When making arrangements with your doctor or with the hospital, discuss the charges that are to be made. Generally your doctor or hospital will be pleased to discuss the charges with you. In fact, most medical societies encourage patients to talk over charges with their doctor in advance.

You should satisfy yourself that the charges will not be more than you would pay if you were not covered by this Plan, nor more than is generally charged for similar services (prevailing range of fees). Also make sure only necessary services are ordered. If you are in doubt about either the amount or the services for which you were billed, please contact Excellus BlueCross BlueShield (EBCBS) or the Plan office. In this way you will be doing your part in keeping the Fund expenses as low as possible and at the same time will be holding your own out-of-pocket expenses to a minimum. Be sure you keep accurate

records of your medical expenses. This will help you to be properly reimbursed.

Submission of claims in a timely manner will improve the ability to serve you.

Since not all charges for hospital, medical or dental benefits will be paid by the Plan, you should understand before any charges are incurred, what portion of those charges you must pay and obtain a pre-treatment estimate of the charges where appropriate.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the Electrical Workers Local No. 86 Health and Welfare Plan for Retirees 65 and Over (the “Plan”) for the dental, medical, and vision benefits provided by the Plan.

The Plan’s duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan’s legal duties and privacy practices with respect to your health information. It’s important to note that these rules apply to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or manage-

ment of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*

- Payment includes activities by the Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as “behind the scenes” plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan (such as a Plan in another geographical area) in order to coordinate payment of benefits.*
- Health care operations include activities by the Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations may also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs.*

The amount of health information used or disclosed will be limited to the “minimum necessary” for these purposes, as defined under the HIPAA rules. The Plan shall also require any agent or subcontractor of the Plan to follow the Plan’s practices and procedures regarding the use and disclosure of individual health information. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation

Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.

Necessary to prevent serious threat to health or safety

Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.

Public health activities

Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug

Administration to collect or report adverse events or product defects.

Victims of abuse, neglect, or domestic violence

Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).

Judicial and administrative proceedings

Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).

Law enforcement purposes

Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.

Decedents

Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.

Organ, eye or tissue donation

Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.

Research purposes

Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your

health information and treatment of the information during a research project.

Health oversight activities

Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.

Specialized government functions

Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.

HHS investigations

Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rules.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your individual rights

You have the following rights with respect to your health information that the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See p. 14 at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information:

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or

health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to family members, close friends or other persons you identify and to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to receive confidential communications of your health information:

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information:

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “designated record set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjustment, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or informa-

tion compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with the access, or copies, you requested or:

- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or to file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies and postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete:

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;

- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information:

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an “accounting of disclosures.” You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- for treatment, payment, or health care operations;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a “limited data set” (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will

provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request:

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this HIPAA notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect immediately. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via first class mail sent to your home address.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be subject to retaliation for filing a complaint. To file a complaint, written notice must be delivered by certified, return receipt requested mail to the HIPAA Complaint Manager.

Contacts

For more information on the Plan's privacy policies or your rights under HIPAA including information on Restricted disclo-

sure, Confidential communications, Access to or copies of your health information, Amendment to your health information or Accounting of disclosures, contact the Plan's office.

The following is the address and telephone numbers of the office and the names of the key persons you may need to contact.

Electrical Workers	Julie Ann A. White
Local No. 86	Kathy Clayton-Roy
for Retirees 65	Debra Mangos, or
and Over Plan	Thomas J. Sykes

2300 East River Road
Rochester, New York 14623
Telephone: 585-235-1515 or 888-511-7393
FAX: 585-436-1649

HIPAA Procedures

The persons who shall have access to the protected health information of Plan Participants shall be Excellus BlueCross BlueShield (EBCBS) and its designated employees, the Trustees of the Local #86 Health and Welfare Plan for Active Members, the employees of the Trustees and the agents and subcontractors of each of them. The Trustees shall advise EBCBS in writing of the names of its employees who have been designated to have access to such protected health information and of any other persons subsequently designated. The employees of the Trustees who have access to such protected health information as of June 1, 2004 have been identified at the end of the HIPAA Notice. See p. 15.

All such access to, and use by, such persons (including agents and subcontractors) shall be restricted to the Plan administrative functions that such persons perform, and shall be the minimum amount of such information that is necessary for the health care treatment, payment activities and health care operations of the Plan as outlined in the preceding notice. Such uses and disclosures shall be those permitted or required by law and shall not be inconsistent with the applicable regulations of the Department of Health and Human Services.

It is not anticipated that either the Rochester N.Y. Chapter, National Electrical Contractors Association or the Local #86 I.B.E.W. will have any access to any protected health information and the Trustees shall only have access to such information as is necessary to enable them to administer the Plan. However, in all such cases the parties shall preserve an adequate separation between the Plan and the Plan Sponsors.

The protected health information of the Plan Participants shall be made available for purposes of making amendments to it. Information required to provide an accounting of disclosures of such information shall also be made available. The Plan shall make its internal practices and records relating to the use and disclosure of such information available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with applicable laws and regulations. All such uses and disclosures shall be in accordance with section

164.524 of the regulations of the Department of Health and Human Services.

All protected health information other than information held by EBCBS shall be returned to the Plan when no longer needed or destroyed unless return or destruction is not feasible and in that event any further use of such information shall be limited to the use of such information that made such return or disclosure infeasible. No copies of such information shall be retained by the person to whom disclosure was made.

In the event that any person who has access to protected health information does not comply with these provisions or with any governmental regulations applicable to such protected health information, or grants to another person any access to such information, the Trustees, or one or more persons designated by the Trustees, shall review and resolve such issues of noncompliance in a full and fair proceeding.

INFORMATION REQUIRED BY ERISA

The Employee Retirement Income Security Act of 1974

Plan Name: Electrical Workers Local No. 86 Health and Welfare Benefits Plan for Retirees 65 and Over.

Identification Number: 16-0778220

Plan Number: 501

Type of Plan: A Health and Welfare Plan which is intended to supplement Medicare benefits with respect to payments of, or reimbursement for, Hospital Expenses, Surgical Expense, Physician's Inhospital Expenses, Hospital Outpatient Services, Emergency Services, and various other Medical Services, Dental Services, Prescription Drugs, and Vision Care.

Plan Year: November 1st through October 31st

Plan Sponsor: The Rochester N.Y. Chapter, National Electrical Contractors Association, 100 Metro Park, Suite #102, Rochester, New York 14623 and Local No. 86 I.B.E.W., 2300 E. River Road, Rochester, New York 14623 established the Plan. The Plan is administered by the Trustees of the Plan.

Name and Address of Union or Association Maintaining the Plan: Participants may submit a written request to the Plan Administrator for a complete list of the employer and employee organizations sponsoring the Plan.

