

ELECTRICAL WORKERS LOCAL #86



HEALTH AND WELFARE PLAN FOR ACTIVE MEMBERS

June, 2004

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ELECTRICAL WORKERS LOCAL #86 HEALTH AND WELFARE PLAN FOR ACTIVE MEMBERS

Dear Fellow Members:

Over the years your Trustees have tried to communicate the benefits available to you and your families in a clear and prudent manner. The Insurance Insert in the black binder booklet has been our primary method of communication about the Plan. In prior years the Plan has sometimes been called “the Insurance Fund” and sometimes just “the Fund.”

Please contact the Plan Office at 585-235-1515 or 888-511-7393 if you have any questions regarding insurance 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

As of 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

*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.

Collective Bargaining Agreement

The Plan is established pursuant to 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 the Collective Bargaining Agreement may be obtained from the Plan Administrator.

How You Can Do Your Part

The benefits for medical care described in these pages 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 Plan Participants.

When making arrangements with your doctor, hospital or dentist, 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 to keep the Plan 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 and the expenses of each of your covered dependents. This will help you to be properly benefited by the Plan.

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

Since not all charges for hospital, medical, dental or other 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 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 Active Members (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, not your employer – that’s the way the HIPAA rules work. Different policies may apply to other programs provided by your employer, if any, or to data unrelated to the health 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 management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*
- Payment 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 that is described above. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan may share your health information with your employer

The Plan, or its contracted vendors, may disclose your health information without your written authorization to your employer for plan administration purposes.

Here's how additional information may be shared between the Plan and your employer, as allowed under the HIPAA rules:

- The Plan, or its contracted vendors, may disclose “summary health information” to your employer if necessary. Summary health information is information that summarizes participants’ claims information, but from which names and other identifying information has been removed.
- The Plan, or its contracted vendors, may disclose to your employer information on whether an individual is participating in the Plan, or has enrolled or disenrolled in a plan option offered by the Plan.

In addition, you should know that your employer is not permitted to use health information obtained from the Plan for any employment-related actions. However, health information collected by your employer from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers’ compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close

friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'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 disclo-

tures 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. 15 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 information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 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 desig-

nated 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 disclosures, 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
Health & Welfare Plan	Debra Mangos, or
for Active Members	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 and in no event shall any protected health information be disclosed or used for employment related actions and decisions or in connection with any other benefit or employee benefit plan of 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 Plan for Active Members.

Identification Number: 16-0778220

Plan Number: 501

Type of Plan: A Health and Welfare Plan which provides for the payment of, or reimbursement for, Hospital Expenses, Surgical Expenses, Physician's Inhospital Expenses, Hospital Outpatient Services, Emergency Services, and various other Medical Services, Dental Services, Vision Care, Jury Duty, Death Benefits, Physical Examinations for Members, Spouses and Dependents, Accidental Death and Dismemberment Benefits and Short Term and Long Term Disability Benefits.

Plan Year: November 1st through October 31st

Plan Sponsors: 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 Electrical Workers Local #86 Health and Welfare Plan for Active Members.

Name and Address of Employer, Union or Association Maintaining the Plan: Participants may submit a written request to the Plan Administrator to determine whether a particular employer is a plan sponsor and, if so, the employer's address. Participants may also request a complete list of the employer and employee organizations sponsoring the Plan.

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

Eligibility: Members of the Local No. 86 I.B.E.W. and employees of certain related Employers who have completed the eligibility requirements of the Plan, together with their Spouses and Dependents. See p. 23.

Loss of Benefits: A loss of benefits for a Plan Member, the Member's Spouse and Dependents will generally occur when the Plan Member does not have sufficient work credits, enters active military service, becomes temporarily disabled, retires or dies. See p. 48 for Service in the Armed Forces and p. 42 for the definition of Retirement.

Plan Costs: Paid by Employer and Employee Contributions.

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

Claims are Paid by:

Excellus BlueCross BlueShield (EBCBS)
165 Court Street
Rochester, New York 14647,
The Local 86 Health and Welfare Plan
for Active Members
2300 East River Road
Rochester, New York 14623

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

Plan Continuance: The Trustees expect and intend to continue the Health and Welfare Plan for Active Mem-

bers indefinitely; however, the Sponsors and 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 Plan, you should know as much as possible about it. 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. 27 for the filing of Claims and p. 30 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.

In any event, no one, including your employer, your union or any other person can fire you or discriminate against you to prevent you from obtaining benefits or exercising your rights under ERISA.

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 paying all or a portion of the cost of the 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 Plan, 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 various laws, contracts and records of the Plan. For those benefits paid directly by the Plan office, the terms and conditions are as set forth in this Plan and the documents describing such benefits.

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 an Out-of-Network 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. See p. 54 for the Pre-Certification requirement before receiving certain benefits.

Initial Eligibility for Active Members

An Active Member of the Electrical Workers Local No. 86 Health and Welfare Plan for Active Members is:

- (a) any Member of Local No. 86 I.B.E.W. who meets the eligibility and/or contribution requirements of the Plan and
 - (i) is employed by an employer who is obligated under a collective bargaining agreement or reciprocity agreement to contribute to the Plan or
 - (ii) is unemployed but is registered with Local No. 86 as available for work and who continues to satisfy the Local No. 86's requirements for being available for work and
- (b) any employee of the Local No. 86 I.B.E.W. and the Electrical Workers Local No. 86 Health and Welfare Plan for Active Members who meets the eligibility and/or contribution requirements of the Plan.

An Active Member will become eligible on the first day of the second month after a three consecutive month period during which the Member has been credited with 350 hours. You may determine your eligibility status at any time by inquiring at the Electrical Workers Local 86 Plan Office.

In order to participate in the Plan you must complete and sign an Application. A Plan Beneficiary Form should also be completed.

Eligibility for Spouse and Dependents

If a Member of the Plan meets the current eligibility rules, the Spouse and the Dependents of the member will

also be covered. A copy of the marriage certificate for each Member and Spouse and a copy of the birth certificate of each Dependent must be submitted to the Plan Administrator at 2300 East River Road, Rochester, New York 14623.

