

SUMMARY PLAN DESCRIPTION
As Amended to June 1, 2018

**EMPLOYEES SECURITY FUND
OF THE
ELECTRICAL PRODUCTS
INDUSTRIES**

***HEALTH AND WELFARE
PLAN***

ESTABLISHED 1944

**Harry Van Arsdale Jr.
Founder**

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As part of a total benefits package negotiated on your behalf, the following benefits are provided to eligible Participants of the Employees Security Fund and their eligible dependents.

This booklet describes the Plan in effect as of June 1, 2018.

GENERAL INFORMATION

Name of Plan:	Employees Security Fund of the Electrical Products Industries 158-11 Harry Van Arsdale Jr. Avenue Flushing, NY 11365 (718) 591-1100
Plan Sponsor Identification No.:	13-6100908
Plan Number:	501
Plan Year:	January 1 through December 31
Plan Administrator and Agent for Legal Process:	Joint Industry Board of the Electrical Industry 158-11 Harry Van Arsdale Jr. Avenue Flushing, NY 11365 (718) 591-2000

Service may also be made upon any of the Trustees.

This booklet is available in Spanish upon request. To obtain a copy of this booklet in Spanish, please contact the Fund Office at 718-591-1100

Esta guía es disponible en Español por solicitud. Para obtener una copia de esta guía en Español, por favor llame a la Oficina de Beneficios al (718) 591-1100

Type of Plan:	The Plan is a self-insured employee welfare benefit plan under which Participants are covered for certain services relating to their health.
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Type of Administration:

The Plan is maintained by a Joint Board of Trustees consisting of Trustees appointed by Local Union No. 3 of the International Brotherhood of Electrical Workers, AFL-CIO (the “Union”) and employers under contract with the union. The Trustees’ names and office addresses are listed below.

Michael Bellovin
Legion Lighting Co., Inc.
221 Glenmore Avenue
Brooklyn, NY 11207

Mitchell Bloomberg
Picasso Lighting
46 Sellers Street
Kearny, NJ 07032

Dominick Cutrone
Manhattan Electric Supply
1104 Ave. P
Brooklyn, NY 11229

Jonathan Lifton
L. B. Electrical Supply Co., Inc.
5202 New Utrecht Avenue
Brooklyn, NY 11219

Jerry Schiff
Harbor Elec Fabrication & Tool Inc.
29 Portman Road
New Rochelle, NY 10801

Barry Seitles
Tremont Electric Supply
1785 Jerome Avenue
Bronx, NY 10453

Annette Diaz
Business Representative
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
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Christopher Erikson
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Anthony Esponda
Business Representative
Local Union No. 3, I.B.E.W.
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John E. Marchell
President
Local Union No. 3, I.B.E.W.
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Local Union No. 3, I.B.E.W.
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Robert Olenick
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Local Union No. 3, I.B.E.W.
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Luis Restrepo
Assistant Business Manager
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

Lance Van Arsdale
Assistant Business Manager
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

NONDISCRIMINATION

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call 718-591-2000 or write to: The Joint Industry Board of the Electrical Industry, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-718-591-2000.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-718-591-2000。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-718-591-2000.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-718-591-2000.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-718-591-2000 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-718-591-2000.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסס פריי פון אפצאל. רופט 1-718-591-2000

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৭১৮-৫৯১-২০০০

UWAGA: Jezeli mówisz po polsku, mozesz skorzystac z bezplatnej pomocy jezykowej. Zadzwon pod numer 1-718-591-2000.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-718-591-2000

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-718-591-2000.

خدمات مفت یمدد ک ی تو آپ کو زبان ک، سی خبردار: اگر آپ اردو بولتے ہ
1-718-591-2000 سی کال کر۔ سی ہ ابی دست سی م

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-718-591-2000.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-718-591-2000.

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-718-591-2000 まで、お電話にてご連絡ください

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-718-591-2000.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-718-591-2000.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-718-591-2000

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-718-591-2000 पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-718-591-2000

SOURCES OF CONTRIBUTIONS

The Plan was established and is maintained under Collective Bargaining Agreements between Local Union No. 3, I.B.E.W., AFL-CIO, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, and Employers in the Electrical Manufacturing and Supply Industry, as well as other Employers. Upon a written request from any Participant or beneficiary, the Plan Administrator will state in writing whether a particular employer is obligated to contribute to the Plan, the employer's principal business address and the level of benefits applicable to the particular employer. The Plan Administrator will also provide upon a written request from a Participant or beneficiary, a copy of the Collective Bargaining Agreement between the Union and the Participant's employer. Copies of Collective Bargaining Agreements are available for inspection at the office of the Plan Administrator during normal business hours.

ELIGIBILITY FOR BENEFITS

Active Participants

The following eligibility rules apply to Participants who are or were covered under a Collective Bargaining Agreement that is recognized by the Plan. In order to receive the benefits provided by the Plan, you must be an "eligible Participant," either active or retired. Initial eligibility is attained on the earlier of (1) a date no more than 90 days after the Participant achieves 1,200 hours of service or (2) the date immediately following the Participant's completion of 26 out of 52 weeks of full-time work during which time contributions were received on his or her behalf. Thereafter, at least 26 weeks of contributions out of the past 52 must be received prior to incurring a reimbursable expense, or, if unemployed during all or any portion of such period, the Participant must have been registered as available for employment.

Employees at companies newly organized by Local Union No. 3 become eligible Participants under the Plan after four (4) or more weeks of contributions have been paid by the Employer. Coverage for the Participant's legal spouse and eligible children begins after 26 weeks of contributions have been received.

Eligibility for benefits terminates as of the day when contributions cease to be made on behalf of the Participant. However, a Participant who is covered by a Local 3 Collective Bargaining Agreement and who is

unemployed and has registered as available for employment can remain eligible under this Plan for up to 6 months after the period for which the last contribution was made to the Plan. Participants will be responsible for expenses incurred and any benefit payments erroneously made by the Plan after eligibility for coverage terminates.

Benefits may be reinstated following a termination of eligibility once the Participant works again for a contributing Employer to this Plan for at least 26 out of 52 weeks.

In order to be eligible for benefits, you must complete an enrollment form and submit applicable documentation. Benefits will not be paid until appropriate documentation is received by the Joint Industry Board.

Participants who leave an employer who provides one level of benefits and goes to work for an employer who provides either a higher or lower level of benefits will keep his or her former health benefits for the first 26 weeks of employment with the new employer. After those first 26 weeks are completed and contributions are received by the Plan, the new level of benefits will take effect.

Retired Participants:

Participants who have retired on a Normal Retirement Pension (with 20 or more pension credits), a Standard Pension or a Disability Pension from the Employees Security Fund of the Electrical Products Pension Plan, and their eligible dependents, are eligible only for dental, optical, prescription drug and annual diagnostic medical benefits as described in Section II of this booklet. This coverage ends upon the death of the Participant. Retired Participants, the legal spouses and eligible children lose all other coverage (including hospitalization, surgery, and anesthesia) upon the Participant's retirement. Pensioned Participants, their legal spouses and eligible children may be eligible to purchase COBRA continuation coverage, which is described on pages 39-46.

DEPENDENTS' ELIGIBILITY

Once you satisfy the eligibility requirements previously described, you become a Participant and your eligible dependents, as defined below, are covered under the Plan, provided you complete the applicable enrollment forms and submit the appropriate documents on their behalf.

Eligible dependents are:

1. Your lawful spouse.
2. Your children from birth up to their 26th birthday.

The term “children” shall mean natural, legally adopted children and stepchildren. If an eligible Participant needs to add a new dependent, the Participant may enroll the dependent by submitting to the Members’ Records Department of the Joint Industry Board, at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, a copy of the marriage or birth or adoption certificate, as applicable. Coverage is effective as of the date of marriage or birth of child, provided the Participant was then eligible. Dependent eligibility terminates at the same time as the Participant’s eligibility.

SECTION I

BENEFITS

There are two levels of health benefit plans; Plan A and Plan C. The Collective Bargaining Agreement between Local Union #3, International Brotherhood of Electrical Workers, AFL-CIO and your Employer will state which plan level you are covered under.