Plan Administrator: The Trustees of the Local No. 86 Health and Welfare Benefits Plan for Retirees 65 and Over
2300 East River Road
Rochester, New York 14623
Telephone Number 585-235-1515

Eligibility: Retirees of Local No. 86 I.B.E.W. and certain related Employers, who have attained age 65 and have completed the eligibility requirements of the Plan. See p. 22. The Spouse of the Member at the time the Member begins to participate in the Plan will be eligible to participate when such Spouse attains age 65.

Loss of Benefits: A loss of benefits, for a Retiree and the Retiree's Spouse will generally occur when the Retiree or Spouse does not make the required contributions to the Plan.

Plan Costs: Paid by Retiree Contributions.

Agent for Service of Legal Process: For disputes arising under the Plan, service of legal process may be made upon the Plan Trustees.

For Claims arising on or after June 1, 2004 Plan Benefits are Paid by:

Excellus BlueCross BlueShield
165 Court Street
Rochester, New York 14647,
Local 86 Health and Welfare Benefits Plan
for Retirees 65 and Over
2300 East River Road
Rochester, New York 14623

Plan Documents: These pages describe only the highlights of your Health and Welfare Benefits and do not attempt to cover all details. These details are contained in the Plan records and the contracts (and interpretations thereof) with Excellus BlueCross BlueShield.

Plan Continuance: The Trustees expect and intend to continue indefinitely the Health and Welfare Benefits Plan for Retirees 65 and Over. However, the Trustees reserve the right to amend or terminate the Plan.

Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) – which became law on September 2, 1974 – was designed to protect employees' rights under their benefit plans.

As a participant in the Health and Welfare Benefits Plan for Retirees 65 and Over, you should know as much as possible about the Plan. By making a written request to the Plan Administrator, you can review, during normal working hours, all supporting plan documents and Department of Labor reports. These will be available for review within 10 days of the request.

Or, if you wish, you may receive copies of these documents, by making a written request to the Plan Administrator. These will be available within 30 days of the request at a reasonable charge for reproduction.

You also have a right to expect fiduciaries – i.e., the Trustees who are responsible for the operation of the Plan – to act prudently and in the best interests of Plan members and beneficiaries. In addition, you have a right to receive a written notice if a claim you submitted for benefits should, for any reason, be denied in whole or in part and you have the right to have your claim reconsidered. See p. 24 for the filing of claims and p. 27 for the right to appeal the denial of any claims.

Because your rights under ERISA are protected by law, you can also begin legal proceedings if the need ever arises. For example, if the Plan Administrator should fail to furnish within 30 days any documents you have requested in writing, you can file suit in a federal court. The Court may require the Plan Administrator to pay you up to \$100 for each day's delay until the materials are received – unless the documents were not sent because of matters beyond the control of the Administrator. You may also seek assistance from the Department of Labor or file suit in a federal court if you believe a fiduciary may have misused Plan funds or if there is interference with your rights under the law. Legal action can also be taken in either a state or federal court if you believe you have been improperly denied a benefit.

In every case the court will decide who pays the court costs and legal fees. If you are successful, the party you have sued may have to pay. But if you lose – because, for example, your case is considered frivolous – you may have to pay all these costs and fees on your own.

If you have any questions about your rights under ERISA, contact the Plan Administrator or the nearest area office of the U.S. Labor-Management Service Administration, Department of Labor.

GENERAL PROVISIONS

How To Use Your Plan

This Plan protects you by providing a supplement to the Medicare benefits you may receive for the cost of hospital, surgical, medical, dental or other specified benefits, according to the description of those benefits as outlined in these pages.

These pages are not an insurance policy. They describe the principal features of the Health and Welfare Benefits Plan for Retirees 65 and Over, but are not to be considered a contract of insurance. The complete terms and conditions of the benefits provided by the Plan are set forth in the Plan documents.

In the event that any section of this Plan is contrary to any law, such section shall be automatically null and void. All other sections shall remain in effect and in force.

As of June 1, 2004, the Plan will be using a Preferred Provider Organization (PPO) product administered by Excellus BlueCross BlueShield to provide medical benefits. Hospitals, Physicians and other Health Care Providers who participate in the PPO are referred to as "In-Network." Hospitals, Physicians and other Health Care Providers who do not participate are referred to as "Out-of-Network."

Where services are rendered in the area of a BlueCross BlueShield organization other than EBCBS, the benefit payable hereunder will depend on whether the Provider participates in the local BlueCross BlueShield PPO Network. Any In-Network Provider cannot "balance bill" the Plan participants for any amounts greater than the Excellus BlueCross BlueShield payment amount.

You are free to choose your own hospital and your own doctor. There are no restrictions as long as you use a LICENSED hospital and a LICENSED physician. However, if you use a hospital, doctor, dentist or other health care provider that does not participate in the EBCBS PPO Network, you will likely incur a greater level of out-of-pocket cost than if you had used an In-Network provider.

Eligibility for Retirees

A Member of the Electrical Workers Local No. 86 Health and Welfare Plan for Active Members who has retired may become a Participant in this Plan if the Member meets the following requirements:

1. The Member has attained the age of 65;
2. At the Member's date of retirement the Member is eligible for the retirement benefits of the I.B.E.W. pension plan. If the Member is not eligible for the retirement benefits of the I.B.E.W. pension plan then the Member must have been credited with 6,000 hours in the Electrical Workers Local #86 Health and Welfare Plan for Active Members and have been a Participant in the Active Members Plan for at least five years immediately preceding the month in which the Member retired; and
3. The Member pays the required contribution for benefits under the Plan. Contact the Plan Administrator for current information.

In order to participate in the Plan you must complete and sign an Application and provide a copy of your Medicare card.

Retirees of Electrical Workers Local #840 who have never been a Participant in the Electrical Workers Local #86 Health and Welfare Plan for Active Members and their Spouses are not eligible to participate in this Plan.

Eligibility for Spouses

The Spouse of a Retiree who is age 65 or over and meets the current eligibility rules, will also be eligible for coverage if married to the Member at the time he begins to participate in this Plan. The Spouse of a Member who died while a member of this Plan, or the Plan for Active Members, will also be eligible for coverage if such Spouse is age 65 or over. The divorced Spouse of a Member who died while a member of this Plan, or the Plan for Active Members, will also be eligible for coverage if such Spouse is age 65 or over.

Changes to Report

After your coverage under this Plan becomes effective, it is necessary to notify the Fund Office of any of the following changes with respect to any covered person by submitting copies of all appropriate certificates and other documents:

1. Marriage
2. Divorce
3. The beneficiary of your Death Benefit under the Active Members Plan.

Coordination with Medicare Benefits

Hospital and Medical coverage under this plan for any covered individual, whether Retiree or Spouse, will be based upon the Medicare benefits that the individual could receive regardless of whether he/she is actually receiving such benefits.

For each Hospital or Medical coverage, the amount of “regular benefits” will be calculated. This will be the amount that would be payable for such expense if there were no Medicare benefits. If this is more than the amount Medicare pays for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim for Hospital or Medical coverage.