The term “Dependents” includes the Member’s unmarried children under 19 years of age, but excludes any person otherwise eligible for coverage under the Plan as a Member. Such Dependents include (1) a blood descendant of the first degree, (2) a legally adopted child (including a child living with the adopting parents during the period of probation), (3) a stepchild residing in the Member’s household, or (4) a person under 19 years of age permanently residing in the household of which the Member is the head if such person is actually being supported solely by the Member, and the Member is related to the person by blood or marriage or is the person’s legal guardian. To be eligible for Dependent coverage, proof may be required that the Dependent comes within the foregoing definition.

The term Dependent also includes a Member’s unmarried child who is over 19 years of age but under 26 years of age if the child is solely dependent on the Member and is attending school full time. Status as a student must be verified each year.

If a Member’s child is born after the Member’s death, that child may be covered as a Dependent while coverage for the Member’s other Dependents is in force.

Continuation of Coverage for Disabled Children

If a Member has an unmarried child who is chiefly dependent upon the Member for support and maintenance and the child is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation, as defined in the New York State Mental Hygiene Law, or physical handicap and the child became so incapable prior to attaining the

age at which coverage would otherwise terminate (see the section within on “Termination for Dependents of Members”), the child’s coverage under this Plan will be continued as long as the child remains incapable of self-sustaining employment and the Member’s coverage continues under this Plan or, if sooner, the date on which the child no longer meets the Plan’s definition of a child for any reason except the age or residence of the child.

In order, however, for the coverage of such child to continue past the age at which Dependent coverage would otherwise terminate, the Member must continue to be a Participant in this Plan and submit proof that the child is and continues to be incapable of self-sustaining employment by reason of one or more of the conditions mentioned above and that the child is unmarried and is chiefly dependent upon the Member for support and maintenance. The Member must supply this proof within 31 days after the dependent’s coverage as a dependent would otherwise have ceased and when requested thereafter by the Plan Office.

Changes to Report

After your Plan coverage becomes effective, it is necessary to notify the Plan office in writing 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. Births
4. Adoptions
5. When a Dependent who is over 19 is a full-time student.
6. When a Dependent who is over 19 and under 26 and has been a full-time student graduates from school or ceases attending school as a full-time student.
7. The beneficiary of a Member’s Death Benefit

8. A disabled Dependent over the age at which Dependent coverage would normally terminate becomes capable of self-sustaining employment.
9. A disabled Dependent over the age at which Dependent coverage would normally terminate ceases to be chiefly dependent upon you.

The failure of the Member to notify the Plan Office of any such change shall make the Member and the person whose status has changed each liable for the cost of any Plan benefits provided to such person whose status has changed and who, therefore, does not qualify for such benefit.

HOW TO FILE A CLAIM

A claim form must be presented with each claim for benefits under the Health and Welfare Plan for Active Members.

Procedure for Presenting Claims for Benefits

1. Claims for hospital benefits and doctor's surgical benefits will be submitted to Excellus BlueCross BlueShield (EBCBS) by the Provider of such services if the Provider participates with EBCBS.
2. Claims for other services from a doctor who is in the PPO must be submitted directly by the doctor.
3. It is your responsibility to see that all claims for services from Out-of-Network Providers are submitted to EBCBS.
4. Claim forms may be obtained either from EBCBS or from the Plan Office.
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 of the Plan, EBCBS will pay either the Member or the Provider.
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. EBCBS will keep a record of your claims and your deductibles. See The Deductible p. 72. 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 reduce the deductible for the following calendar year.

If you receive services covered by this Plan outside of the Excellus service area from an In-Network BlueCross BlueShield Provider in that area, the Provider should submit its claim for services to the local BlueCross BlueShield organization of that area and the claim will be forwarded to EBCBS for processing. If you receive services from an Out-of-Network Provider, it may be necessary for you to submit your claims for those services directly to EBCBS.

EBCBS personnel can help you complete the EBCBS 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 E. 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 you 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 Fund Office at 585-235-1515. If appropriate, EBCBS will conduct a Medical Review of the claim and its processing.

Claims Processing

The Trustees of the Plan have retained Excellus BlueCross BlueShield (EBCBS) to process all claims for Hospital, Medical, 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 cov-

ered or payable under the Plan, EBCBS shall notify the Participant as soon as possible, but not later than 24 hours after 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 Fund 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 medical or vocational 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, a Dependent of a Member or a person claiming to be a Member, Spouse or Dependent 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 or from the Member through whom the person claims to be entitled to such benefits.

Such recoupment or recovery of the costs of such 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 or to the Member through whom such person claimed to be entitled to such benefits, or both of them. 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 costs 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 the costs of such unauthorized benefits have been recovered in full or whether a fixed percentage of the future benefits of such person will be denied until such costs have been recovered in full.

EXTENDED BENEFITS OF THE HEALTH AND WELFARE PLAN FOR ACTIVE MEMBERS

The Local 86 Health and Welfare Plan for Active Members provides Extended Benefits for its Members, Members' Spouses and Members' Dependents in order to enable them to continue some of the health care benefits of the Plan through periods of uncertain employment that are common in the electrical industry and through various unexpected events in their lives. These Extended Benefits are available either at substantially reduced costs or at no costs to the covered persons.

The opportunity for these benefits, which have sometimes been called Self-Payment Rights, precede the rights under COBRA and in no way diminish or replace COBRA Continuation Rights.

The Extended Benefits: The Extended Benefits available are, except where otherwise noted below, all Hospital, Medical, Vision, Prescription Drug and Dental Benefits described in the Plan.

The Extended Benefit Cost: The Extended Benefit Cost is determined on a monthly basis and is the product of (a) the number of monthly hours required by the Trustees for eligibility to participate in the Plan as an Active Member and (b) the rate of contributions to the Plan in effect under the Collective Bargaining Agreement between the Rochester NY Chapter N.E.C.A. and Local No. 86 I.B.E.W.

Unless otherwise provided by law or the Trustees, the payment of the Extended Benefit Cost must be submitted to the Plan office not later than 15 days after notification by the Plan office that such payment is due. Failure to submit the required payment will terminate the Extended Benefits at the end of the last month for which the required payment was made.