PLAN “A” BENEFITS

Covered Plan “A” Hospital Expenses

Covered Service	Benefit
In-Patient Hospital Admission Room & Board - paid through Empire Blue Cross and Blue Shield (“Empire”)	\$400 per day, subject to a \$1,000 per admission co-payment.
Out-patient Hospital Admission Facility Charge – paid through Empire	\$400 per day
Nursery – paid through Empire	\$400 per day, subject to applicable \$1,000 co-payment.
Chemotherapy – paid through Empire	Up to 100% of Empire Fee Schedule
Dialysis – paid through MagnaCare if facility based; paid through Empire if hospital based.	Up to 100% of applicable network Fee Schedule, \$1,000 co-pay for facility charge.
Anesthesia – paid through MagnaCare	Up to 100% of MagnaCare Fee Schedule.

Covered Plan “A” Non-Hospital Expenses

Covered Service	Benefit
Surgery – paid through MagnaCare	Paid at 100% of MagnaCare Fee Schedule. Any surgical procedure whose allowable Plan reimbursement exceeds \$250 will be subject to a maximum \$1,000 co-payment. There is an annual \$1,000 cap on surgical co-payments.
Annual Diagnostic* Medical Benefit – paid through MagnaCare <i>* 1 routine gynecological visit may be used as an annual diagnostic visit.</i>	Up to one annual diagnostic visit. Visits are paid at 100% when rendered at JIB Medical, Morristown Hospital or PEMG. Diagnostic visits rendered at other facilities or by other providers will be paid at the MagnaCare rate, subject to a \$50 co-payment.
Prosthetics – Paid through MagnaCare	Paid at 100% of MagnaCare Fee Schedule.
Dental Care	See page 24
Optical Care	See page 27
Prescription Drug Benefits	See page 20
Home Health Care – paid through MagnaCare	Paid at 100% of MagnaCare Fee Schedule for eligible Participants with cancer for diagnosis only.

Alcohol and Substance Abuse Benefits

In-Patient Hospital Benefits

All in-patient hospital admissions will be covered at \$400 per day and are paid through Empire.

In-Network Treatment and Confinement Benefits

Participants who elect to use a JIB Substance Abuse Services (“JIB SAS”) approved facility will have such confinement paid at 100% of the approved rate with no out of pocket responsibility.

The JIB SAS is located at the Joint Industry Board and can be reached at (718) 591-2000 ext. 1396. Please see page 17 for more information about JIB SAS.

Participants who do not elect to use a JIB SAS-approved facility will be reimbursed at the rate of \$400 per day subject to a \$1,000 co-payment. Any balance will be the responsibility of the Participant.

LIMITATIONS OF PLAN “A” BENEFITS

No coverage is provided under Plan “A” for expenses incurred for any of the following (these limitations are in addition to all Plan Limitations found on page 35).

- 1) Physician Services, in-patient and out-patient
- 2) Lab and pathology, radiology, x-rays, MRI/MRA, CT Scan, SPECT/PET Scans, EKG/EEG/EMG
- 3) Emergency Room services when patient is not admitted to the hospital.
- 4) Any and all other ancillary charges related to a hospital admission.

Your health coverage, provided by the Employees Security Fund of the Electrical Products Industries Health and Welfare Plan, does not meet the minimum standards required by the Affordable Care Act.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns, contact the Joint Industry Board of the Electrical Industry at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, (718) 591-2000 .

MEDICAL SERVICES PROVIDER NETWORK

(applies to Plan “C “only)

Non-Hospital Network

The Plan has contracted with the MagnaCare Preferred Provider Organization (“Network”) to provide a network of medical providers. Since all providers in the Network agree to accept the Plan’s assigned payment, there is no out-of-pocket expense to the Participant if a Network medical provider is used, other than any applicable co-payment as described on the following pages. There is no requirement that you use a Network medical provider. However, the Plan’s benefits are limited to the Network’s contracted amounts, less the applicable co-payments and for some services there is no reimbursement if you use a non-network provider. Thus, there will generally be a greater out-of-pocket cost to you if you use a Non-Network provider. A listing of participating providers may be obtained by requesting a directory from the Members’ Records Department at the Joint Industry Board, or by contacting MagnaCare at 1-800-548-0138 or utilizing its website at www.magnacare.com.

Hospital Network

The Plan has contracted with Empire Blue Cross and Blue Shield (“Empire”) to provide a network of hospitals. Since all facilities in the Empire network agree to accept the Plan’s assigned payment, there is no out-of-pocket expense to the participant if an Empire facility is used, other than any applicable co-payment as described on the following pages.

PLAN “C” LEVEL OF BENEFITS

Covered Plan “C” Hospital Expenses (continued on next page)

Covered Service	Benefit
In-patient Hospital Admission Room & Board – paid through Empire	Paid at 100% of Empire Network Fee Schedule, subject to a \$500 co-payment. <u>This is an in-Network benefit only for non-emergency admissions.</u> All hospital admissions must be pre-notified through Empire as described on page 16.
Out-patient Hospital Procedure Facility Charge – paid through Empire	Paid at 100% of Empire Network Fee Schedule, subject to a \$250 co-payment. <u>This is an in-Network benefit only for non-emergency procedures.</u> All hospital services should be pre-notified through Empire.
Effective hospital-based pre-surgical testing performed within 10 days of an admission – paid through Empire	Paid at 100% of Empire Network Fee Schedule, subject to a \$100 co-payment. <u>This is an in-Network benefit only.</u>
Emergency Room – paid through Empire	Paid at 100% of Empire Fee Schedule, subject to a \$100 co-payment. Emergency Room co-payment is waived if patient is admitted to the hospital.
In-Patient Physician Visit – paid through MagnaCare	Paid at 100% of Network Fee Schedule.
Nursery – Paid through Empire	Paid at 100% of Empire Fee Schedule, subject to applicable \$500 co-payment. <u>This is an in-Network benefit only</u>
Chemotherapy – paid through Empire	Up to 100% of Empire Network Fee Schedule. This is covered in and out of Network.

Covered Service	Benefit
Dialysis – paid through MagnaCare if facility based/paid through Empire if hospital based.	Up to 100% of applicable Network Fee Schedule. This is covered in and out of Network.
Radiation Therapy – paid through MagnaCare if facility based/paid through Empire if hospital based.	Up to 100% of applicable Network Fee Schedule. This is covered in and out of Network.
Anesthesia – paid through MagnaCare	Up to 100% of Network Fee Schedule. This is covered in and out of Network.
Substance Abuse Rehabilitation – paid through Empire	Up to 100% of Empire Network fee. <u>This is an in-Network benefit only.</u>
Hospice – paid through Empire	Paid at 100% of Empire Network Fee Schedule, subject to a \$500 co-payment. <u>This is an in-Network benefit only and must be pre-notified through Empire as described on page 16.</u>
Out-Patient Physical Rehabilitation – paid through Empire	This benefit is limited to 15 days per incident and must immediately follow a hospital discharge. This is an in-Network benefit only and must be pre-notified through Empire as described on page 16.

PRE-NOTIFICATION REQUIREMENTS

Plan “C” requires pre-notification of certain services, as described below:

Pre-notification Required Through Empire: Hospitals will be required to contact Empire’s Pre-Certification Department at 1-844-243-5566 for the following:

- Hospital admissions
- Any surgical procedure to be performed at a hospital or surgi-center. This includes procedures done on both an in-patient and out-patient basis
- Transplant services
- Hospital based homes health care agencies

Pre-notification Required Through MagnaCare: Participants, physicians and/or hospitals will be required to contact MagnaCare’s Pre-notification Department at 1-877-335-4725 for any of the following:

- Non-hospital services including, but not limited to office based surgical procedures and home health care

Your failure to pre-notify the foregoing services may result in no coverage for the service, if it is later determined that the services were not medically necessary, or otherwise not appropriate.