Charges used to satisfy a person’s Part B deductible under Medicare will be applied under this Plan in the order received. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating “other plan” benefits with those under this Plan will be applied after this Plan’s benefits have been calculated under the above rules.

HOW TO FILE A CLAIM

A claim form must be presented with each claim for benefits under the Electrical Workers Local #86 Health and Welfare Benefits Plan for Retirees 65 and Over.

A. Claims for Medicare Benefits are Required to be Submitted First

If a covered individual is eligible for Medicare benefits for any claim, the individual must submit his claim for those Medicare benefits before submitting a claim for benefits under this Plan. When the Medicare claim has been finally determined, the covered individual should then submit to Excellus BlueCross BlueShield (“EBCBS”) copies of all bills for the expenses incurred, a copy of the Medicare Explanation of Benefits and the individual’s claim form for benefits under this plan. (See below).

If a covered individual is not eligible for Medicare benefits for his claim, he should submit a statement to EBCBS that he is not eligible for Medicare benefits and the reason why he is not eligible along with his claim form for benefits under this plan. (See below).

B. Claims for Benefits Under this Plan

1. Claims for hospital benefits and doctor’s surgical benefits should be submitted to EBCBS by the provider of such services or the provider may require you to submit the claim.
2. It is your responsibility to see that all claims for services from a hospital or doctor are submitted to EBCBS.
3. Claim forms may be obtained either from EBCBS or from the Plan office.
4. The completed claim form for benefits paid directly by the Plan office should be mailed along with copies of all bills or statements to:

Electrical Workers Local No. 86 Health and Welfare Benefits Plan for Retirees 65 and Over, 2300 East River Road, Rochester, New York 14623.

5. When claims are submitted to EBCBS by a provider, EBCBS will pay that provider directly. When claims are submitted to EBCBS by a Member participating in the Plan, EBCBS will pay the Member directly.
6. Please be sure to read and follow the instructions for completing and submitting a claim form. The instructions are printed on the back of the form or on a separate sheet of paper. This will expedite the processing of the claim. Be sure all questions are answered fully and all required information is submitted.
7. Medical and Dental Expense Benefit claims should be reported when a covered person has accumulated in a calendar year Covered Medical or Dental Expenses in excess of the Deductible. You should not wait until the end of the year to submit your claim. Any expenses incurred during the last quarter of the calendar year that are applied against an individual's deductible will also reduce the deductible for the following calendar year.

EBCBS personnel can help you complete the Blue Cross and Blue Shield claim form. If you have any questions about your claim, call EBCBS at 585-325-3630 or 1-800-847-1200. If you have any questions about any benefits paid directly by the Plan office, or about the Plan generally, contact the Plan office at 2300 East River Road, Rochester, New York 14623 585-235-1515 or 888-511-7393.

Explanation of Benefits

When your claim is processed, you will receive an Explanation of Benefits advising of the benefits paid and/or any denial of Benefits. If you have any questions about the Explanation of Benefits, you may call EBCBS at 585-325-3630 or 1-800-847-1200 or the Plan office at 585-235-1515 or 888-511-7393. If appropriate, EBCBS will conduct a Medical Review of the claim and its processing.

Claims Processing

The Trustees of the Plan have retained Excellus Blue Cross and Blue Shield (EBCBS) to process claims for Hospital, Med-

ical, Dental, Vision Care, and Prescription Drug benefits. EBCBS processes claims for many other health plans and is thoroughly aware of the Department of Labor Regulations regarding such processing.

If a claim involves urgent care, EBCBS shall notify the Participant as soon as possible, but not later than 72 hours after receipt of the claim by the Plan, of the Plan's benefit determination. If additional information is necessary to determine whether, or to what extent, benefits are covered or payable under the Plan, EBCBS shall notify the Participant as soon as possible, but not later than 24 hours after the receipt of the claim if additional information is necessary to complete the claim and shall notify the Participant of the benefit determination no later than 48 hours after the earlier of the receipt of such information or the end of the period within which the Participant is to provide such additional information.

If an ongoing course of treatments has been approved, and there is any reduction in, or termination of, such treatments before the end of the approved course of treatments, the Participant shall be notified by EBCBS of such benefit determination in sufficient time to appeal the determination and obtain a decision on the appeal before the benefit determination goes into effect.

Any request by a Participant to extend a course of treatments beyond the approved period shall be decided as soon as possible but not later than 24 hours after receipt of such request, provided that the request is made at least 24 hours prior to the expiration of the approved period of treatments.

In the case of all other pre-service claims, the participant shall be notified of the benefit determination within a reasonable period but not later than 15 days after the receipt of the claim. This 15-day period may be extended one time for up to 15 additional days if the Plan determines such extension is necessary and notifies the Participant before the 15-day period expires of the circumstances requiring the extension and of the expected decision date. If the Participant is required to submit additional information, the Participant shall be given at least 45 days to provide such information.

In the case of a post-service claim, a Participant shall be notified of an adverse determination not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 additional days if the Plan determines such extension is necessary and notifies the Participant prior to the expiration of the 30-day period of the circumstances requiring the extension and of the expected decision date. If the Participant is required to submit additional information, the Participant shall be given at least 45 days to provide such information.

In the event that any claims for hospital, medical, dental, vision care, and prescription drug benefits of the Plan are administered directly by the Plan Administrator, the Plan Administrator shall follow the procedure described above that is appropriate for the particular claim.

If a Participant's claim for Plan benefits is denied either in whole or in part, he/she will receive notification from EBCBS or the Plan office. The notification will include the reason for denial and an explanation of the claims review procedure.

Right to Appeal

Within 180 days after receiving the written notice of a claim being denied, the Participant or a duly authorized representative may appeal the denial of the Participant's claim. Such Appeal shall be conducted by the Trustees, or one or more persons designated by the Trustees, and shall provide the Participant with a full and fair review of the Participant's claim that is independent of the person or persons who denied the claim and their subordinates. The Participant shall have the opportunity to submit any information relevant to the claim and such information shall be considered in deciding the Appeal. The Participant shall also have the opportunity to review all records relevant to the denial of the claim. The Appeal procedure shall identify the experts whose advice was considered in the denial of the claim. If the denial of the claim was based on a medical judgment, the persons conducting the Appeal procedure shall consult with a health care professional with appropriate training and experience independent of the person or persons who denied the claim and their subordinates. If the claim involved urgent care, the Appeal procedure shall be expedited and the

Participant may request the Appeal orally or in writing. In such event information may be transmitted between the Plan and the claimant by any available expeditious method.

The Plan Administrator shall notify the Participant of the result of the Appeal no later than the date of the first regularly scheduled meeting of the Trustees after the Participant's request for review is received unless the request for review is received within thirty days preceding the meeting. In such event the notification of the result of the Appeal shall be no later than the date of the second regularly scheduled meeting of the Trustees. If special circumstances require a further extension of time to complete the review, the result of the Appeal shall be provided to the Participant no later than the date of the third regularly scheduled meeting of the Trustees after the Participant's request for review is received and the Plan Administrator shall notify the Participant in writing prior to the commencement of the extension that the extension is required, the special circumstances that require the extension and the date when the Appeal will be completed.