Members' Extended Benefits:

1. **Permanent Disability:** If a Member is determined to be permanently disabled due to an (a) injury or sickness that is not incurred in the course of employment, (b) the Member receives a Social Security Disability award and (c) the Member is not eligible for Medicare or retired, the Member is entitled to the Extended Benefits under the Plan at no cost to the Member. Such benefits shall continue for as long as (1) the Member's disability continues to be permanent but not beyond the Member's retirement or eligibility for Medicare whichever first occurs, (2) the Member submits such reasonable evidence of the continued disability as the Trustees may request and (3) the Member is not engaged in any occupation or employment. For disability income benefits see p. 75.

2. **Temporary Disability:** If a Member (a) is determined to be temporarily disabled by a physician due to an injury or sickness that is not incurred in the course of employment and (b) the Member is not eligible for Medicare or retired, the Member is entitled to the Extended Benefits under the plan at the Extended Benefit Cost described above. Such benefits shall continue for as long as (1) the Member's disability continues but not more than 24 months from the date of the disability, (2) the Member continues to submit such reasonable evidence of the continued disability as the Trustees may request and (3) the Member is not engaged in any occupation or employment but not beyond the Member's retirement or eligibility for Medicare, whichever first occurs. See EVENTS THAT TERMINATE BENEFITS, Temporary Disability p. 41 for insufficient work credits. For disability income benefits see p. 74.

3. **Loss of Eligibility Due to Insufficient Work Credits (Layoff or Termination):** If a Member uses all of his work credits and keeps his or her I.B.E.W. card active, the Member is entitled the Extended Benefits under the Plan at the Extended Benefit Cost described above. Such benefits shall continue but not more than 24 months from the

loss of eligibility and only so long as the Member submits such reasonable evidence of continued lack of employment as the Trustees may request but not beyond the Member's retirement.

4. Early Retirement: In the event a member receives retirement benefits from the Local #86 Pension Plan after attaining the age of 55, but before attaining the age of 65, and has been a Member of the Plan for at least 10 years, the Member is entitled to the Extended Benefits under the Plan at the Extended Benefit Cost described above. Such benefits shall not continue beyond the Member's attaining age 65.

Spouses' Extended Benefits:

1. Member's Coverage: A Spouse of a Member is entitled to the same Extended Benefits under the Plan as the Member for so long as the Member meets the conditions, including the payment of any applicable Extended Benefit Cost, for such benefits and the Spouse continues to be legally married to the Member.

2. Death of a Member: Upon the death of a Member, the Member's Spouse is entitled to the Extended Benefits under the Plan at no cost to the Spouse for a period of up to 24 months from the death of the Member but not beyond the remarriage of the Spouse.

3. Member's Retirement and/or Medicare Coverage: If a Member retires or obtains Medicare coverage and the Member's Spouse has not yet attained age 65, the Spouse is entitled to the Extended Benefits under the Plan at no cost to the Spouse until the Spouse attains age 65, but for not more than 60 months from the date of the Member's retirement or obtaining Medicare coverage, whichever is earlier. Thereafter the Spouse is entitled to a continuation of such benefits upon the payment of the Extended Benefit Cost described above but not beyond the Spouse attaining the age of 65.

Dependents' Extended Benefits:

1. Coverage of the Member or the Member's Spouse: If a Member or the Spouse of a Member is entitled to Extended Benefits under the Plan or is receiving Extended Benefits, the Dependents of the Member are entitled to the same Extended Benefits as the Member or the Spouse for so long as the Member or the Spouse meets the conditions, including the payment of any applicable Extended Benefit Cost, for such benefits and the Dependents meet the requirements for Dependent coverage under the Plan.

2. Disabled Dependents: If a Member has an unmarried Dependent who is chiefly dependent upon the Member for support and maintenance and is incapable of self-sustaining employment by reason of mental illness, developmental disability or mental retardation as defined in the New York State Mental Hygiene Law, or a physical handicap, at the age at which the Dependent's coverage would otherwise terminate under the Plan, such Dependent is entitled to the Extended Benefits under the Plan at no cost to the Dependent so long as (a) the Member is a participant in this Plan, (b) the Dependent remains incapable of self-sustaining employment, (c) the Dependent continues to meet the definition of a dependent under the Plan notwithstanding the age or residence of the Dependent, and (d) such reasonable evidence of the incapability of fulfilling self-sustaining employment and the Dependent's continuing dependent status and the dependent's unmarried status, as the Trustees may request, is submitted to the Plan.

The coverage of each Disabled child of a Member who is over the age when a Dependent's coverage would normally terminate under the Plan, will terminate when the Member ceases to participate in the Plan.

If a Member, Spouse or Dependent does not make timely payments of the Extended Benefit Cost, he/she will be deemed to have rejected the Extended Benefits available under the Plan and his/her benefits under

the Plan will terminate. Benefits under the Plan will also terminate at the end of the Extended Benefit period and/or when the requirements of the Extended Benefit are no longer satisfied.

EVENTS THAT TERMINATE BENEFITS

There are a number of different events that will result in the Termination of Benefits under this Plan for Members, Spouses and Dependents.

Termination for Members

A Member's benefit will terminate upon the occurrence of any of the following events:

1. Rejecting any Extended Benefits and/or failing to pay the Extended Benefit Cost.
2. Beginning active military service in the Armed Forces of the United States.
3. A period of time after the occurrence of Temporary Disability. See p. 41.
4. Retirement. See p. 42.
5. Death.
6. Being credited with less than the required hours of work credits.

Effective October 1, 2003 termination will occur as of the end of any calendar month for any Member who is not receiving Extended Benefits under the Plan and has not been credited with 350 hours of work for the preceding consecutive three calendar month period when the Member was last working *or* has not been credited with the following number of hours of work:

700 hours during the preceding six consecutive month period when the Member was last working

1050 hours during the preceding nine consecutive month period when the Member was last working

1400 hours during the preceding twelve consecutive month period when the Member was last working

When you move from one contributing employer to another, your benefits will continue provided you continue to meet the minimum hours of work described above. You should make sure that your new employer is

contributing to the Plan. When you are asked to perform work outside the Local 86 area you should inquire from your employer whether you will be credited for this work on the Fund records so that there will be no misunderstanding about that at a later date.

