

ELECTRICAL WORKERS LOCAL #86



SUPPLEMENTAL MEDICAL PLAN

June, 2004

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ELECTRICAL WORKERS LOCAL #86 SUPPLEMENTAL MEDICAL PLAN

Dear Fellow Members:

The Trustees of the Electrical Workers Local #86 Health and Welfare Plan for Active Members have adopted a Supplemental Medical Plan for the benefit of the current and future Members of the Plan. The Plan began to operate as of June 1, 2004 and the basic provisions of the Plan are described in these pages.

The Plan is a reimbursement plan and will only pay benefits if an appropriate election is filed with the Plan office and such evidence as the Trustees may require that the expenses have been incurred, is also submitted to the Plan office. Some of the benefits will supplement benefit available under the Electrical Workers Local #86 Health and Welfare Plan for Active Members and that Plan will be referred to hereafter as the "Active Members Plan." Funds in this Plan may also be used to pay required contributions to the Electrical Workers Local #86 Health and Welfare Plan for Retirees 65 and Over and the Plan will be referred to hereafter as the "Retirees 65 and Over Plan."

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

These pages are an outline of the Plan in layman's terms. The terms and conditions of any other documents, or descriptions of the benefits of this Plan that the Plan may adopt 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: 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: 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

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 supplement the hospital, medical and dental benefits available to members of the Electrical Workers Local #86 Health and Welfare Plan for Active Members.

The Plan is funded by Employer contributions for each hour worked by Plan Members and the contributions for each member will be credited to an Account in the name of that Member. The benefits payable to that Member and his/her Spouse and Dependents will be limited to the amount of that account from time to time.

The Member's accounts will be maintained by the Plan office and you may determine the amount in your Account at any time by contacting the Plan office at 585-235-1515 Extension #1 or 888-511-7393 Extension #1.

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 Supplemental Medical 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 disclosures to the Food and Drug Administration to collect or report adverse events or product defects.

Victims of abuse, neglect, or domestic violence

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

Judicial and administrative proceedings

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

Law enforcement purposes

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

Decedents

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

Organ, eye or tissue donation

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

Research purposes

Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.

Health oversight activities

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

Specialized government functions

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

HHS investigations

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

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

it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your individual rights

You have the following rights with respect to your health information that the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See p. 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 designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

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

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

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

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

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

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

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

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

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

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

Changes to the information in this HIPAA notice

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

Complaints

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

Contacts

For more information on the Plan's privacy policies or your rights under HIPAA including information on Restricted 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 Local No. 86 Health & Welfare Plan for Active Members	Julie Ann A. White Kathy Clayton-Roy Debra Mangos, or Thomas J. Sykes
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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 the Trustees of the Local #86 Supplemental Medical Plan, the employees of the Trustees and the agents and subcontractors of the Trustees. 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. ____.

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 shall be destroyed unless 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 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 Supplemental Medical Plan.

Identification Number: ___-_____

Plan Number: ____

Type of Plan: An individual account plan which provides for the reimbursement of various hospital, medical, dental, vision care and other medical expenses that are required to be paid by the individual Member, Spouse or Dependent in order to obtain certain benefits under the Active Members Plan. The Plan also provides funds to pay Extended Benefits Costs under the Active Members Plan and required contributions under the Retirees 65 and Over Plan.

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 Supplemental Medical Plan.

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 Administrator: The Trustees of the Electrical Workers Local No. 86 Supplemental Medical Plan
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. ____.

Loss of Benefits: A loss of benefits for a Plan Member, the Member's Spouse and Dependents will occur when the Plan Member has a zero Account balance in the Plan.

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:

The Electrical Workers Local 86 Supplemental Medical Plan
2300 East River Road
Rochester, New York 14623

Plan Documents: These pages describe only the highlights of your Supplemental Medical Plan and do not attempt to cover all details. These details are contained in the Plan records.

Plan Continuance: The Trustees expect and intend to continue the Supplemental Medical Plan 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 Supplemental Medical 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 benefits you by reimbursing you for certain hospital, medical, dental, vision care and other medical expenses that are not paid by the Active Members Plan. The Plan may also be used to pay amounts due for Extended Benefits Costs under the Active Members Plan, COBRA continuation costs and required contributions under the Retirees 65 and Over Plan.

These pages are not an insurance policy. They describe the principal features of the Supplemental Medical 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 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.

Initial Eligibility

Each Member of the Electrical Workers Local No. 86 Health and Welfare Plan for Active Members as of June 1, 2004 will become a Member of this Plan. The Spouse and the Dependents of the member will also be covered.

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.