Recoupment of Benefits

In the event that the Trustees determine after benefits have been provided under the Plan to a Member, the Spouse of a Member, or a person claiming to be a Member or Spouse of a Member, that the person who received such benefits was not entitled to receive such benefits, (the unauthorized benefits), the Trustees may elect to recoup and/or recover the value of such unauthorized benefits plus expenses and reasonable interest on such amounts (the "costs") from the person who received such benefits.

Such recoupment or recovery of unauthorized benefits may take the form of a direct legal or other proceeding seeking such recovery or the form of a denial of, or offset against, future benefits to the person who improperly received such benefits. Any such denial of, or offset against, future benefits shall be treated as a denial of a claim for benefits under the Plan as of the date of such denial or offset and the affected persons shall have the same rights of notification and appeal as a person with a claim for

benefits whose claim has been denied before the benefits were provided.

If the Trustees decide to recover the value of such unauthorized benefits through the denial of, or offset against future benefits, the Trustees will also decide whether all future benefits of such person will be denied until such unauthorized benefits have been recovered in full, or that a fixed percentage of the future benefits of such person will be denied until such unauthorized benefits have been recovered in full.

EVENTS THAT TERMINATE BENEFITS

The events that will result in the Termination of Benefits under this Plan for Retirees and Spouses who are covered under this Plan are:

Termination for Retirees

A Retiree's benefit will terminate upon the death of the Retiree or upon the failure to pay the required contributions for benefits under the Plan.

Termination for Spouses of Retirees

The benefits of a Spouse of a Retiree will terminate upon the death of the Spouse or upon the failure to pay the required contributions for benefits under the Plan.

No Reinstatement

A Retiree or Spouse whose benefits under this Plan are terminated for the failure to pay the required contributions, will not be able to resume participation in the Plan at a later date.

COBRA

Federal Law (Public Law 99-272, Title X), commonly known as COBRA, provides that you, your spouse and your dependents have the right to purchase a temporary extension of your group health benefits coverage at certain times when coverage under the Plan would end.

The information set forth in this section of the Electrical Workers Local No. 86 Health and Welfare Plan for Retirees 65 and Over is your notice of your right to COBRA continuation coverage which you are entitled to receive as a Member of the Plan. COBRA continuation coverage can also become available to your Spouse. This notice gives only a summary of your COBRA continuation coverage. For more information about your rights and obligations under the Plan and under federal law, you should contact: Thomas J. Sykes or Julie Ann A. White, 2300 E. River Road, Rochester, New York 14623 (telephone: 585-235-1515 or 888-511-7393).

COBRA continuation coverage is a continuation of the Medical, Dental, Vision Care and Prescription Drug coverage that would otherwise end because of a “qualifying event.” A Member’s election of continued coverage shall apply to the Member’s Spouse, unless specified otherwise. However, Spouses of Members have an independent right to elect continuation coverage and may file a separate election form for that purpose.

The qualifying events for Members and Spouses are as follows:

For a Member – failing to pay the required contributions for benefits under the Plan as determined by the Trustees of the Plan.

For a Spouse – failing to pay the required contributions for benefits under the Plan as determined by the Trustees of the Plan.

When this occurs, complete details on how coverage may be continued will be provided to the affected persons. Any person who elects COBRA continuation coverage must pay the amounts charged for such coverage and that person will be

advised of that amount at the time of receipt of the Notice of Termination.

You, or a member of your family, have the responsibility to notify the Plan office and provide appropriate certificates of any of the events described in the section “Changes to Report” above with respect to yourself and your Spouse.

It is also important to notify the Plan of any changes in the addresses of Members and Spouses.

The law provides that the continuation of coverage may terminate for any of the following reasons:

1. The Plan no longer provides coverage for any of its Members or their Spouses;
2. The payments for the continuation of coverage are not made;
3. A person covered under this Plan becomes covered under another group health plan;

You will be notified of the termination of coverage and of the existence of your COBRA rights at the appropriate times. Each individual entitled to COBRA rights will be notified by First Class U.S. Mail. If a spouse resides with a Member, one notice will be sent to the address, but each individual may make an independent election of COBRA extension.

If a person covered under this Plan does not elect to continue coverage in accordance with these provisions, that person still has the opportunity to exercise the conversion privilege to Hospital and Medical Benefits under an individual policy of the kind then being issued by Excellus BlueCross BlueShield. Conversion rights and the right to obtain replacement coverage without proof of insurability may be governed by federal and New York State law.

HOSPITAL, MEDICAL AND DENTAL BENEFITS

The Hospital, Medical and Dental benefits provided under the Plan are designed to supplement Medicare benefits and will be provided whether or not the covered person is entitled to Medicare. No benefits will be provided under this Plan for amounts that would be paid by Medicare. As a result, most of the actual payments under the Plan will be for Medicare deductibles and expenses in excess of Medicare payments.

The amounts paid by the Plan for the benefits described above will be based upon the EBCBS Schedule of Allowances if the services are provided in the EBCBS area of operations. That area is the following counties in New York State: Monroe, Wayne, Ontario, Livingston, Seneca and Yates. If such services are provided in a different BlueCross BlueShield area, the amounts will be based upon the applicable Schedule of Allowances for that area.

The amounts paid will also be based upon whether the hospital, physician or provider participates in EBCBS's PPO Network or with the local BlueCross BlueShield PPO Network in the other area.

The deductible amount and Out-of-Pocket Maximum that apply to the benefits under the Plan and the restoration and reinstatement of such Maximum Amount are described in the sections below.

Except where otherwise specifically noted, the Hospital, Medical and Dental benefits provided hereunder are the same for a Retiree and the Retiree's Spouse.

In any case in which Medicare and the Plan do not pay the full cost of a Hospital, Medical or Dental benefit, the Retiree or Spouse must pay the balance of those costs so you should obtain a Pre-Treatment estimate of charges where appropriate.

Pre-Certification Requirement for Certain Benefits

Beginning on July 1, 1997, Plan Participants were required to notify EBCBS before the Participant, or the Spouse of the Par-

participant incurs any expenses for a non-emergency (i) organ or tissue transplant or (ii) health care for Psychiatric or Substance Abuse. The Trustees have adopted a Pre-Certification requirement in order to provide access to the case management services of EBCBS to Participants and their Spouses who could utilize these services. The Pre-Certification is accomplished by contacting Personalized Benefit Services of EBCBS at 1-800-363-4659 and providing the information requested. The failure to provide this Pre-Certification will reduce the amount of these benefits that are provided by the Plan to the Participant, or the Spouse of any Participant by \$500.00 and the Participant will be liable for that amount.