Termination for Spouses of Members

The benefits of a Spouse of a Member will terminate upon the occurrence of any of the following events:

1. Rejecting any Extended Benefits and/or failing to pay the Extended Benefit Cost.
2. Any event which terminates the Member's benefits. But see below and see p. 42 in the case of a Member who becomes Totally and Permanently Disabled prior to attaining age 65.
3. The earlier of 24 months after the death of an Active Member or when the Spouse remarries.
4. When the Member and Spouse become legally divorced.

Termination for Dependents of Members

The benefits of a Dependent of a Member shall terminate upon the occurrence of any of the following events:

1. Rejecting any Extended Benefits and/or failing to pay the Extended Benefit Cost.
2. Any event which terminates the Member's benefits. But see the following paragraphs and also Extended Benefits p. 33.
3. Two years after the death of the Active Member who is supporting such Dependent. But see paragraph 7 and p. 36.
4. When the Dependent marries.
5. When the Dependent attains age 19 unless the Dependent is attending school full time and is solely dependent on the Member. But see the applicable rules governing disabled dependents.

6. If a Dependent is age 19 or over, is attending school full-time and is solely dependent on the Member, the Dependent's benefits will terminate at the earliest of the date when the Dependent attains age 26, ceases to attend school full-time or ceases to be solely dependent on the Member.
7. A disabled child who is over the age at which dependent coverage would normally terminate becomes capable of self-sustaining employment or ceases to be chiefly dependent on the Active Member.

Employment in the Jurisdiction of another I.B.E.W. Local

If you do not meet the eligibility requirements of the Plan and are employed in the jurisdiction of another I.B.E.W. Local, the benefits of the Member, Member's Spouse and Member's Dependents will terminate and work credits will not be recognized by this Plan unless you meet the following conditions:

1. You elect to have the Employer contributions from your Employer to the I.B.E.W. Health and Welfare Plan in the other jurisdiction for all hours worked reciprocated to this Plan pursuant to The Electrical Industry Health and Welfare Reciprocal Agreement and such contributions are reciprocated from the other Benefit Plan on a regular basis.
2. You authorize the representatives of the Fund to obtain any necessary information regarding your hours of credited employment and compensation from employment in the other jurisdiction from the Health and Welfare Fund in the other jurisdiction and from any other benefit fund in which you are participating and such information is obtained.
3. You pay to the Plan any amount that may be required by the Trustees.

Temporary Disability

The Temporary Disability of a Member will result in the termination of benefits for the Member, the Member's Spouse and Dependents, unless the Member is eligible for Extended Benefits hereunder and pays the Extended Benefit Cost. Temporary Disability occurs when a Member is unable to work because of either an occupational or non-occupational disability and is under the care of an authorized physician. During such period, a Member shall be credited with 28 Hours of work for each week of such disability but not more than 700 hours during any twelve consecutive calendar months and not more than 1400 hours during any twenty-four consecutive calendar

months. No hours will be credited after twenty-four consecutive calendar months.

Permanent and Total Disability

In the event that the Member receives a Social Security Disability Award, the Member will be deemed to be Permanently and Totally Disabled.

If a Member is Permanently and Totally disabled, the Member, the Member's Spouse and Dependents shall be entitled to continued coverage under this Plan provided the Member has 4000 credited hours in the Plan. But see Retirement below.

Member or Spouse's Eligibility for Medicare

In the event that a Member becomes eligible for Medicare regardless of whether the Member has incurred a previous Terminating Event, the Member's coverage under the Plan shall terminate. Such event may also constitute a Terminating Event for the Spouse and Dependents of the Member. See Spouses Extended Benefits and Dependents Extended Benefits p. 35.

In the event that the Spouse of a Member becomes eligible for Medicare, such event shall not be a Terminating Event for the Spouse if the Member's coverage continues under the Plan, unless the Spouse elects to be covered by Medicare. The coverage of the Member and Dependents shall continue regardless of the Spouse's continuation or noncontinuation of coverage.

Retirement of a Member

Upon the retirement of a Member, the Member may be eligible to participate in the Electrical Workers Local No. 86 Health and Welfare Plan for Early Retirees, the Electrical Workers Local No. 86 Health and Welfare Plan for Disabled Retirees or the Electrical Workers Local No. 86 Health and Welfare Plan for Retirees Age 65. See p. 49 for the Plan for Early Retirees. See p. 51 for the Plan for Disabled Retirees. See the separate booklet for the Plan for Retirees Age 65 and Over.

Each of those Plans may allow the retired Member to continue some of the benefits provided under this Plan so long as the Member makes the payments required by the Trustees. The Trustees may allow Extended Benefits for Spouses and Dependents. See p. 35 for Spouses Extended Benefits and p. 36 for Dependents' Extended Benefits. You should contact the Plan Office to determine the eligibility for such benefits and the current payments required for such benefits.

Under certain circumstances, the Trustees may allow a retired Member who is not eligible for the Early Retiree Plan, the Disabled Retirees Plan or the Retirees Age 65 and Over Plan, to continue coverage under this Plan for a limited period of time so long as the Member makes the payments required by the Trustees. The Trustees may also allow the Spouse and Dependents of such a Retired Member to continue coverage under this Plan for a limited period of time even though the Retired Member is not covered under the Plan, so long as any payments for the Spouse and Dependents that are required by the Trustees, are made.

The Trustees have determined that a Member who receives pension benefits from the Electrical Workers Local #86 Pension Plan or the Pension Plan of Local #86 International Brotherhood of Electrical Workers shall be deemed to have retired for purposes of this Plan and is no longer entitled to benefits from this Plan as an Active Member.

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, including the coverage available under the Plan's Extended Benefits, would end.

The information set forth in this section of the Electrical Workers Local No. 86 Health and Welfare Plan for Active Members 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 and your Dependents. 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 and Dependent children of a Member, unless specified otherwise. However, Spouses of Members and Dependent children have an independent right to elect continuation coverage and may file a separate election form for that purpose. Parents may elect to continue coverage on behalf of their Dependent children.

The qualifying events for Members, Spouses and Dependent children are as follows:

For a Member – the loss of sufficient work credits required for coverage because of a reduction in working hours or termination of employment and the expiration of, or rejection of, Extended Benefits.

For a Spouse – because of any of the following reasons:

1. Rejecting any Extended Benefits or failing to pay any Extended Benefit Costs;
2. Death of the Member;
3. Termination of the Member’s eligibility for loss of sufficient work credits as indicated above;
4. Divorce from the Member;
5. The Member becomes entitled to and elects Medicare as primary coverage.