EMERGENCY ROOM BENEFITS – PLAN “C” ONLY:

Emergency care provided by a hospital, surgi-center or other licensed medical facility due to an injury or other sudden illness for which any delay in obtaining medical care would seriously jeopardize the life or health of the individual, will be paid in accordance with the Plan’s established procedure. For services rendered in an Emergency Room, when the Participant has no choice as to the selection of a provider, the Plan will negotiate the reimbursement amount so that there is no out-of-pocket expense to the Participant. This may include services rendered by a physician or a facility within a hospital. Examples of emergency conditions include but are not limited to: heart attacks, severe chest pain, cardiovascular accidents, and severe breathing difficulty such as asthma, shock, hemorrhaging or other acute conditions. This benefit is subject to a \$100 co-payment.

ALCOHOLISM OR DRUG ADDICTION BENEFITS

If a Participant or eligible dependent is referred to an alcohol or drug treatment facility for the effective treatment of alcohol or drug addiction, the expenses of this treatment facility will be covered only if the following conditions are met:

1. ***Pre-certification is required for in-patient facility care. Providers must contact Empire's Pre-certification Department at 844-243-5566.***

For an elective admission, Participants may contact JIB Substance Abuse Services at 718-591-2000 ext. 1396, in order to be referred to a preferred provider.

JIB Substance Abuse Services Disease Management Program

The JIB Substance Abuse Services ("JIB SAS") now offers a disease management program. This program offers outreach to plan participants who suffer from alcohol or other substance abuse issues. JIB SAS staff will reach out and offer guidance in matching you with the right level of care at effective treatment programs. JIB SAS can provide you with information about substance abuse, addiction, and the recovery process. We will also help identify resources for your aftercare needs. This includes referral to exclusive and confidential Local 3 support groups. Any members who seek treatment for a substance use problem will be automatically enrolled and will receive an introductory letter. If you do not wish to be contacted, you may opt out at any time by calling the JIB SAS office. If you are interested in assistance now and don't want to wait, you may also contact JIB SAS at 718-591-2000, extension 1396.

We encourage all Participants to use JIB Substance Abuse Services in order to receive high quality care at a reasonable cost.

Covered Plan “C” Non-Hospital Expenses (expenses other than facility charges)

Covered Service	Benefit
Surgery – physician’s charge (in hospital) – paid through MagnaCare	Paid at 100% of Network Fee Schedule. <u>In-Network Benefit only.</u>
Surgery – physician’s charge (in office) - – paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment. <u>In-Network Benefit only.</u>
Pre-surgical consultation - – paid through MagnaCare	Limit one per surgical procedure. Paid at 100% of Network Fee Schedule. <u>In-Network Benefit only.</u>
Physician’s Office Visit - paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a maximum of \$50 co-payment.
Immunization – paid through MagnaCare	Paid at 100% of Network Fee Schedule. Children covered up to 18 years of age. <u>In-Network Benefit only.</u>
Annual Diagnostic* Medical Benefit – paid through MagnaCare <i>* 1 routine gynecological visit may be used as an annual diagnostic visit.</i>	Up to one annual diagnostic visit. Visits are paid at 100% when rendered at the JIB Medical, Morristown Hospital or PEMG. Diagnostic visits rendered at other facilities or by other providers will be paid at 100% of Network Fee Schedule, subject to a maximum of \$50 co-payment.
Prosthetics – paid through MagnaCare	Must be pre-authorized through MagnaCare by calling 1-877-335-4725.

Plan “C” – Continued

Covered Service	Benefit
Diagnostic – Radiology (x-rays) – not hospital based – paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a \$50 co-payment. <u>In-Network Benefit Only.</u>
Diagnostic – Lab & Pathology – not hospital based – paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a \$30 co-payment. <u>In-Network Benefit Only.</u>
MRI (not hospital based) – paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment. <u>In-Network Benefit Only.</u>
CT Scan (not hospital based) – paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment. <u>In-Network Benefit only.</u>
Ambulance – paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment.
Well-Care Mammography – paid through MagnaCare	Paid at 100% of Network Fee Schedule, subject to a \$50 co-payment. <u>In-Network Benefit only.</u> This benefit is available one time per year.
Dental Care	See page 24
Optical Care	See page 27
Prescription Drug Benefits	See page 20
Home Health Care * – paid through MagnaCare <i>* limited to cancer diagnosis only</i>	Paid at 100% of Network Fee Schedule

SECTION II

The following benefits Apply to all eligible Plan “A” and “C” Participants and all eligible retirees.

PRESCRIPTION DRUG BENEFIT

The Plan provides a Prescription Drug Program that is managed by Express Scripts for Participants and all eligible dependents. The Plan will issue a separate identification card which, when presented to pharmacies who participate in the Express Scripts Network, will cover the cost of the prescription, except for the applicable co-payment. You should call Express Scripts at 1-800-413-7402 for any questions on the Prescription Drug Plan.

The Prescription Drug Plan includes a mandatory generic substitution policy. If a prescription drug has a generic equivalent and the Participant or dependent elects the brand name or the physician indicates that only the brand name should be dispensed, the Participant must pay the pharmacist the difference between the maximum allowable cost of the generic drug and the cost of the brand drug, plus the generic drug co-payment. There may be an exception to this mandatory generic substitution policy if the physician confirms there is a medical necessity requiring the individual to utilize a brand name drug. Contact the Members’ Records Department at 1-718 591-1100 to obtain a form, which you may submit to seek approval of such an exception.

Generic drugs are the least expensive medications, while Preferred (Formulary) brand name drugs cost less than Non-preferred (non-Formulary) brand name drugs. For more information on Preferred brand name drugs and Non-preferred brand name drugs, please refer to the Express Scripts “*Preferred Prescriptions Member Guide*” or contact Express Scripts directly at 1-800-413-7402 or visit the Express Scripts website at www.express-scripts.com. Note that certain medications may be listed in the *Member Guide*, but are not covered by the Plan. See page 23 for the types of drugs that are not covered by the Plan. Participants may submit direct reimbursement claim forms to the Plan in those instances where the Participant does not use a participating pharmacy. In such cases, however, the Participant will incur out-of-pocket expenses because the Plan’s reimbursement will be based on the Plan’s allowable cost, less the applicable co-payment.

Cost Level	Retail Network Pharmacy Co-Payment	Mail Order Pharmacy Co-Payment
Generic Drugs	\$15 (up to 34 day supply)*	\$45 (90 day supply)**
Preferred Brand Name Formulary Drugs	\$25 (up to 34 day supply)*	\$75 (90 day supply)**
Non-preferred Brand Name Drugs	\$40 (up to 34 day supply)*	\$120 (90 day supply)**

* Prescriptions filled at the retail pharmacy may only be filled up to a maximum 34-day supply.

** For certain prescription drugs you take on a long-term basis (12 months or more), you may use a participating retail pharmacy for your initial prescription and one refill (for a total of 2 fills). If you continue taking that medication, you **must** order subsequent refills through the Express Scripts by Mail Pharmacy Service or **pay the entire cost** of the medication yourself at the retail pharmacy. For more information on the Express Scripts by Mail Pharmacy Service, see page 22.

If a brand name drug is prescribed when a generic equivalent is available, your cost will be the difference between the cost of the brand-name drug and the generic drug, plus the generic co-payment.

PRIOR AUTHORIZATION OF CERTAIN MEDICATION

Prior authorization is required for certain drugs. In an effort to promote safety and health, certain drugs may require a Network pharmacist to discuss the medical appropriateness with the prescribing physician before approval is given to dispense the medication. Examples of drug categories managed by Express Scripts are drugs relating to growth hormones, multiple sclerosis, migraines, sleeping disorders, arthritis, high blood pressure and stimulants along with certain compound prescriptions.

If you receive a new prescription for one of the medications that require prior authorization, the pharmacist will advise you of the need to obtain a coverage review and will provide the toll-free number for Express Scripts' Coverage Review Unit to the prescribing physician's office. The pharmacist can also take the necessary information from you and the physician and provide it to Express Scripts, and Express Scripts will contact the physician directly. If the medication is approved, Express Scripts will send a letter to you and the physician and will also notify the pharmacist who will then fill the prescription. If you are using the mail order facility for one of these medications requiring advance review, the Express Scripts Coverage Review Unit will contact the prescribing physician directly and, if the drug is approved, will mail the medication to you. If the medication is not approved, a letter with the reason for the denial will be sent to you and the doctor. The letters will contain information and instructions on the appeal procedures, which are described later in this booklet on page 55.