Hospital Inpatient Benefits

These benefits are for semi-private accommodations for up to 70 days in a Hospital as a result of a non-occupational accidental injury or disease. The benefits include room and board and all medically necessary services for acute care during such confinement.

If you go to:

(a) *an In-Network Hospital:*

The Plan pays 100% of the amount charged for those services in excess of Medicare by the Hospital.

(b) *an Out-of-Network Hospital:*

The Plan pays 100% of the amount charged for those services in excess of Medicare by that Hospital.

If the confinement in any of the Hospitals described above exceeds 70 days, the Plan pays 80% of the amounts described above that are charged for such excess days after the deductible. A new period of 70 days of coverage begins when a covered person has not been confined to a Hospital for a period of 60 days. The Trustees may approve private accommodations if a covered person is suffering from a contagious disease.

Skilled Nursing Facility Benefits

These benefits are for semi-private accommodations in a Skilled Nursing Facility for a medically necessary confinement for up to 120 days.

If you go to:

(a) *an In-Network facility:*

The Plan pays 100% of the amount charged in excess of Medicare by the Facility pursuant to its agreement with EBCBS.

(b) *an Out-of-Network facility:*

The Plan pays 80% of the amount charged by the Facility in excess of Medicare and after the deductible.

If the confinement in any of the Skilled Nursing Facilities described above exceeds 120 days, the Plan pays 80% of the amount charged for such excess days by an In-Network Facility in excess of Medicare and after the deductible. If the Facility is an Out-of-Network Facility the Plan pays 80% of the amount charged by an In-Network Facility for comparable benefits in excess of Medicare and after the deductible.

The Plan does not pay the cost of custodial care or Hospice care.

Hospital Outpatient Benefits

These benefits are for Diagnostic X-ray services, Diagnostic Laboratory and Pathology services, Chemotherapy, Radiation Therapy, Surgical Care and Preadmission Testing provided by a Hospital or other Facility.

If you receive these services at:

(a) *an In-Network Hospital or Facility:*

The Plan pays 100% of the amount charged for those services pursuant to the EBCBS Schedule of Allowances that is in excess of Medicare.

(b) *an Out-of-Network Hospital or Facility:*

The Plan pays 100% of the amount charged for those services pursuant to the EBCBS Schedule of Allowances that is in excess of Medicare.

Emergency Services

These benefits are for any Life Threatening and Urgent Medical emergency services if medical care has begun within 72

hours following the accident causing the Medical emergency or within 24 hours of the onset of a sudden illness causing the medical emergency.

If you receive these services from:

(a) *an In-Network Hospital:*

The Plan pays 100% of the amount charged for those services by the Hospital pursuant to the EBCBS Schedule of Allowances that is in excess of Medicare.

(b) *an Out-of-Network Hospital:*

The Plan pays 100% of the amount charged for those services pursuant to the EBCBS Schedule of Allowances that is in excess of Medicare.

(c) *a Physician:*

The Plan pays 100% of the amount charged for those services pursuant to the EBCBS Schedule of Allowances that is in excess of Medicare.

The Plan also pays the charges for dental services required as a result of an accident causing injury to sound and natural teeth if such services are rendered within 12 months of the accident.

Physician Services for Surgery and Anesthesia

If you receive these services from:

(a) *an In-Network Physician:*

The Plan pays 100% of the amount charged for those services by the Physician pursuant to the EBCBS Schedule of Allowances that is in excess of Medicare.

(b) *an Out-of-Network Physician:*

The Plan pays 80% of the amount allowed for such services under the EBCBS Schedule of Allowances that is in excess of Medicare.

Physician Inhospital Visits and Consultations

If you receive these services from your Physician or a Physician consulting with your Physician and such consultation takes place in the Hospital:

(a) *an In-Network Physician:*

The Plan pays 100% of the amount charged for those services by the Physician pursuant to the EBCBS Schedule of Allowances during the first 70 days of confinement in excess of Medicare and 80% of such amount for such services after 70 days in excess of Medicare.

(b) *an Out-of-Network Physician:*

The Plan pays 80% of the amount allowed for such services under the EBCBS Schedule of Allowances during the first 70 days in excess of Medicare and after the deductible and the same amount for such services after 70 days.

Physician Services for Chemotherapy, Radiation Therapy, Diagnostic X-Ray Services

If you receive these services from:

(a) *an In-Network Physician:*

The Plan pays 100% of the EBCBS Schedule of Allowances in excess of Medicare and after the deductible.

(b) *an Out-of-Network Physician:*

The Plan pays 80% of the EBCBS Schedule of Allowances in excess of Medicare and after the deductible.

Physician Services for Mastectomies and Related Benefits

The Hospital Inpatient Benefits and benefits for Physician Services for Surgery and Anesthesia are applicable to mastectomies. The following services are also available: breast reconstruction, reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Such services shall be provided in the manner determined in consultation with the attending Physician and the patient.

If you receive these services from:

- (a) *an In-Network Physician:*
The Plan pays 100% of the EBCBS Schedule of Allowances in excess of Medicare.
- (b) *an Out-of-Network Physician:*
The Plan pays 80% of the EBCBS Schedule of Allowances in excess of Medicare.

Physician's Office Services; Allergy Tests and Injections

If you go to a Physician who is:

- (a) *an In-Network Physician:*
The Plan pays 80% of the EBCBS Schedule of Allowances in excess of Medicare and after the deductible.
- (b) *an Out-of-Network Physician:*
The Plan pays 80% of the EBCBS Schedule of Allowances in excess of Medicare and after the deductible.

Psychiatric Inpatient Benefits

These benefits are for semi-private accommodations, including room and board, in a Hospital for an acute psychiatric problem for up to 70 days per calendar year.

If you go to:

- (a) *an In-Network Hospital:*
The Plan pays 100% of the amount charged for those services by the Hospital pursuant to its agreement with EBCBS in excess of Medicare.
- (b) *an Out-of-Network Hospital:*
The Plan pays 80% of the amount charged for those services in excess of Medicare.

Psychiatric Outpatient Benefits

These benefits are for professional services for an acute psychiatric problem for up to 40 visits per covered individual per calendar year if such services are rendered by a Licensed Psychiatrist, Clinical Psychologist, NYS Certified Social worker with a "R" number or such services are provided at an approved facility. Outside New York State, such services must be provided at

a licensed Facility or by a licensed provider. Also, outside New York, Social Workers must have a Masters Degree and a minimum of two years experience in the mental health field to qualify as a covered provider.

If you go to:

(a) *an In-Network Provider:*

The Plan pays 50% of the EBCBS Schedule of Allowances for those services in excess of Medicare and after the deductible.

(b) *an Out-of-Network Provider:*

The Plan pays 50% of the EBCBS Schedule of Allowances for those services in excess of Medicare and after the deductible.