For a Dependent – because of any of the following reasons:

1. Rejecting any Extended Benefits or failing to pay any Extended Benefit costs;
2. Death of the Member;
3. Termination of the Member’s eligibility for loss of sufficient work credits as indicated above;
4. The Member becomes entitled to and elects Medicare as primary coverage;
5. The Dependent ceases to meet the eligibility requirements for a Dependent as described elsewhere in this booklet.

When any of these events occur, 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, your Spouse or your Dependents. You must also notify the Plan of a determination by the Social Security Administration that a Member, Spouse or Dependent has become

disabled by submitting a copy of such determination to the Plan. Those notifications should occur as soon as possible and *must* occur within 60 days (except that notification of the end of disability must be provided within 30 days).

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

The maximum period of a temporary continuation of benefits required by law is as follows:

- 18 months in the case of ineligibility due to the Members' reduction in hours or termination of employment except that such period is extended to 29 months for you or a member of your family if you or that member of your family becomes disabled during the first 60 days of COBRA continuation coverage. Also, if the former Member dies, enrolls in Medicare, or becomes divorced, or legally separated while receiving COBRA continuation coverage, the COBRA continuation coverage may be extended to a maximum of 36 months. This extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. In all of these cases, the Plan Administrator must be notified of the second qualifying event within 60 days of the occurrence of the second qualifying event.
- 36 months for all other situations.

The temporary continuation of benefits will also cover a child born to, or placed for adoption with, a Member during the period of a temporary continuation of benefits.

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 Active Members;
2. The self-payments for the continuation of coverage are not made:

3. A person covered under this Plan becomes covered under another group health plan;
4. A person covered under this Plan becomes entitled to Medicare;
5. The continuation of coverage as a result of a disability shall terminate at the earlier of 29 months or the cessation of the disability.

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 or dependent 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.

REINSTATEMENT OF BENEFITS

Service in the Armed Forces

A Member who enters active service in the Armed Forces on a full time basis may elect either (a) or (b) with respect to his/her participation in this Plan:

(a) To cease coverage under this Plan and to freeze his/her Work Credits under the Plan as of that date, or

(b) To continue his/her coverage under the Plan until his/her Work Credits are used up and then to exercise his/her right to a Member's Extended Benefits after the loss of Eligibility Due to Insufficient Work Credits. See p. 34.

If a Member's health and welfare benefits are terminated because of his/her beginning active military service, the Member will be reinstated to full coverage on the day the Member again commences work with one of the participating employers provided that the Member commences work within a period of 120 days from the date the Member ceases active military service. If the Member commences work for a participating employer after 120 days, the Member will be treated as a new employee for the purpose of determining eligibility under this Plan.

Newly Credited Hours After Coverage Terminates

If your coverage is terminated because of your failure to perform the necessary hours of work for participating employers, you may again be reinstated to full coverage by meeting the qualification set forth below. You may become eligible on the first day of the second calendar month following any consecutive three month period when you are credited with 350 hours of work.

However, the Trustees may delay your reinstatement if you have not paid any amount that you owe to the Plan. You may determine your eligibility status at any time by inquiring at the Plan office.

CONTINUATION OF PARTICIPATION FOR EARLY RETIREES

Eligibility:

The Trustees have determined that Members of the Active Members Plan who retire after attaining age 55 and before attaining age 65 may continue to participate in the Active Members Plan as modified below. All other provisions of the Active Members Plan that are not inconsistent with the following shall apply to such Early Retirees:

To continue to participate, the Member is required to:

- a) Pay any amount that is required by the Trustees for continued participation in the Plan.
- b) Have been a Member of the Health and Welfare Plan for Active Members for at least 10 years.

Benefits:

The benefits shall be the same benefits as are payable under the Active Member's Plan *except* that such benefits *shall not include* the following:

- a) Short term disability income benefits.
- b) Long term disability income benefits.
- c) Jury Duty and Subpoena as a Witness.
- d) Accidental Death and Dismemberment.

No Reinstatement of Benefits:

If a Member's participation in the Plan is terminated for the failure to pay the amounts required by the Trustees for Participation in the Plan, there will be no subsequent participation and reinstatement of benefits.

No Right to Extended Benefits:

There is no right to Extended Benefits or any other temporary extension of benefits under the Plan except any applicable COBRA continuation coverage.

Plan Continuance:

The Trustees expect to continue the Health and Welfare Plan for Early Retirees indefinitely; however, the Trustees reserve the right to amend or terminate that continuation of participation.

CONTINUATION OF PARTICIPATION FOR DISABLED RETIREES

Eligibility:

The Trustees have determined that Members of the Active Members Plan who become permanently and totally disabled and are unable to work before attaining age 65 may continue to participate in the Active Members Plan as modified below. Any other provisions of the Active Members Plan that are not inconsistent with the following shall apply to such Disabled Retirees.

To continue to participate, the Member is required to:

- a) Have 4000 Credited Hours in the Active Members Plan.
- b) Obtain a Certificate of Disability from the Social Security Administration.
- c) Become eligible for Medicare.
- d) Pay any amount that is required by the Trustees for continued participation in the Plan.

Benefits:

The benefits under the Plan shall be supplemental to Medicare benefits and be payable at the 90% rate after deducting the Medicare benefit. The benefits available shall be the same benefits as are payable under the Active Member's Plan *except* that such benefits *shall not include* the following:

- a) Jury Duty and Subpoena as a Witness.
- b) Physical examinations.
- c) Accidental Death and Dismemberment.

Short term disability income benefits and long term disability income benefits received from prior participation in the Health and Welfare Plan for Active Members shall continue.

The benefits under the Plan shall include a reimbursement for Medicare Part B premiums paid by a Participant in the Plan.

Plan Continuance:

The Trustees expect to continue the Health and Welfare Plan for Disabled Retirees indefinitely; however, the Trustees reserve the right to amend or terminate that continuation of participation.