MAIL ORDER PHARMACY

The Prescription Drug Plan requires the use of Express Scripts' Mail Order Program for all maintenance medications. If you are using a maintenance medication to treat an ongoing illness, you can have your doctor prescribe the initial prescription for a month's supply that can be filled at a local retail pharmacy and a second prescription for a 90-day supply. After mailing your 90-day prescription to Express Scripts, allow 14 days for delivery. The cost to you for a 90-day supply is only the applicable co-payment unless you request a brand name drug when a generic is available (and you have not demonstrated the medical necessity of the brand name drug). In that case, you are responsible for paying the difference in cost between the brand name drug and the generic drug, plus the co-payment.

Illnesses that require maintenance medication include, but are not limited to:

- Epilepsy
- Arthritis
- Thyroid Disease
- Constipation
- High Blood Pressure
- Heart Disorder
- High Cholesterol
- Ulcers

The Plan will allow only the initial prescription and one refill of a maintenance medication to be filled at a local retail pharmacy. **Any**

subsequent prescription or refill relating to the same maintenance medication must be filled through the Express Scripts Mail Order Program, or you will be responsible for the payment of the entire cost of the drug and will not receive any reimbursement from this Plan. For this reason, it is strongly recommended that you ask your physician for a 90-day supply, in cases where he or she would ordinarily prescribe a 30-34 day supply, with 2 or more refills.

After filling a maintenance medication at your local pharmacy two times, there may be circumstances when your physician needs to monitor the strength and/or dosage of the medication on a short-term basis. In such a case, you may call the Members' Records Department at 718-591-2000, ext. 2491 to request an override that will allow you to continue to get a monthly supply from your local pharmacy until your physician is ready to prescribe a 90-day supply.

EXCLUDED PRESCRIPTIONS

The following prescriptions are excluded from coverage under the Plan, unless determined by the Plan to be medically necessary:

Non-sedating antihistamines	Vitamins (other than pre-natal -
Fertility drugs	vitamins, with applicable co-
	payments
Anti-obesity drugs	Erectile dysfunction drugs

If you think one of the medications listed above is medically necessary, you may request a medical review of your prescription by contacting the Members' Records Department at 718-591-2000, ext. 2491 to obtain a form, which you and your doctor must submit.

The Plan does not coordinate payment of prescription drug benefits with other health plans.

Additional exclusions relating to medical and prescription drug coverage are set forth on pages 35-37.

DENTAL BENEFITS

You, your legal spouse and eligible children may obtain dental treatment through the Dental Benefits provision of this Plan. You may use the Dental Benefits provided by the Plan in either of the following ways:

- You may use the dental facilities of DDS, Inc. (“DDS”), a closed panel of participating dentists who agree to accept the Plan’s dental allowances for covered services as payment in full. If you do this, you do not have to file a Dental Benefit Request Form. Call DDS at (800)-255-5681 for information.
- You may use any licensed dental facility in the United States or its possessions. The cost of this treatment is paid for by the Plan up to the limits of the dental allowances for covered services. Any out of pocket balances incurred as a result of using a non-DDS provider will be the patient’s responsibility.

You and your adult eligible dependents each have a \$1500 annual maximum on all dental work performed in a single calendar year. All charges above the \$1500 annual maximum are the patient’s responsibility, regardless of whether or not the service was provided by a DDS, Inc. provider or a non-Network provider.

You and your eligible dependents each have an annual \$50 deductible on services that are not preventative or basic. Preventative or basic services include:

- examinations
- prophylaxis
- pulp cap fillings
- cementing of crowns and bridges
- x-rays
- fillings
- simple extractions
- palliative treatment to prevent pain

PRE-AUTHORIZATION OF CERTAIN SERVICES

All crown, bridge, prosthetics, osseous surgery or root canal require preauthorization *before* such dental work is done. A DDS dentist will automatically obtain pre-authorization for you. If you use a non-DDS dentist, it is the patient’s responsibility to see that the dentist obtain pre-authorization. To obtain pre-authorization for services provided by a non-DDS dentist, have your dentist list the required dental work and fees on a Dental Benefit Request Form. All relevant x-rays must be attached

to this form. Sign the form and send it to DDS, Inc., located at 1640 Hempstead Turnpike, East Meadow, NY 11554. DDS will then review the case, notify the dentist of the total amount that the Plan will pay for the dental work and the portion that the patient will be responsible for. X-rays will be returned to the dentist.

The following services are excluded from coverage under the Dental Benefit:

- Services for which there is no charge
- Cosmetic Dentistry
- Orthodontics
- Dental Implants
- Prosthetic replacement unless five (5) years have elapsed since the prior insertion
- Replacement of lost dentures, unless five (5) years have elapsed since the prior insertion
- Services which exceed the \$1500 limit per calendar year per covered individual
- Any procedure not listed in the Schedule of Dental Allowances available in the Fund Office

See pages 35-37 for further exclusions.

DIAGNOSTIC MEDICAL

This benefit enables you, your legal spouse and eligible children to obtain, once each year, a physical examination for diagnostic purposes only. The Diagnostic Medical Benefit provided by the Plan is available in the following ways:

- You may use JIB Medical P.C., located at:
Electric Industry Center
158-11 Harry Van Arsdale Jr. Avenue, 2nd Floor
Flushing, NY 11365

For information on how to arrange an appointment, please see the section on JIB Medical P.C. on pages 26-27.

- You may use the diagnostic medical services available at a facility located in New Jersey or Long Island.

Morristown Hospital is located at 100 Madison Avenue, Morristown, NJ 07962. Call 973-971-7291 to make an appointment. It is not necessary to file a claim for this benefit. This is a paid in full benefit subject to Plan limitations as described below.

Professional Evaluation Medical Group (“PEMG”) is located in Manhattan, Nassau and Suffolk Counties. Call 516-935-4378 to make an appointment. It is not necessary to file a claim for this benefit. This is a paid in full benefit subject to Plan limitations as described below.

You may also use any medical doctor or doctor of osteopathy licensed and practicing in the United States or its possessions. This benefit is paid at the Network rate and is subject to a \$50 co-payment,

The following charges are not covered by the Diagnostic Medical Benefit:

- Treatment
- More than one physical examination per patient per calendar year.

JIB MEDICAL, P.C.

All Participants and their eligible dependents are entitled to the services provided by JIB Medical, P.C. (“JIB Medical”) at the Electrical Industry Center, located at 158-11 Harry Van Arsdale Jr. Ave., Flushing, New York, 11365.

JIB Medical sees patients who come to the facility for primary care as well as patients who have outside doctors. For those patients who have an outside doctor primarily managing their healthcare, JIB Medical doctors will work with the other doctor(s) as needed.

Provided services include:

Annual physicals

Mammograms

Lab Tests

Chest X-Rays

EKGs

Pap Smears

P.S.A. Tests
Proctology Exams

To schedule a medical appointment, contact JIB Medical at (718) 591-2014 from Monday - Friday, 8:00 A.M. to 7:15 P.M. and Saturday from 8:00 A.M. to 2:45 P.M. Appointments should be made approximately 2 weeks in advance.

OPTICAL BENEFITS

The Optical Benefit enables you, your legal spouse and eligible children to obtain an eye examination once each year by an optometrist or an ophthalmologist and, if prescribed, obtain one pair of eyeglasses once each year. The Optical Benefit is available in the following ways:

You may use the optical services (optometrist for examination and optician for eyeglasses) of JIB Medical located at:

Electric Industry Center
158-11 Harry Van Arsdale Jr. Avenue, 2nd Floor
Flushing, NY 11365

To schedule an optical appointment, contact JIB Medical at (718) 591-2014 from Monday - Friday, 8:00 A.M. to 7:15 P.M. and Saturday from 8:00 A.M. to 2:45 P.M. Appointments should be made approximately 2 weeks in advance.

If you obtain the benefit in this way there will be no charge to you. You do not have to file a claim form.