Minimum Account Balance

No claims for reimbursement from the Plan will be honored until a Member's Account Balance exceeds \$250.00 and no claim will be paid that would reduce a Member's Account Balance below \$250.00 except in the following circumstances:

1. A Member requests that funds from the Member's Account be used to pay the costs of Extended Benefits for that Member, the Member's Spouse or Dependents that are available under the Electrical Workers Local #86 Health and Welfare Plan for Active Members.
2. A Member, the Member's Spouse or Dependents request that funds from the Member's Account be used to pay the costs of COBRA Continuation Coverage for that Member, the Member's Spouse or Dependents that is available under the Electrical Workers Local #86 Health and Welfare Plan for Active Members.

3. A Member requests that funds from the Member's Account be used to pay the costs of the Member or the Member's Spouse under the Electrical Workers Local #86 Health and Welfare Plan for Retirees 65 and Over.
4. After the death of a Member, the Member's Spouse or Dependents request that funds from the Member's Account be used to pay benefits from the Plan for the Member's Spouse or Dependents.
5. A Member retires.

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.

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. A disabled Dependent over the age at which Dependent coverage would normally terminate becomes capable of self-sustaining employment.
8. 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.

Death of a Member

If a Member dies with an Account Balance in the Plan, claims for benefits under the Plan received from the Member's Spouse and/or Dependents within twenty-four months of the death of the Member will be paid from the Account Balance until the balance is reduced to zero. In the event there is any remaining Account Balance after twenty-four months, that remaining Account Balance will be forfeited. If a Member dies without a Spouse or any Dependents, that Member's Account Balance will be forfeited at that Member's death.

Re-Allocation of Forfeitures

Any Account Balance that is forfeited under the Plan will be re-allocated on a per capita basis to the Accounts of all the other Members of the Plan on the date of re-allocation including the Accounts of any Members who have died leaving a Spouse or Dependents who are eligible to obtain reimbursement from the deceased Member's remaining Account Balance at that time.

Plan Assets and Earnings

The Trustees shall invest and reinvest the assets of the Plan in such investments from time to time as they deem appropriate after taking into consideration the probable distribution rate of those assets. All income earned on such Plan Assets shall be used to pay Plan expenses and any remaining income shall periodically be allocated on a per capita basis to the Accounts of all Members of the Plan on the date of allocation including the Accounts of any Members who have died leaving a Spouse or Dependents who are eligible to obtain reimbursement from the deceased Member's remaining Account Balance at that time.

HOW TO FILE A CLAIM

A claim form must be presented with each claim for benefits under the Supplemental Medical Plan.

Procedure for Presenting Claims for Benefits

1. Claim forms for the reimbursement of deductibles, co-payments and excess payments incurred by a Member, the Member's Spouse or Dependents in connection with benefits obtained under the Active Members plan may be obtained from the Plan office.
2. Please be sure to read and follow the instructions for completing and submitting a claim form. This will expedite the processing of the claim. Be sure all questions are answered fully and all required information describing the nature of the expense incurred and your payment of that amount is submitted with the form. An Explanation of Benefits form issued by Excellus BlueCross BlueShield (EBCBS) upon the payment of benefits under the Active Members Plan, may supply the required information for this Plan.
3. The Plan office will keep a record of your claims. You should not wait until the end of the year to submit your claims. All claims for reimbursement of prescription drug expenses must be submitted within 6 months of the date the expenses were incurred. All other claims for reimbursement must be submitted within 12 months of the date the expenses were incurred.
4. Claims will be paid by the Plan on a regular basis throughout the year and not less often than once each calendar quarter.
5. If a Member, the Member's Spouse or Dependents elect to have Extended Benefits Costs, COBRA Continuation Costs or the cost of participation in the Retirees 65 and Over paid by this Plan, a form for that purpose may be obtained from the Plan office. Please be sure to read and follow the instructions for completing and submitting that form to the Plan office.

If you have any questions about any benefits, 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.

Claims Processing

All claims will be processed by the Plan office. Members will be notified of a claim denial within 30 days of the receipt of the claim unless it is determined that special circumstances require an extension of time. In such event the Member will be notified before the expiration of the 30 day period of the extension, the circumstances requiring it and the date by which the Plan expects to render a decision. If a Member is required to submit additional information, the Member shall be given at least 45 days to submit that information. Notification of a denial shall include the reason for the denial, references to applicable Plan provisions, a description of any additional information necessary for the Member to perfect the claim and the reason why it is necessary, a description of the Plan's appeal procedures and time limits and any criterion relied upon in making the claim denial.

The claimant will 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 claimant prior to the expiration of the 30-day period of the circumstances requiring the extension and of the expected decision date.

If the claimant is required to submit additional information, the claimant shall be given at least 45 days to provide such information.