HOSPITAL, MEDICAL AND DENTAL BENEFITS

The Hospital, Medical and Dental benefits provided under the Plan as of June 1, 2004 may be divided into a number of major categories: (1) Hospital Inpatients benefits, (2) Hospital Outpatient benefits, (3) Emergency benefits, (4) Physician benefits, (5) Maternity benefits, (6) Psychiatric and Substance Abuse benefits, (7) Other Medical benefits (8) Dental benefits and (9) Prescription Drug benefits. Vision Care and Routine Physical Examination are also paid by EBCBS. There are other Member benefits that are administered directly by the Plan office.

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 the 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 an Active Member of the Local No. 86 Health and Welfare Plan, the Member's Spouse and the Member's Dependents.

The Plan does not pay the full cost of many of the Medical and Dental benefits and some of the Hospital

benefits described below. Also, 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 all of those cases, the Member, Spouse or Dependent should obtain a Pre-Treatment estimate of charges since you must pay the balance of those costs, if any.

Pre-Certification Requirement for Certain Benefits

Beginning on July 1, 1997, Members were required to notify EBCBS before the Member, or the Spouse or Dependents of the Member incurs any expenses for a non-emergency (i) organ or tissue transplant or (ii) health care for In-Patient 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 Members and their Spouses and Dependents who require this care. This 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 Member, or the Spouse or Dependents of any Member by \$500.00 and the Member will be liable for that amount.

Hospital Inpatient Benefits

These benefits are for semi-private accommodations for up to 120 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 by the Hospital.

(b) an Out-of-Network Hospital:

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

If the confinement in any of the Hospitals described above exceeds 120 days, the Plan pays 90% of the amounts described above that are charged for such excess days after the deductible. A new period of 120 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 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.

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 a participating Facility after the deductible. If the Facility is not participating, the Plan pays 80% of the amount charged by a participating Facility for comparable benefits.

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 by the Hospital or Facility.

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

The Plan pays 100% of the usual customary and reasonable charges for those services.

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.

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

The Plan pays 100% of the amount charged for those services.

(c) *a Physician:*

The Plan pays 100% of the amount charged for those services.

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.

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

The Plan pays 90% of the amount allowed for such services under the EBCBS Schedule of Allowances.

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 120 days of confinement and 80% of such amount for such services after 120 days.

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

The Plan pays 90% of the amount allowed for such services under the EBCBS Schedule of Allowances during the first 120 days and 80% of such amount for such services after 120 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.

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

The Plan pays 80% of the EBCBS Schedule of Allowances.

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.

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

The Plan pays 90% of the EBCBS Schedule of Allowances.

Physician's Office Services; Allergy Tests and Injections

If you go to a Physician who is:

(a) *an In-Network Physician:*

The Plan pays 90% of the EBCBS Schedule of Allowances after the deductible.

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

The Plan pays 90% of the EBCBS Schedule of Allowances after the deductible.

Pre-Natal Care

If you go to:

(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.

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

The Plan pays 90% of the amount that would be paid to a participating Physician pursuant to the EBCBS Schedule of Allowances.

Maternity Benefits

These benefits are for semi-private accommodations, including room and board, in a Hospital, all delivery room charges, all medically necessary services for acute care, delivery, and all new born nursery care.

If you go to:

(a) *an In-Network Hospital:*

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

(b) *an In-Network Physician:*

The Plan pays 100% of the amount charged for those services.

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

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

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

The Plan pays 90% of the amount charged for those services.

Well Child Care Benefits

The following well child visits by a Physician will be covered in accordance with the standards of the American Academy of Pediatrics:

At birth: Up to two visits while the newborn is in the Hospital;

Every two months from birth to age six months;

Every three months from age nine months to age 18 months; and

Every year from age two up to and through age eighteen.

The following services will also be covered if rendered in conjunction with a well child visit:

Complete medical histories;

Complete physical exam;

Laboratory tests and/or services ordered at the time of the well child visit and billed by a hospital or independent laboratory.

Immunizations based on guidelines established by the New York State Commissioner of Health as follows:

- DTP (diphtheria, tetanus and pertussis) at months 2, 4, 6, 15-18, and at 4-6 years;
- Polio at months 2, 4, 15-18, and at 4-6 years;
- MMR (mumps, measles, and rubella) at 15 months and at 11-12 years for those children who have not had measles;
- Hepatitis B at birth, at 1-2 months and at 6-18 months;
- Tetanus-Diphtheria at 14-16 years.
- Chicken Pox

If you go to:

(a) *an In-Network Physician:*

The Plan pays 100% of the EBCBS Schedule of Allowances.

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

The Plan pays 100% of the EBCBS Schedule of Allowances.

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.

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

The Plan pays 80% of the amount charged for those services.

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.

(b) an Out-of-Network Provider:

The Plan pays 50% of the EBCBS Schedule of Allowances for those services.

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.

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

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

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.

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

The Plan pays 80% of the amount charged for those services.

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.

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

The Plan pays 90% of the EBCBS Schedule of Allowances.

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 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 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. 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. Such exams and expenses from an Out-of-Network Provider are covered at 90% of the EBCBS Schedule of Allowances for such services.

Mammograms for women age 50 and over, are covered at 100% of the EBCBS Schedule of Allowances if provided by an In-Network Physician and at 80% of such amount if provided by an Out-of-Network Physician as follows:

- (a) Age 50 and over – once a year.
- (b) Age 40 through 49 – once every two years.
- (c) Age 35 through 39 – one baseline mammogram.

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

Physical Therapy Services; Occupational Therapy Services; Speech Therapy

Physical therapy services and occupational therapy services are covered after the deductible at 90% of the EBCBS Schedule of Allowances for such services. Speech therapy services are also covered at 90% of the EBCBS Schedule of Allowances for such services after the deductible if such therapy becomes necessary as a result of an accident.

Diabetic Supplies

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

Other Medical Benefits

Eye examinations that are related to a disease or injury are covered at 90% of the EBCBS Schedule of Allowances for such services after the deductible. One pair of Eye Glasses or Contact Lenses after cataract surgery are also covered at 90% of the cost of such Eye Glasses or Contact Lenses after the deductible. See p. 67 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 90% of the EBCBS Schedule of Allowances for such services after the deductible.

Hearing aids are covered at 90% of the charge for each hearing aid up to \$700 per hearing aid after the deductible but not more often than one hearing aid per ear during any period of three consecutive years. Replacement or repairs are covered only if the hearing aid being replaced or repaired has been in use for at least three years and a letter of medical necessity from a Physician certified as an Otolaryngologist accompanies the request.