Optical Benefits Provided Outside of JIB Medical

- You may use an optical provider who belongs to the Vision Screening Optical Group. These providers offer optometric eye care to Participants, their legal spouses and eligible children living in New York, New Jersey and Florida. Their service includes one eye examination by an optometrist and, if prescribed, a pair of eyeglasses (mono-focal or bi-focal) and a selection of frames once a year. If you use this method and you buy supplies or services for which you are not eligible or covered, you will be responsible to pay these charges, but you will receive a 20% discount. To use a Vision Screening provider,

please contact the Fund Office at (718) 591-1100 to request an optical voucher.

- You may use a panel optical provider located in New Jersey. Their service includes one eye examination by an optometrist and, if prescribed, a pair of eyeglasses (mono-focal or bi-focal) and a selection of frames once a year. If you obtain the benefit in this way there will be no charge to you. You do not have to file a claim form. Please contact the Fund Office at (718) 591-1100 to request an optical voucher for a New Jersey panel provider.
- You may have an eye examination by any other optometrist or ophthalmologist, licensed and practicing in the United States or its possessions. You may purchase eyeglasses, if necessary, from any licensed facility operating in the United States or its possessions. If you use this method, you must file a claim form with the Fund Office. The Plan will reimburse you or your optical provider up to the amounts below:

Exam including tonometry: \$ 35

Single vision lenses & frames: \$ 45

Bi-focal lenses & frames: \$ 85

The Following Charges are not Covered by the Optical Benefit:

- Payment for an eye examination by an optician.
- Treatment (other than prescribing corrective glasses).
- Eyeglasses with tinted lenses (except when obtained free of charge by a Vision Screening provider), special frames or other cosmetic features.
- Contact lenses.
- More than one eye examination and one pair of glasses per patient in each calendar year once every 12 months.

HEALTH ADVOCATE

Health Advocate is a valuable benefit provided by the ESF to help you and your entire family navigate the healthcare system and maximize your healthcare benefits.

Health Advocate can assist you with many clinical and administrative issues including, but not limited to:

- Finding an in-network physician
- Helping to understand complex provider bills and statements
- Help with eldercare issues
- Help to make arrangements for special needs services

Health Advocate's services are available to all eligible Participants, dependents and even parents and parents-in-law.

Health Advocate can be reached at 1-866-799-2723.

BENEFITS IF YOU ARE ON WORKERS' COMPENSATION OR DISABILITY

If you are eligible for health benefits and become unable to work due to illness, injury or a work-related injury or illness, the Plan will extend health benefits to you, your legal spouse and eligible children for up to 26 weeks. **Please contact the Fund Office at (718) 591-1100 to immediately inform them of this occurrence.**

SERIOUS INJURY

What Is the Benefit?

When you are seriously injured on the job and are directly taken to a hospital and admitted to a bed, this Plan will pay you your straight time work-week wages as defined in your Employer's collective bargaining agreement with the Union for up to ten weeks for hospitalization. This payment is made to you regardless of any other coverage you may have.

Who Is Eligible?

- Participants employed by a contributing Employer who makes contributions to the Plan on their behalf, who are seriously injured on the job or on an assignment at the direction of their Employer, and are directly admitted to a hospital for that injury.

What Is Excluded?

- Wages for days other than standard work days (e.g. Saturday and Sunday).

- Wages for days on which you are not confined to a hospital.
- Wages for the day of admission.

How Do You File A Claim?

- Request an application for the Serious Injury Benefit from the Fund Office.
- Complete the application, including your name, address, union card number, social security number and the shop in which you are employed. Return it to the Fund Office along with a statement from the hospital indicating the dates of admission and discharge.

DEATH PREMIUM

What Is the Benefit?

When you became a member of Local 3, I.B.E.W., you also became a member of the Electrical Workers Death Benefit Society located at:

Electric Industry Center
158-11 Harry Van Arsdale Jr. Avenue
Flushing, New York 11365
(718) 591-4000

The membership provides you with a death benefit in the amount determined by the Board of Directors of the Electrical Workers Death Benefit Society. The dollar amount or the face value of the certificate(s) issued to you by the Electrical Workers Death Benefit Society determines the premium amount that will be paid on your behalf by this Plan. Death Benefit payments will be made to the beneficiary named on the certificate(s) in your possession. You should periodically examine your certificate(s) to see if the beneficiary you named is still the one you want. If you wish to change your beneficiary, contact the Electrical Workers Death Benefit Society at (718) 591-4000. Under the Death Premium Benefit, this Plan will make premium payments to the Electrical Workers Death Benefit Society for eligible Participants.

Who Is Eligible?

- Participants who are employed by a contributing Employer who makes contributions to the Plan on their behalf and who have a

\$4,000 or a \$6,000 graduating certificate, or a \$2,000 or a \$3,000 graduating certificate because they became members at 55 years of age or over, permanent death benefit certificate (and any supplemental death benefit) issued by the Electrical Workers Death Benefit Society.

- Participants who have been laid off for less than 26 weeks who are registered with the Union’s Employment Department as available for work.
- Pensioners receiving a Standard Pension or a Disability Pension.

Who Is Not Eligible?

- Participants who have been laid off for 26 weeks or more even though they are registered with the Union’s Employment Department as available for employment.
- Pensioners receiving a Normal Retirement Pension or a Vested Pension.

How Do You Apply?

- No application is necessary. Your employment with a contributing Employer automatically makes you eligible for the Death Premium Benefit.

DUES PAYMENT

What is the Benefit?

Your membership in Local 3, I.B.E.W., requires that you be designated either an “A” charter member or a “BA” charter member of the International Brotherhood of Electrical Workers. This membership requires that you pay dues or fees to one or more of the following: Local Union No. 3; International Brotherhood of Electrical Workers; Overage Fund; and Electrical Workers Death Benefit Society. Under the Dues Payment Benefit, this Plan will make payments on behalf of eligible pensioned Participants of any of the dues or fees that the Participant is required to make.

Who Is Eligible?

- Pensioners receiving a Standard Pension or a Disability Pension are eligible for the Payment Benefit on the effective date of their pension.

Who Is Excluded?

- Active Participants
- Pensioners receiving a Normal Retirement Pension or a Vested Pension
-

How Do You Apply?

- No application is necessary. Approval of your application for the Standard Pension or the Disability Pension automatically makes you eligible.

I.B.E.W. PENSION BENEFIT FUND PREMIUM

What Is the Benefit?

Your membership in Local 3, I.B.E.W., requires that you be designated either an “A” charter member or a “BA” charter member of the International Brotherhood of Electrical Workers. If you have been designated an “A” charter member of the I.B.E.W., you also became a member of the I.B.E.W. Pension Benefit Fund located at:

International Brotherhood of Electrical Workers
1125 15th Street, N.W.
Washington, D.C. 20005

This membership provides you with Pension and Death Benefits in amounts as defined under the rules and regulations for the I.B.E.W. Pension Plan. Under the I.B.E.W. Pension Benefit Fund Premium Benefit, this Plan will pay premiums to the I.B.E.W. Pension Benefit Fund for eligible Participants.

Who Is Eligible?

- Participants who are employed by a contributing Employer that makes contributions to this Plan on their behalf, who are “A” charter members of the I.B.E.W.

Who Is Excluded?

- Participants who voluntarily leave their covered employment with a contributing Employer and take a position in non-covered employment.
- Participants who have been laid off for 26 weeks or more even though they are registered with the Union’s Employment Department as available for employment.

- Participants who are “BA” charter members of the I.B.E.W.

How Do You Apply?

- No application is necessary. If you are an “A” charter member of the I.B.E.W. and work in covered employment with a contributing Employer, you are entitled to this benefit automatically.

SCHOLARSHIP

What is the Benefit?

- The Scholarship Benefit may be awarded to one student each year. The award is mailed directly to the institution, not to the recipient. Two types of scholarships are available: either one four-year scholarship or one two year scholarship.

Four-year Scholarship

One four-year scholarship to an accredited college or university (public or independent, located in a state whose borders are within a 500-mile radius of New York City) that grants a bachelor degree, is available each year. The amount of the scholarship is determined as follows:

- If the annual tuition expense of the institution is \$2,000 or less, the Plan will pay the full annual tuition expense each year for a total of four years.
- If the annual tuition expense of the institution is more than \$2,000, but is less than \$10,000, the Plan will pay 50% of the annual tuition expense or \$2,000 a year whichever is the greater amount, for a total of four years.
- If the annual tuition expense of the institution is more than \$10,000, the Plan will pay the maximum amount of \$5,000 a year, for a total of four years.