Hospital and Physician Services for Detoxification

Hospital admissions for detoxification are covered under Hospital Inpatient Benefits described above for up to 30 days of confinement.

If you go to:

(a) *an In-Network Hospital and In-Network Physician:*

The Plan pays 100% of the EBCBS Schedule of Allowances for those services in excess of Medicare.

(b) *an Out-of-Network Hospital and Out-of-Network Physician:*

The Plan pays 80% of the EBCBS Schedule of Allowances for those services in excess of Medicare.

Rehabilitation for Substance Abuse

These benefits are for semi-private accommodations, including room and board, in a Hospital for up to 45 days per person per year and all medically necessary services during such confinements but for not more than two such confinements per covered person per lifetime.

If you go to:

- (a) *an In-Network Hospital:*
The Plan pays 100% of the amount charged for those services by the Hospital for such allowed confinements pursuant to its agreement with EBCBS in excess of Medicare.
- (b) *an Out-of-Network Hospital:*
The Plan pays 80% of the amount charged for those services in excess of Medicare.

Physician's Services during a Rehabilitation for Substance Abuse

If you go to:

- (a) *an In-Network Physician:*
The Plan pays 100% of the EBCBS Schedule of Allowances in excess of Medicare.
- (b) *an Out-of-Network Physician:*
The Plan pays 80% of the EBCBS Schedule of Allowances in excess of Medicare.

Outpatient Professional Services for Substance Abuse

If you go to:

- (a) *an In-Network Provider:*
The Plan pays 100% of the EBCBS Schedule of Allowances for those services by the Provider in excess of Medicare for up to 60 visits per covered individual per year if provided by a licensed individual or a facility licensed by the New York State Office of Alcohol and Substance Abuse Services. Such visits may include 20 family counseling visits.
- (b) *an Out-of-Network Provider:*
The Plan pays 80% of the EBCBS Schedule of Allowances for those services by the Provider in excess of Medicare for up to 60 visits per covered individual per year if provided by a licensed individual or a facility licensed by the New York State Office of Alcohol and Substance Abuse Services. Such visits may include 20 family counseling visits.

Pap Smears, GYN Exams and Mammograms

Pap smears are covered at 100% of the EBCBS Schedule of Allowances for such services in excess of Medicare. Such charges are to be submitted directly to EBCBS and those amounts are payable by EBCBS directly to the providers.

GYN exams and the related laboratory expenses from In-Network Providers are covered at 100% of the EBCBS Schedule of Allowances for such services in excess of Medicare. Such exams and expenses from an Out-of-Network Provider are covered at 80% of the EBCBS Schedule of Allowances for such services in excess of Medicare.

Annual mammograms for women age 50 and over, are covered at 100% of the EBCBS Schedule of Allowances in excess of Medicare if provided by an In-Network Physician and at 80% of such amount in excess of Medicare if provided by an Out-of-Network Physician.

Other mammograms prescribed by your Physician are also covered at the same amounts.

Diabetic Supplies

Diabetic Supplies, including Insulin and blood glucose self testing and monitoring are covered at 90% of the EBCBS Schedule of Allowances in excess of Medicare and after the deductible.

Routine Colonoscopies and Sigmoidoscopies

Routine Colonoscopies and Sigmoidoscopies are covered at 100% of the EBCBS Schedule of Allowances for these services in excess of Medicare.

Cosmetic Surgery

No Medical Expense Benefits are provided under the Plan for charges incurred in connection with cosmetic or reconstructive surgery except for the following.

1. Charges for cosmetic surgery necessary for the prompt repair of a non-occupational injury which occurs while the individual concerned is covered by the Plan.

2. Charges for reconstructive surgery incidental to or following surgery resulting from trauma, infection or other diseases of the involved part.

Other Medical Benefits

Eye examinations that are related to a disease or injury are covered at 80% of the EBCBS Schedule of Allowances for such services in excess of Medicare and after the deductible. One pair of Eye Glasses or Contact Lenses after cataract surgery are also covered at 80% of the cost of such Eye Glasses or Contact Lenses in excess of Medicare and after the deductible. See p. 45 for routine vision care benefits.

Diagnostic hearing evaluations that are medically necessary, meet professional standards of practice and which have been approved by an Otolaryngologist are covered at 80% of the EBCBS Schedule of Allowances for such services in excess of Medicare and after the deductible.

Physical therapy services are covered after the deductible at 80% of the EBCBS Schedule of Allowances for those services in excess of Medicare and after the deductible. Speech therapy services are also covered at 80% of the amount charged for those services in excess of Medicare and after the deductible if such therapy becomes necessary as a result of an accident.

Home care services, when ordered by your Physician, are covered in full for up to 90 days per calendar year. Any home care services in excess of this amount are covered at 80% of such costs in excess of Medicare and after the deductible.

The Plan pays for Durable Medical Equipment at 100% of the cost of such equipment in excess of Medicare and after the deductible if provided by an In-Network Durable Medical Equipment Provider and at 80% of the cost of such Equipment in excess of Medicare and after the deductible if provided by an Out-of-Network Durable Medical Equipment Provider. The maximum benefit per individual is \$15,000 per calendar year.

Internal Prosthetics are covered at 100% of the EBCBS Schedule of Allowances for such services in excess of Medicare and

External Prosthetics and Orthotics are covered at 80% of the EBCBS Schedule of Allowances in excess of Medicare for such Prosthetics and Orthotics up to \$15,000 per individual per calendar year.

Temporomandibular Joint Dysfunction (TMJ) appliance therapy and reconstructive therapy is covered, after the deductible, at 80% of the EBCBS Schedule of Allowances in excess of Medicare for such therapy up to a maximum of \$1200 per covered individual per lifetime.

Chiropractic services and Acupuncture services are covered at 80% of the EBCBS Schedule of Allowances in excess of Medicare and after the deductible up to \$800 per covered individual per calendar year.

Ambulance services are covered at 80% of the charges for such services, in excess of Medicare and after the deductible, when such services are medically necessary.

The Plan pays for wigs to cover hair loss resulting from Chemotherapy, Radiation Therapy and similar treatments at 80% of the EBCBS Schedule of Allowances in excess of Medicare and after the deductible up to a maximum of \$400 per covered individual per lifetime.

Prescription Drugs

As of June 1, 2004, the Trustees changed the Prescription Drug Benefit under the Plan to the 3-Tier Prescription Drug Program adopted by Excellus BlueCross BlueShield.

Under the 3-Tier program all prescription drugs are assigned to one of the three tiers and the Member's payment for each prescription is based upon the assigned tier as follows:

Tier 1 Drugs	Generic	\$ 3
Tier 2 Drugs	Preferred Brand	\$10
Tier 3 Drugs	Non-Preferred Brand	\$25

The new 3-Tier prescription drug program provides Members with a financial incentive to use generic drugs when they are available. If a Member elects to use a brand name drug when a generic alternative is available, the Member will be responsible for the brand name drug co-payment (\$10 if it is a Tier 2 brand

or \$25 if it is a Tier 3 brand) plus the difference between the cost of the brand name drug and its generic alternative.