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 90% of such costs after the deductible.

Private duty nursing services are covered, after the deductible, at 90% of the charges for such services up to \$3,000 per covered individual per calendar year.

The Plan pays for Durable Medical Equipment at 100% of the cost of such equipment after the deductible if provided by a participating Durable Medical Equipment provider and at 90% of the cost of such Equipment after the deductible if provided by a non-participating 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 and

External Prosthetics and Orthotics are covered at 90% of the charges 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 90% of the BlueCross BlueShield Schedule of Allowances for such therapy up to a maximum of \$1200 per covered individual per lifetime.

Chiropractic services and Acupuncture services are covered at 90% of the EBCBS Schedule of Allowances after the deductible up to \$800 per covered individual per calendar year.

Ambulance services are covered at 90% of the charges for such services, 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 after the deductible, at 90% of the EBCBS Schedule of Allowances 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

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 website (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. 63. Nicotine patches and nicorette gum are not covered under either the 3-Tier Program or the Plan.

Routine Physical Examinations

Each Member and the Spouse of each Member will receive an allowance of \$300 every two years for routine physical examinations which include examinations and laboratory work not covered under the other provisions of this Plan.

Routine Colonoscopies and Sigmoidoscopies are covered at 100% of the EBCBS Schedule of Allowances for such services.

Routine Vision Care

The Plan pays for one routine eye examination, lenses, and eye glass frames per covered adult 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

One routine eye examination and lenses, for children under age 19, is covered in each 12-month period.

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 coverage. See p. 56.

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 100% 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) Up to two fluoride treatments per covered child under age 19 per calendar year
- (f) Emergency treatment to relieve pain
- (g) Sealants on first and second permanent molars for covered children up to the age of 16 once in each three-year period

The Plan pays for the following Basic Restorative benefits, Oral Surgery, Periodontics (Gum and tissue), Endodontics (Nerve and Pulp) and Prosthetics at 90% 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.

- (h) 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.
- (i) Oral Surgery including Routine Extractions, Surgical Extractions, removal of odontogenic cysts and tumors and alveoplasty.
- (j) Periodontal Scaling/Root Planning, 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.
- (k) Periodontal Surgery, including Gingivoplasty, Gingivectomy, Osseous Surgery, Mucogingival Surgery, and bone replacement and soft tissue replacement procedures in one area of the mouth once any 36 consecutive month period.
- (l) Endodontics, including Pulpotomy, Pulp Capping Apicoectomy and Root Canal Treatment. Pulp Caps rendered 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.
- (m) 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.

- (n) 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.
- (o) Cast Post and Core for endodontically treated teeth.
- (p) Prosthetics, consisting of fixed bridge work, implants and grafts. 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. 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.

- (q) 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 (h) through (p) 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.

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. 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.

Out-of-Pocket Annual Maximum

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 10% of the schedule amount for such services. That amount is sometimes referred to as your co-insurance. The maximum annual aggregate amount of these co-insurance payments per individual per calendar year is \$500 and the maximum annual aggregate amount of these co-insurance payments for any two or more covered family members per calendar year is \$750. When the amount of those payments for a Member, his or her Spouse and the Member's Dependents exceeds those limits in any calendar year in the aggregate, any further benefits payable on behalf of that individual or family 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.

gate amount that is necessary for this Annual Out-of-Pocket Maximum to become applicable.

OTHER MEMBER BENEFITS

Short Term Disability Income Benefit

The purpose of this Benefit is to provide any Member of the Plan who is actively at work with a guaranteed income if the Member should become temporarily disabled and unable to work due to an accident or sickness. For this purpose “actively at work” is defined as being present and employed in a full-time, non-temporary capacity, working at least 30 hours a week.

The guaranteed income is a weekly benefit of 50% of the Member’s Average Rate of Weekly Earnings, but in no event will the amount of the Weekly Benefit exceed \$200. The Average Rate of Weekly Earnings means the Member’s Average Weekly W-2 Earnings for the eight weeks immediately preceding the first day of the disability.

Payment of this benefit shall begin after 180 days of continuous total disability and payment will be made for a maximum of 104 weeks for all absences during a single disability period.

Successive periods of disability separated by less than two consecutive weeks of continuous, active, full-time work shall normally be considered one period of disability. However, if a new disability period is due to a cause different from the causes of any prior disability, it need only be separated from the prior disability by one day of full-time active work in order for a Member to be eligible for payment up to the maximum number of weeks for the new absence.

No benefits are payable for

1. The first 180 days of the period of disability;
2. Any day on which the Member is not under the care of a physician; no period of care shall be considered to have started until the Member has been seen and treated personally by the physician;
3. Any day on which the Member is performing work of any kind, anywhere, for compensation or profit.

A Member's Short Term Disability Income Benefits will terminate at the earliest of the following times:

1. When the Plan terminates;
2. When the Member's eligibility terminates;
3. When the Member is no longer a member of a class of employees eligible for the benefits;
4. When the Member retires.

However, if the Member's other benefits under this Plan terminate while the Member is totally disabled, the Member will nevertheless continue to be eligible for Short Term Disability Income Benefits, subject only to the operation of the usual provisions of the Plan.

The Trustees have the right to substantiate a Participant's continued eligibility to receive Short Term Disability Income Benefits.

Long Term Disability Income Benefit

If a Member remains continuously disabled after receiving the maximum 104 weeks of payments under the Short Term Disability Income Benefits coverage provided by the Plan, the Plan office will make long term disability payments to the Member of \$100 per week every two weeks, if the Member meets these criteria:

- The Member continues to receive a Social Security Disability Benefit
- The Member is not engaged in any occupation or employment.

Payments will continue for the maximum period of time shown below:

AGE WHEN DISABILITY COMMENCES	DURATION OF BENEFITS
Prior to Age 62	to the Member's 65th birthday or the date when 36 months of payments have been made, whichever is later
Age 62, 63 or 64	the date when 36 months of payments have been made

- Age 65, 66 or 67 the date when 24 months of payments have been made
- Age 68 or 69 the date when 12 months of payments have been made

Long Term Disability Income Benefits will not be paid if the inability to work was caused by an injury or sickness arising out of:

- War (whether declared or not), insurrection, rebellion, or participation in a riot or civil commotion;
- The Member's commission of, or the Member's attempt to commit an assault, battery or felony;
- Intentionally self-inflicted injuries.