Or

Two-year Scholarship

One two-year scholarship to an accredited community college (public or independent, located in a state whose borders are within a 500-mile radius of New York City) that grants an associate degree is available. The amount of the award is the annual tuition expense of the institution, or \$2,000, whichever is less, for a total of two years of study. Winners of the two-year scholarship who complete their associate degree with an

academic average of at least 3.0 will be encouraged to continue their education toward a bachelor degree, and be permitted to extend their scholarship for two additional years. The amount of the scholarship award for these two additional years will be determined according to the rules of the four-year scholarships above.

Who Is Eligible?

- An Active Participant's dependent child who files an application to enter the scholarship competition within a year of high school graduation will be eligible for the Scholarship Benefit if:
- The Active Participant who is the child's parent is an Employee of a contributing Employer, and at least 60 months (258 weeks) of contributions have been paid on the Participant's behalf by one or more contributing Employers during the six years immediately preceding the application to enter the competition.

What is Excluded?

The Scholarship Benefit is not available to your children:

- If you voluntarily leave your covered employment with a contributing Employer and take a position in non-covered employment.
- If your children, at the time of filing an application, are not within a year of graduating from high school.
- If your children attend a school other than a two-year community college or an accredited degree-granting four-year college or university located in a state whose borders are within a 500-mile radius of New York City.
- Children of pensioned Participants are not eligible for the Scholarship Benefit. Active Participants and their legal spouses, and pensioned Participants and their legal spouses, are not eligible for the Scholarship Benefit.

How Do You Apply?

On or around October 1st of each year the announcement and application form for the Scholarship Benefit to enable your child to enter the annual scholarship competition is mailed to all eligible Participants. Follow the directions on the applications. Each application filed in the Fund Office is screened for eligibility. All eligible application forms are then forwarded to the Plan's Scholarship Director for judging and selection of winners.

LIMITATIONS OF BENEFITS

No coverage is provided under this Plan for expenses incurred with any of the following:

1. Charges resulting from injuries caused by acts of war or insurrections;
2. Charges incurred as the result of any illegal acts, including but not limited to driving while intoxicated;
3. Charges for eye refractions and eyeglasses except as provided herein;
4. Charges the insured individual is not required to pay;
5. Accidental bodily injury arising out of or in the course of employment, or sickness entitling the insured Participant to benefits under a Workers' Compensation Act or similar legislation;
6. Charges for services or supplies that are provided or required by reason of past or present service of any person in the armed forces of a government;
7. Charges for services or supplies that any school system is required to provide under any law;
8. Charges for services and equipment that are provided or required under any law of government;
9. Charges for services and supplies not necessary or reasonable, as determined by the Plan, for the diagnosis, care or treatment of the physical or mental condition involved, even if prescribed, recommended or approved by a covered health care provider;
10. Charges for services and supplies not prescribed, recommended and approved by the covered person's attending physician;
11. Charges for services of a resident physician or intern rendered in that capacity;
12. Charges for medical care provided by a hospital that is not equipped for diagnosis, major surgery and 24-hour nursing service, except those specific facilities approved by the Plan;
13. Cosmetic surgery, except treatment of accidental injuries sustained while covered if the treatment begins within 90 days of the accident or reconstructive surgery necessitated by major surgery;
14. Charges for dentistry, except as described on pages 23-24 and for the following dental treatment performed within 90 days after an accident;

- a. Dental treatment of accidental injuries to natural teeth;
 - b. Setting of a jaw fractured or dislocated in an accident.
15. Chiropractic services;
 16. Charges in connection with Temporomandibular Joint Disorder/Disease (“TMJ”);
 17. Charges, as determined by the Plan, for maintenance or custodial care;
 18. Charges related to the treatment of obesity or for diet or weight control;
 19. Charges related to liposuction;
 20. Charges related to sexual dysfunctions or inadequacies, including but not limited to surgery, therapy, supplies or counseling;
 21. Charges related to artificial insemination, in vitro fertilization or embryo transfer procedures;
 22. Charges in connection with any birth control device; except as provided under the Prescription Drug Plan;
 23. Abortions;
 24. Charges for the reversal of a sterilization procedure;
 25. Charges relating to primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy;
 26. Charges relating to counseling services including but not limited to marriage, family, child, career, social adjustment, pastoral and financial;
 27. Charges in connection with speech therapy ;
 28. Charges in connection with occupational or physical therapy unless otherwise described herein;
 29. Charges in connection with developmental delay or learning disabilities;
 30. Charges for services, procedures, drugs and other supplies relating to treatment that are determined by the Plan to be experimental. For purposes of this section, experimental means any medical procedure, device, technology, treatment, course of treatment, drug or biological product that is: used for investigational or research purposes; restricted to use at centers which are primarily intended for the purpose of carrying out clinical and scientific studies; not proven to have therapeutic value or benefit for diagnosis or treatment of the covered person’s condition; or whose effectiveness is medically questionable or not generally recognized by the medical

literature as effective or appropriate for diagnosis or treatment of the covered person's particular condition. Government approval of a procedure, device, technology, treatment, drug or biological product is relevant but not conclusive in determining whether such procedure, device, technology, treatment, drug or biological product is experimental;

31. Charges for services rendered in a skilled nursing facility;
32. Charges incurred for the acquisition of donor organs in the case of an organ transplant;
33. Charges for infant formula, regardless of medical condition of infant;
34. Charges for behavioral therapy or biofeedback;
35. Charges for acupuncture unless provided through the Medical Department located at the Electric Industry Center;
36. Charges for genetic testing;
37. Charges for Laser surgery and Lasik eye surgery;
38. Charges for transcendental meditation;
39. Charges for the treatment of Attention Deficit Disorder or Adult Attention Deficit and Hyperactivity Disorder, unless the treatment is by a psychiatrist;
40. Charges for services by assistant surgeons in teaching hospitals where residents are available;
41. Charges for the HPV vaccination;
42. Charges for full-body screening CT scans and virtual colonoscopies;
43. Charges for hearing aids;
44. Charges for hair prosthesis not related to a cancer diagnosis;
45. Charges for home health care except as provided herein. Any exclusion under this section will not apply to the extent that coverage is otherwise specifically provided in this document;
46. Charges for dependent, other than spouse, maternity care;
47. Charges related to sleep studies;
48. Durable medical equipment;
49. Allergy testing and treatment.

Excluded charges will not be used when determining reimbursement.

The above list of exclusions is provided for illustrative purposes and is not all inclusive.

COORDINATION OF BENEFITS

Occasionally, a Participant or eligible dependent entitled to receive benefits under this Plan will also be eligible for health benefits under another group health plan. If this happens, the two Plans will coordinate their benefit payments so that the combined payments of both Plans will not exceed the actual expenses incurred by the Participant or eligible dependent. One plan (*the primary Plan*) will pay its full benefits. The other plan (*the secondary Plan*) will pay any expenses in excess of the primary Plan's benefits, up to a maximum amount that it would pay if the Coordination of Benefits ("COB") provision was not in effect. **A Participant must report other group coverage to the Fund Office.**

The order in which this group health Plan will coordinate with other group health Plans is as follows:

1. A Plan with no rules for coordination with other benefits will be deemed to pay its benefits (that is, will be deemed the primary plan) before a Plan that contains such rules.
2. A Plan that covers a person other than as a dependent will be deemed to pay its benefits before a Plan that covers the person as a dependent. For example: If Participant John's spouse Mary, is covered for health insurance through her job, her own insurance would be her primary Plan and this Plan (John's health coverage) would be her secondary Plan.
3. A 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 that covers the person as a dependent of a person whose birthday comes later in that calendar year. For example: John's birthday is January 1 and Mary's birthday is June 1. John's insurance would be primary for their children because it comes first in the calendar year. Mary's insurance would be secondary for their children. If a Plan does not have this provision regarding birthdays, then the rule set forth in that Plan will determine the order of benefits.
4. 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 the benefits of a Plan

which covers the person as a retired employee or the dependent of such person shall be determined after the benefits of any other Plan which covers such person as an employee who is not retired or a dependent of such person. If either Plan does not have a provision regarding retired employees and as a result each Plan determines its benefits after the other, then the preceding sentence will not apply.