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

Right to Appeal

Within 180 days after receiving the written notice of a claim being denied, the claimant or a duly authorized representative may appeal the denial of the claimant's claim. Such Appeal shall be conducted by the Trustees, or one or more persons designated by the Trustees, and shall provide the claimant with a full and fair review of the claimant's claim that is independent of the person or persons who denied the claim and their subordinates. The claimant shall have the opportunity to submit any information relevant to the claim and such information shall be considered in deciding the Appeal. The claimant 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.

The Plan Administrator shall notify the claimant of the result of the Appeal no later than the date of the first regularly scheduled meeting of the Trustees after the claimant'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 claimant no later than the date of the third regularly scheduled meeting of the Trustees after the claimant's request for review is received and the Plan Administrator shall notify the claimant 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 described above.

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.

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. The reduction of a Member's Account Balance to zero unless the balance is increased by subsequent Employer contributions.
2. Beginning active military service in the Armed Forces of the United States.

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. Any event which terminates the Member's benefits. But see below.
2. The earlier of 24 months after the death of a Member or when the Spouse remarries.
3. 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. Any event which terminates the Member's benefits. But see below.
2. Twenty-four months after the death of the Member who is supporting such Dependent. But see paragraph 6 and p. ___.
3. When the Dependent marries.
4. 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.
5. 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.
6. 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.

COBRA

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

The information set forth in this section of the Electrical Workers Local No. 86 Health and Welfare Plan for 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 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 reduction of a Member’s Account Balance to zero.

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

1. The reduction of a Member’s Account Balance to zero;
2. The earlier of twenty-four months after the death of a Member or when the Spouse remarries;
3. Divorce from the Member.

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

1. The reduction of a Member’s Account Balance to zero;
2. Twenty-four months after the death of a Member;
3. 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 Members;
2. The payments for the continuation of coverage are not made.

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.

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 Account Balance under the Plan as of that date, or
- (b) To continue his/her coverage under the Plan until his/her Account Balance is used up.

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.

THE SUPPLEMENTAL MEDICAL BENEFITS

The Supplemental Medical benefits provided under the Plan as of June 1, 2004 are described below.

Deductibles and Co-Payments Under the Active Members Plan

Any Member of the Plan may elect on a form submitted to the Plan office to be reimbursed from his/her Account in the Plan for the amount of any deductibles or co-payments the Member has incurred for benefits received by the Member, his/her Spouse and Dependents for benefits under the Active Members Plan. In the event of the death of the Member, the Member's Spouse and Dependents may be reimbursed for any deductibles and co-payments they have incurred for benefits received by the Member's Spouse or Dependents within the twenty-four month period following the death of the Member. See p. ___.

Excess Costs of Certain Benefits Available Under the Active Members Plan

Any Member of the Plan may elect on a form submitted to the Plan office to be reimbursed for any amounts paid by the Member, his/her Spouse or Dependents for certain hospital, medical, dental or vision care incurred by such Member, his/her Spouse or Dependents that are in excess of the specific dollar limit on such benefits provided in the Active Members Plan.

Extended Benefit Costs

Any Member of the Plan may elect on a form submitted to the Plan office to pay any Extended Benefit Costs of the Member under the Active Members Plan. When there are insufficient funds available to make any such payments that may become due, the Plan office shall notify the Member of the insufficient funds. In the event of the death of the Member, the Member's Spouse and/or Dependents may elect to pay their Extended Benefit Costs to the Active Members Plan within the twenty-four month period following the death of the Member. See p. ___.

COBRA Continuation Costs

Any Member of the Plan may elect on a form submitted to the Plan office to pay any COBRA Continuation Costs of the Member under the Active Members Plan. When there are insufficient funds available to make any such payments that may become due, the Plan office shall notify the Member of the insufficient funds. In the event of the death of the Member, the Member's Spouse and/or Dependents may elect to pay their COBRA Continuation Costs to the Active Members Plan within the twenty-four month period following the death of the Member. See p. ___.

Retirees 65 and Over Plan Costs

Any Member of the Active Members Plan who retires after the effective date of this Plan and then participates in the Plan for Retirees 65 and Over may elect on a form submitted to the Plan office to pay the contributions required for participation in the Retirees 65 and Over Plan for himself and/or his/her Spouse from the Member's Account in this Plan. In the event of the death of the Member, the Member's Spouse ??????????????

The Trustees have determined that commencing as of June 1, 2004 the benefits of the Plan are as described above but the Trustees may from time to time increase or decrease the benefits and shall notify the Members when any such changes occur. Any future changes will be solely within the discretion of the Trustees and will not be dependent upon the treatment of the benefits, and the expenses on which they are based, for purposes of the Internal Revenue Code of 1986 as amended.

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