The Trustees have the right to substantiate a Participant's continued eligibility to receive Long Term Disability Income Benefits.

Jury Service and Subpoena as a Witness

The purpose of this Benefit is to provide a guaranteed income if a Member should be unable to work because the Member is serving as a juror or complying with a subpoena requiring the Member's service as a witness in a legal action.

In order to be considered eligible for this Benefit the Member must have been covered by the Health and Welfare Plan for Active Members prior to the Member's call for jury service or the date of the Member's subpoena as a witness. Furthermore, the Member must have satisfied the eligibility requirements as to hours worked for Active Members at the time of the Member's call as a possible juror or witness.

If the Member is called for jury service or subpoenaed as a witness the Member shall be eligible for benefits for the days on which the Member serves, including required reporting for jury duty when summoned, whether or not the Member is used as a juror.

Days on telephone alert will be paid if the Member would not be paid wages for these days or if the Member does not receive Unemployment Benefits. The Member's employer will be called to verify if the Member was working for wages or was receiving Unemployment Benefits. If necessary, verification with the appropriate governmental authority will be made to confirm the Member's telephone alert status.

For each day of jury service or acting as a witness on which the Member otherwise would have been employed, the Member will receive a benefit of \$50 for a maximum of 20 days for any one jury call or subpoena.

Such benefit shall be based on the number of days the Member would normally have worked had the Member not been performing such service.

A separate benefit maximum is available for each separate call for jury service or subpoena to serve as a witness.

A Member will be required to present proof that the Member did serve as a juror or was subpoenaed and reported as a witness, and the amount of pay, if any, received therefor.

Employee Assistance Program

In cooperation with the New York State AFL-CIO, an Employee Assistance Program is available to all Members, their Spouses and Dependents without cost. This program helps Members and their families to resolve personal, persistent problems such as alcoholism, drug abuse, financial difficulties, family tensions and conflicts with co-workers, so that they are effective both at home and at the workplace.

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 coun-

seling 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.

Accidental Death and Dismemberment

The Accidental Death and Dismemberment coverage provides benefits for a Member's loss of life, limbs, or the entire and irrecoverable loss of sight, including losses resulting from occupational bodily injuries. Benefits are payable if the loss is the direct result of a bodily injury caused by an accident, and the loss is sustained within 90 days after the date of the accident.

The full Principal Sum of \$2,000 will be paid for such loss of:

- a) Life
- b) Both hands
- c) Both feet
- d) One hand and one foot
- e) One hand and sight of one eye
- f) One foot and sight of one eye
- g) Sight of both eyes

One-half the Principal Sum will be paid for that loss of one hand, one foot or the sight of one eye. In no case will more than the full Principal Sum be paid for all losses resulting from one accident.

Since the purpose of this coverage is to provide benefits for losses due to accidents, no benefits are paid on account of a loss contributed to or caused by:

- i) bodily or mental infirmity; or
- ii) disease, ptomaine or bacterial infection; or
- iii) medical or surgical treatment (unless made necessary by an injury covered under the Plan); or
- iv) suicide or intentionally self-inflicted injury; or
- v) war or any act of war.

The injury must occur while the Plan is in effect.

Death Benefit

A Death Benefit in the amount of \$2,000 is payable in the event of a Member's death from any cause at any time or place while a Member of the Plan. Payment will be made in a lump sum or installments to the Member's beneficiary. A Member may change the beneficiary whenever the Member wishes.

If a Member becomes totally and permanently disabled while a Member of the Plan and before age sixty, the Member's Death Benefit will remain in force as long as the Member remains so disabled provided proofs of disability are furnished as required. The first proof should be filed within three months after the total disability has lasted for nine months. Subsequent proofs of disability must be furnished each year thereafter.

If membership in the Plan terminates as a result of the Member's retirement, the Member's Death Benefit will remain in effect and the Member will receive a certificate evidencing that Death Benefit. If membership terminates for any reason other than the Member's retirement, the Member's Death Benefit will cease unless the following conditions are met:

1. The Member has attained age 55; and
2. At the Member's date of retirement the Member has at least 16,000 hours credited to the Plan on the Member's behalf and the Member is eligible for the retirement benefits of the I.B.E.W. pension plan. If the Member is not eligible for the retirements benefits of the I.B.E.W. pension plan then the Member must have been either credited with 16,000 hours with the Plan during the ten years immediately preceding the Member's retirement date or insured by the Electrical Workers #86 Insurance Fund for the 120 calendar months immediately preceding the month in which the Member retired.

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 medically 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; or
5. Charges in excess of Allowable Amounts for Out-of-Network providers.

MEDICAL EXPENSE BENEFITS CONVERSION

If your employment terminates, or you cease to be a Member of the Plan, you may apply on behalf of yourself and your insured dependents for an individual policy of Hospital and Medical Benefits, but not Dental Benefits, of a kind then being issued by EBCBS. This right is separate and distinct from your right to Extended or COBRA Benefits described above. The benefits provided under the individual Plan will not be the same as the benefits provided under this Plan. This conversion privilege is also available to any of your covered Dependents who cease to qualify as Dependents under the terms of the Plan and for your surviving insured Dependents should you die.

No evidence of good health will be required. However, written application must be made and the first premium paid.

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. 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 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 or children, makes payroll deductions or contributions and under which plan, medical or dental benefits or services are provided.

“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 a plan which covers the individual as an Employee.

(3) Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year.

If the other plan does not have this provision regarding birthdays, then the rule set forth in that plan will determine the order of benefits.

(4) In the case of a dependent child whose parents are divorced or separated:

(a) If there is a court decree which establishes financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(b) If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent. The benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

(5) If 1, 2 and 3 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 or the dependent of such person;

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

a member who is not laid-off or retired; or a dependent of such person.

(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.

Any eligible active member age 65 and over or any eligible dependent spouse age 65 and over of an active member who has chosen this Plan as primary, will have medical benefits payable first by this Plan. Any eligible expenses not payable by this Plan, should then be submitted to Medicare.

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

1. Consistent with the provisions of HIPAA, 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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