For purposes of this section, another group Plan includes any Plan of medical or hospital expense coverage for individuals in a group or “no-fault” automobile reparations insurance that is required under any law of a government. Individual policies are not subject to the Coordination of Benefits Provision. In addition, the Plan will not act as the primary payer for eligible working dependent children who receive medical benefits from their employer or if a Participant’s automobile policy has a Personal Injury Protection (“PIP”) provision available. The Plan does not coordinate payment of prescription drug benefits with other health plans.

COBRA CONTINUATION COVERAGE

INTRODUCTION

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also be eligible for alternative coverage on the Marketplace that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this entire booklet or contact the Plan Administrator.

The Internal Revenue Service (IRS) has issued a notice (Notice 98-12), in question and answer format, to assist employees and their families in determining whether to elect COBRA continuation coverage. These questions and answers are available at the IRS Internet site (<http://www.irs.ustreas.gov>) and at the Department of Labor (DOL) Internet site (<http://www.dol.gov/dol/ebsa>).

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you elect continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under this Plan to similarly situated Participants or family members.

If you are a Participant covered under this Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Participant covered under this Plan, you will become a qualified beneficiary if you lose coverage because any of the following qualifying events happen:

- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse dies; or
- You become divorced from your spouse.

Your children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced; or
- The child reaches age 26.

The Plan will make the determination that a qualifying event involving a reduction in the employee's hours or termination of employment has occurred and will let you know if you are entitled to COBRA. You or your covered dependent must notify the Plan if you are divorced, or if the dependent ceases to be a "child" as defined above.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries who would lose coverage as a result of the end of the Participant's employment (for other than the Participant's gross misconduct), reduction of hours or the death of the Participant. The Plan will notify the Participant and other qualified beneficiaries of their COBRA election rights.

You Must Give Notice of Some Qualifying Events

If the qualifying event pertains to the divorce of the employee and spouse or a child's attaining age 26, the Participant or family member must notify the Joint Industry Board in writing within 60 days after the date of the divorce or the child's attainment of age 26. The notice must be provided to: Members' Records Department at the Joint Industry Board of the Electrical Industry, 158-11 Harry Van Arsdale Jr. Ave., Flushing, NY 11365. The notice must identify the qualifying event, the date on which it occurred and the names of the covered individual(s) whose coverage under the Plan will be lost due to the qualifying event. If the qualifying event is a divorce, you must include with your notice a copy of the divorce decree. If the qualifying event is a dependent child's 26th birthday, you must identify the child's date of birth.

How Is COBRA Coverage Provided?

Once the Joint Industry Board determines that there has been a death, reduction in hours or termination of employment, or it is notified that a divorce or child's 26th birthday has occurred, COBRA continuation

coverage will be offered to each of the qualified beneficiaries within 60 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Do I Elect COBRA?

Under the law, you have 60 days from the date you would lose coverage because of one of the qualifying events described above or the date of the notice of your election right, whichever is later, to inform the Joint Industry Board that you want to elect the continuation coverage. You then have an additional 45 days to pay for the initial coverage, including all amounts due retroactively from the date on which coverage would otherwise have terminated under the Plan through the month of your election. Monthly premiums are then required. You will be billed for the coverage on a monthly basis.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you will have to pay the premium for your continuation coverage on a timely basis. The Plan is allowed to charge 102% of the cost to the Plan on a monthly basis. If you do not elect continuation coverage, or if you do not pay for your continuation coverage on a timely basis, your coverage under this Plan will end.

How Long Does Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. If the qualifying event is the end of employment or the reduction of the employee's hours of employment, COBRA continuation coverage can last for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as explained on the following page. When the qualifying event is the death of the employee, your divorce, or a dependent child's 26th birthday, COBRA continuation coverage can last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8

months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Joint Industry Board in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide to the Joint Industry Board a copy of your determination letter from the Social Security Administration before the first 18 months of continuation coverage expire. In addition, the Joint Industry Board must be notified within 30 days of the date of any final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

If you die or get divorced, or if your child turns age 26, while your spouse and, where applicable, your child(ren) are receiving COBRA continuation coverage following your loss of employment or reduction of hours, your spouse and children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan and if the event would have caused the spouse or child to lose coverage under the Plan had the first qualifying event not occurred.

Early Termination of Continuation Coverage

The law also provides that your (and any family members') COBRA continuation coverage may be cut short for any of the following reasons:

1. ***The Plan no longer provides coverage to any Participant.***
2. ***The premium for the continuation coverage is not paid on a timely basis.***

3. *You become covered for medical benefits under another group health plan.*
4. *You become entitled to Medicare.*
5. *Any other reason for termination provided under the Plan, such as fraud.*
6. *The employer with respect to whom you obtained your coverage in the first place withdraws from the Plan and covers a classification of its employees under another group health plan. In that case the employer's new plan is required to continue your COBRA coverage (under the terms of the new plan).*

Addition of New Dependents While on COBRA

If a child is born to you or placed with you for adoption while you are on COBRA continuation coverage, the child will be treated as a qualified beneficiary under COBRA and will be eligible for coverage for the balance of the COBRA coverage period available to other qualified beneficiaries with respect to the same qualifying event. You may also add a new spouse to your coverage if you get married while you are on COBRA continuation coverage, but the new spouse is not a qualified beneficiary under COBRA even though he or she will receive coverage under the Plan for the balance of the period. In order to add a new dependent, you must notify the Members' Records Department at the Joint Industry Board, 158-11 Harry Van Arsdale, Jr. Avenue, Flushing, N.Y. 11365, within 30 days after the birth, placement or marriage and provide the birth certificate, adoption papers or marriage certificate, as applicable.

Are there alternative health coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage under the Plan, there may be alternative health coverage options for you and your family, outside of the Plan, through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Military Duty in The United States Armed Forces

When an employee of a Contributing Employer of this Plan goes on military leave, health coverage for the individual is provided under TRICARE, which is a regionally managed health care program for active duty, activated guard and reserves, retired members of the uniformed services, their family and survivors. Eligible family dependents will be covered under this Plan, at no cost, unless enrolled in TRICARE, in which case this Plan will be the secondary payer.

Instead of TRICARE coverage, and in accordance with Federal law, referred to as the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the employee may elect to purchase COBRA coverage under this Plan beginning on the date the employee's absence due to military service begins and ending on the sooner of (a) a date that is two years later or (b) the day after the date on which the employee fails to apply for or return to a position of employment with the employee's pre-military-service employer. If the period of military service is less than 31 days, coverage under this Plan for the employee will continue during the period of military service (without regard to COBRA coverage). If the period of military service exceeds 31 days, the employee can elect to pay the applicable COBRA premium to continue his/her coverage (and that of any family members) for the period of military service. If the employee does not elect COBRA coverage during the period of military service, the employee will be entitled to have coverage reinstated under the Plan on the date he/she returns to Covered Employment with a Contributing Employer within the periods prescribed by USERRA. No exclusion or waiting period will be imposed by the Plan, except in the case of certain service-connected disabilities. These USERRA rights require an honorable discharge from uniformed service.

If You Have Questions

Questions concerning the Plan, your COBRA continuation coverage rights, or your coverage while on military duty should be addressed to the Joint Industry Board. For more information about your rights under ERISA, including COBRA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and

District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Joint Industry Board informed of any changes in the addresses of family members and of any change in your marital status. You should also keep a copy, for your records, of any notices you send to the Joint Industry Board.

Plan Contact Information

If you have any questions about continuation coverage or about the Plan, please communicate with the Joint Industry Board at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, 718-591-2000, Monday through Friday between the hours of 8:30 A.M. and 4:30 P.M.

FAMILY AND MEDICAL LEAVE ACT

Eligible Participants who properly notify their Employer of their election to take up to 12 weeks of leave from employment for the specific purposes allowed under the Family and Medical Leave Act will continue to be covered by the Plan during such leave. After the Employer has verified that the leave is in compliance with this Act, the Employer will be responsible for providing the Plan with written notification of the leave in order to extend the Participant's health coverage. Coverage under the Plan during the Participant's leave shall be the same as it would have been if the Participant had continued to be employed.