Drug benefits are not subject to the deductible provisions of the Plan and the Plan pays the balance of the cost of each prescription.

A list of the drugs assigned to each tier is available by calling the Excellus BlueCross BlueShield Customer Service telephone number on your identification card or at www.excellusbcbs.com.

Since 1970 the Federal Food and Drug Administration has approved almost 9000 generic drug products as therapeutically equivalent to specific Brand name drugs. Generics have to meet the same rigorous FDA requirements as Brand name drugs. A generic drug is made with the same active ingredients in the same dosage form as the Brand name drug it is intended to replace. The generic drug should treat your illness or condition with the same effectiveness and safety as its Brand name equivalent. Manufacturers of generics spend less money developing and marketing the drugs and most generics are less expensive than Brand name drugs. As a result, in most cases, the use of a generic drug rather than a Brand name drug will save money for both you and the Plan. You can obtain a generic medication by asking your doctor for it and your doctor will write that prescription if he/she thinks it is appropriate for you.

Prescriptions may be filled at any of the more than 54,000 pharmacies participating in the Excellus BlueCross BlueShield network. Most major pharmacy chains participate in the network and you may determine whether a particular pharmacy participates by consulting the www.excellusbcbs.com web site.

Prescriptions may also be filled by mail through Express Scripts, Inc. (ESI) using a mail order form that may be obtained from EBCBS or the Plan office. Thereafter, refills can be obtained by telephone (1-877-603-8404) or from its web site (www.express-scripts.com). Starting August 1, 2004 Participants may obtain a three months supply for a payment of two co-payments.

Diabetic supplies are not covered under the 3-Tier Program. See p. 41. Nicotine patches and nicorette gum are not covered under either the 3-Tier Program or the Plan.

Routine Vision Care

The Plan pays for one routine eye examination, lenses, and eye glass frames per covered individual in each 24 month period up to the following amounts:

EYE EXAMINATIONS	\$34.50
LENSES	
Single or contact	46.00
Bifocals	57.50
Trifocals	80.50
EYE GLASS FRAMES	46.00

Exclusions from Routine Vision Care

No routine vision care benefits are payable for:

1. Plain or prescription sunglasses.
2. Replacement of lost or broken lenses and/or frames.
3. Expenses for medical or surgical treatment of the eyes, special procedures, such as orthoptics, vision training, vision aids and expenses for eye examinations related to a disease or injury or for eyeglasses or contact lenses within 24 months of cataract surgery do not constitute routine vision care. Such services or supplies are considered under the medical or surgical provisions of the Plan.

Dental Benefits

See emergency services for accidental dental services required as a result of an accident. See page 36.

Prior to obtaining any of the following dental services, you should discuss the cost of such services with your dentist. In all cases in which there are alternative procedures for treatment carrying different allowances, the Plan will only pay for the treatment carrying the lesser allowance.

In view of these limitations and the overall limit on annual dental benefits under the Plan, you should seriously consider obtaining a Pre-Treatment estimate of charges for dental services.

The Plan pays for the following preventative and diagnostic dental services at 80% of the EBCBS Schedule of Allowances for those services.

- (a) Initial Oral Examination
- (b) Periodic Oral Examinations and Teeth Cleaning up to two such services per covered individual per calendar year
- (c) Up to four bitewing x-rays per covered individual per calendar year
- (d) Full mouth x-rays once each three year period per covered individual
- (e) Emergency treatment to relieve pain

The Plan pays the following Basic Restorative benefits, Oral Surgery, Periodontics (Gum and Tissue), Endodontics (Nerve and Pulp) and Prosthetics at 80% of the EBCBS Schedule of Allowances for the following services after the deductible up to the maximum amount described below. For these services there is a \$25 deductible per covered individual per calendar year and a \$50 maximum deductible per family per calendar year.

- (f) Amalgam or Resin Restoration for Treatment of Cavities, whichever is less expensive, and Pin Buildups, for one surface per tooth during 12 consecutive month period.
- (g) Oral Surgery including Routine Extractions, Surgical Extractions, removal of odontogenic cysts and tumors and alveoplasty.
- (h) Periodontal Scaling/Root Planing, per quadrant of the mouth, once in any 24 consecutive month period. When provided on the same day as a prophylaxis, the benefit is limited to the most inclusive procedure.
- (i) Periodontal Surgery, including Gingivoplasty, Gingivectomy, Osseous Surgery, Mucogingival Surgery, and bone replacement and soft tissue replacement procedures in one area of the mouth once in any 36 consecutive month period.
- (j) Endodontics, including Pulpotomy, Pulp Capping Apicoectomy and Root Canal Treatment. Pulp Caps ren-

dered in conjunction with restorations are included in the allowance for the restorative procedure, and are not covered as a separate procedure. Therapeutic pulpotomy will be covered once per tooth when not performed in conjunction with root canal therapy.

- (k) Prosthetics, removable, consisting of full and partial dentures; repairs and relines. Tooth preparation, temporary bridges, bases, impressions, anesthesia, preparation of the gingival tissue or other services that are components of a complete procedure are covered in the allowance for the major procedure. Adjustments or repairs to full or partial dentures, will be provided only when the adjustments or repairs are performed more than 6 months after the initial insertion of the prosthesis. Coverage of denture relines or rebases are limited to one in any 36 month period which is at least 6 months after the initial placement. Replacement of a denture with another denture, will only be covered if the existing prosthetic is over five years old and can not be restored. Upgrading from a partial denture to a fixed bridge work is limited to the coverage for a partial denture.

The Plan pays for the following dental benefits at 50% of the EBCBS Schedule of Allowances for the following services after the deductible up to the maximum amount described below. For these services there is a \$25 deductible per covered individual per calendar year and a \$50 maximum deductible per family per calendar year.

- (l) Inlays/Onlays and Crowns will be covered only when teeth cannot be restored by a filling, and only if more than 5 years has elapsed since the last placement. All necessary medications, preparations, impressions, temporary crowns, finishing and occlusal adjustments of the procedure are covered but facings on posterior teeth are limited to the allowance for a full cast metal crown.
- (m) Cast Post and Core for endodontically treated teeth.
- (n) Prosthetics, consisting of fixed bridge work, implants and grafts. Tooth preparation, temporary bridges, bases, impressions, anesthesia, preparation of the gingival tis-

sue or other services that are components for a complete procedure are covered in the allowance for the major procedure. Replacement of fixed bridge work with another fixed bridge, will only be covered if the existing prosthetic is over 5 years old and cannot be restored. Upgrading from a partial denture to fixed bridge work is limited to the coverage for a partial denture.

- (o) Adjustments or Repairs to full or partial bridges or crowns will be provided only when the adjustments or repairs are performed more than 6 months after the initial insertion of the prosthesis. Coverage of rebases are limited to one in any 36 month period which is at least 6 months after the initial placement.

The maximum amount paid by the Plan per covered individual per calendar year for the dental services described in (f) through (n) above is \$1,000.

The Plan pays for Orthodontia services at 50% of the EBCBS Schedule of Allowances for such services up to a maximum of \$2,000 per covered individual per lifetime.

Exclusions from Covered Dental Expenses

Covered Dental Expenses do not include and no benefits are payable for:

1. Charges for any dental care and treatment which are included as Covered Medical Expenses.
2. Charges for treatment by other than a legally qualified dentist except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and direction of the dentist.
3. Charges for dentures and bridgework (including crowns and inlays forming the abutments), when such charges are incurred for replacement of teeth all of which were extracted while the individual was not insured under the Plan.

4. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures.
5. Charges for prosthetic devices including bridges and crowns and the fitting thereof which were ordered while the individual was not insured under the Plan, or which were ordered while the individual was insured under the Plan but are finally installed or delivered to such individual more than thirty days after termination of benefits hereunder.
6. Charges for the replacement of a lost or stolen prosthetic device.

Employee Assistance Program

In cooperation with the New York State AFL-CIO, an Employee Assistance Program is available to all Retirees and their Spouses without cost. This program helps Retirees and their Spouses to resolve personal, persistent problems such as alcoholism, drug abuse, financial difficulties and family tensions.

You can call the NYS Labor Community Services Agency EAP Program at 1-800-EAP-1984 or 585-426-5710, to arrange an interview with a trained employee counselor. After an appraisal, you will be given a recommended course of action. If necessary, follow-up counseling is provided. Most recommended treatment services are covered by the Plan.

Every case handled under this Program is handled on a basis of strict confidentiality.

BENEFIT LIMITS

There are limits on certain Hospital, Dental and other Benefits which are stated in the paragraphs describing the Benefits. All Benefit limits may be changed by the Trustees at any time. If you have any questions about any Benefit limits, you should contact the Plan Office.

The Deductible

The Deductible is the amount of medical and other expenses which you pay before benefits become payable under this Plan. For the calendar year beginning January 1, 1994 and thereafter, the Maximum Amount of the deductible for most medical benefits is \$100 for each individual and the maximum aggregate amount for any two or more covered family members is \$150. There is a separate deductible of \$25 per individual and a \$50 family maximum for most dental benefits including Restorative, Oral Surgery Periodontics, Endodontics and Prosthetics.

The Deductible applies only once in any calendar year even though you may have several different injuries or diseases. So that your claims will not be subject to a deductible late in one calendar year and soon again in the next following year, any expenses applied against an individual's Deductible in the last quarter of the calendar year will also be applied against that individual's Deductible in the next calendar year.

Outpatient acute psychiatric and substance abuse expenses are not subject to this Maximum Amount of the Deductible.

Annual Out-of-Pocket Maximum Deductible

You are required to pay a portion of most of the medical expenses after the application of the deductible. In most cases, that amount is 20% of the schedule amount for such services in excess of Medicare and after the deductible. That amount is sometimes referred to as your co-payment. The aggregate amount of those co-payments is also subject to an annual maximum. When the amount of those co-payments in any calendar year exceeds \$500 per individual or \$750 for a Retiree and Spouse, any further benefits payable on behalf of that Retiree and Spouse in that calendar year will be payable at 100%.

The 3-Tier Prescription Drug co-payments, outpatient acute psychiatric and substance abuse expenses, vision care and dental expenses are not included in the aggregate amount that is necessary for this Annual Out-of-Pocket Maximum to become applicable.

EXCLUSIONS FROM COVERAGE

No benefits are payable under this Plan for the charges listed below, and the amount of any such charges will be deducted from the individual's expenses which are covered under this Plan and from the individual's allowable expenses before the benefits of this Plan are determined.

1. Charges that would not have been made if no benefit existed or charges that neither you nor any of your dependents are required to pay; or
2. Charges for services or supplies which are furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government; or
3. Charges for services or supplies which are paid for or otherwise provided for under law except where the payment or the benefits are provided under a Plan specifically established by a government for its own civilian employees and their dependents; or
4. Charges for services and supplies which are not necessary for treatment of the injury or disease or are not recommended and approved by the attending physician or dentist or charges which are unreasonable.

COORDINATION OF HOSPITAL MEDICAL AND DENTAL EXPENSE BENEFITS WITH OTHER BENEFITS

The Hospital, Medical and Dental Benefits have been designed to help you meet the cost of disease or injury that is not otherwise available to you under Medicare. Since it is not intended that you receive greater benefits than the actual hospital, medical and dental expenses incurred, the amount of benefits payable under this Plan will take into account any coverage you have under Medicare and under other “plans”; that is, the benefits under this Plan will be coordinated with the benefits of the other “plans.”

Specifically, in a calendar year, this Plan will always pay either its regular benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will equal 100% of “allowable expenses” under this Plan.

When the total amount of benefits is reduced, each benefit that would otherwise be payable will be reduced proportionately, and only that reduced amount will be charged against any applicable benefit limit of the Plan.

“Allowable Expenses” means any necessary, reasonable and customary expense, incurred during a calendar year and while eligible for benefits under this Plan, part or all of which would be covered under any Other Plan, but not any expenses contained in the list of Exclusions.

“Other Plans” means any plan for which any employer of yours, or of your spouse makes payroll deductions or contributions and under which plan, medical or dental benefits or services are provided to you or your spouse.

“Other Plans” also means “no-fault” automobile reparations insurance which is required under any law of a government and is provided on other than a group basis, but only to the extent of the level of benefits required by the no-fault law.

The exclusion of governmental benefits or services under this plan is described in the “exclusions” section.

To administer this provision properly, and to determine whether the Plan will reduce its regular benefit, it is necessary to determine the order in which the various plans will pay benefits. The order in which the plans will be considered to pay benefits is determined as follows:

- (1) A plan with no rules for co-ordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- (2) A plan which covers a person other than as an Employee will be deemed to pay its benefits before this Plan or any other plan which covers the individual as an Employee.
- (3) If 1 and 2 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
 - (a) The benefits of a plan which covers the person or whose expenses for a claim is based as a:
laid-off or retired member;

shall be determined after the benefits of any other plan which cover such person as:

a member who is not laid-off or retired;

- (b) If the other plan does not have a provision:
regarding laid-off or retired members and as a result,
each plan determines its benefits after the other;

then the above paragraph will not apply.

If it is necessary in order to administer this provision, the Plan, has the right to:

Release or obtain any data; and make or recover any payments.

In implementing this provision, the Plan, without the consent of any person, will have the following rights:

1. To release or obtain any information the Plan deems to be necessary for such purpose.

2. To make any payments necessary to satisfy the intent of this provision if payments have been made under any other plan which should have been made under this Plan.
3. To recover payments in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision.

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