You may also be entitled to up to a maximum of 12 weeks of unpaid leave because of a "qualifying exigency" (as defined in Department of Labor Regulations) arising out of the fact that your spouse, son, daughter or parent is on active duty, or has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation. (If you believe you are entitled to leave due to a "qualifying exigency," you should contact your Employer.)

In addition, the FMLA now permits a spouse, son, daughter, parent, or next of kin to take up to 26 work weeks of leave (including any other FMLA leave in the same 12-month period) to care for a member of the

Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

Upon return to active employment, the Participant shall not be subject to any restrictions, waiting periods or preexisting condition exclusions under the Plan.

If the Participant does not return to work after the FMLA leave or upon the Participant's determination that he or she will not return to employment, if earlier, the Participant will be considered to have terminated employment, and the Participant will be eligible for COBRA continuation coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. Coverage under this Plan includes reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Coverage for these services will be subject to the Plan's co-payments if rendered by a Network provider. If such services are provided by non-Network providers, reimbursement will be based on the Plan's Network allowances, after applying the applicable co-payments.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

In accordance with the Newborns' and Mothers' Health Protection Act of 1996, the Plan provides that coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a Cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child.

CLAIMS AND APPEALS PROCEDURES

WHAT IS A CLAIM?

A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures. Simple inquiries about benefits or eligibility that are unrelated to any specific benefit claim or requests for prior approval of a benefit that does not require prior approval by the Plan will not be considered as claims for benefits.

TYPES OF CLAIMS

The claims and appeals procedures for benefits will vary depending on whether your claim is Pre-Service, Urgent Care, Concurrent Care, or Post-Service. Read each section carefully to determine which procedures govern your claim.

PRE-SERVICE CLAIMS

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. The types of claims that require prior approval or pre-notification have been previously described.

Important: If you fail to pre-notify services that require prior approval or pre-notification, you will receive a **REDUCED BENEFIT** or **NO BENEFIT**.

For properly filed Pre-Service Claims, you and/or your doctor will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than 5 days after receipt of the claim of the procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-Service Claim if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

If an extension is needed because additional information is needed from you or your doctor, the extension notice will specify the information needed. In that case, you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended until the earlier of either 45 days or the date you respond to the request. The Plan then has 15 days to decide your Pre-Service Claim and notify you of the determination.

URGENT CARE CLAIMS

An Urgent Care Claim is any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

- could seriously jeopardize your life or health or your ability to regain maximum function, or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by the applicable claims payer by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than 24 hours after receipt of the claim of the procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim.

If you are requesting pre-certification of an Urgent Care Claim, the Plan will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical emergencies, but not later than 72 hours after receipt of the claim. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you and/or your doctor will be notified as soon as possible, but not later than 24 hours after receipt of the claim of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the specified information is received or the end of the period given for you to provide this information, whichever is earlier.

CONCURRENT CLAIMS

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a previously approved benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days are appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by plan amendment or termination) will be made as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to the applicable Pre-Service or Post-service timeframes.

POST-SERVICE CLAIMS

A Post-Service Claim is a claim that does not require that you obtain approval prior to obtaining the service. Any claim that is not identified as a Pre-Service Claim is a Post-Service Claim.

Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days of receipt of the claim. This period may be

extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which a decision will be made.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the earlier of either 45 days or until the date you respond to the request. The entity responsible for paying the claim then has 15 days to decide the claim and notify you of the determination.

WHEN CLAIMS MUST BE FILED

All claims must be filed within six months following the date the charges were incurred. Any claim that is not submitted within a 12-month period will be denied as untimely.

HOW CLAIMS MUST BE FILED

Medical Claims

*Pre-Service, Urgent and Concurrent Medical and Hospitalization Claims
Pre-Approval Through MagnaCare*

For Pre-Service claims that require pre-notification through MagnaCare as described above, you must contact MagnaCare's Pre-notification Department at 1-877-335-4725.

Hospital Claims

*Pre-Service, Urgent and Concurrent Hospitalization Claims
Pre-Approval through Empire Blue Cross*

For Pre-Service claims that require pre-notification through Empire as described above, you must contact Empire's Pre-notification Department at 844-243-5566.

Post-Service Medical Claims

In-Network Claims

You are generally not required to file a claim in order to be reimbursed for services received from an in-network provider. You need only present your MagnaCare identification card at the time services are rendered and pay the applicable co-payment; the MagnaCare participating provider or hospital will then submit a bill for services and any other required information directly to MagnaCare, Inc., 1600 Stewart Avenue Suite 700, Westbury, NY 11590

Out-of-Network Claims

If you use an out-of-network provider, you must submit a completed Health Benefit Request Form directly to MagnaCare. You can obtain a Health Benefit Request Form by calling 1-718-591-1100. Send your completed claim form to MagnaCare, with an attached itemized bill to 1600 Stewart Avenue Suite 700, Westbury, NY 11590

Post-Service Hospital Claims

In-Network Claims

You are generally not required to file a claim in order to be reimbursed for services received from an in-network provider. You need only present your Empire identification card at the time services are rendered and pay the applicable co-payment; the Empire participating provider or hospital will then submit a bill for services and any other required information directly to Empire, P.O. Box 1407, Church Street Station, New York, NY 10008-1407.

Out-of-Network Claims

If you use an out-of-network provider, you must submit a completed Health Benefit Request Form directly to Empire. You can obtain a Health Benefit Request Form by calling 1-718-591-1100. Send your completed claim form to Empire, with an attached itemized bill to P.O. Box 1407, Church Street Station, New York, NY 10008-1407.

Prescription Drug Claims

Pre-Service Prescription Drug Claims

For prescription drugs that require pre-approval as described above, you or your pharmacist must contact Express Scripts' Coverage Review Unit at 1-800-818-0883.

For prescription drugs that require proof of medical necessity as described above, you must submit proof of medical necessity to the Joint Industry Board, Members' Records Department at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365. Call (718) 591-1100 to obtain a form.

Post-Service Prescription Drug Claims

In-Network Claims

If you obtain a prescription from a participating Express Scripts pharmacy, you need only submit your identification card to the pharmacist and pay the applicable co-payment.

Out-of-Network Claims

If you get your prescription filled at a non-participating pharmacy, you must submit a Direct Reimbursement Claim Form along with the original pharmacy receipt directly to the Plan. You may obtain a Direct Reimbursement Claim Form by contacting the Plan.

Dental Claims

Pre-Service Dental Claims

For dental services that require pre-approval through DDS, your dentist must submit a Dental Benefit Request Form with all relevant x-rays directly to DDS, 1640 Hempstead Turnpike, East Meadow, New York 11554.

Post-Service Dental Claims

In-Network Claims

You are not required to file a claim in order to be reimbursed for services received from an in-network provider. You need only call DDS at 1-800-255-5681 for information about DDS and to obtain an eligibility card. The DDS dentist will be responsible for any necessary paperwork.

Out-of-Network Claims

If you obtain services from a non-DDS dentist, you will have to submit a Dental Benefit Request Form (and may have to submit x-rays in certain

cases) to DDS, 1640 Hempstead Turnpike, East Meadow, New York 11554. You may obtain a Dental Benefit Request Form by contacting the Plan.

Optical Benefits

In-Network Claims

If you obtain optical benefits at JIB Medical, you need not submit a Health Benefit Request Form; simply call (718) 591-2014 to schedule an appointment.

If you obtain optical benefits from a Vision Screening provider or a panel optical provider located in New Jersey, you need only contact the Plan for an optical voucher and are not required to submit a claim form.

Out-of-Network Claims

If you do not obtain services from a participating optical provider, you must submit a claim form along with the original optical bill for services to the Plan. Contact the Fund Office to obtain a claim form.

Notice of Decision

You will be provided with written notice of a denial of a claim, whether denied in whole or in part. This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive a statement that a copy of the rule is available upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that a copy of the exclusion is available upon request at no charge.

For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

APPEALS PROCEDURE FOR CLAIMS OTHER THAN DENTAL CLAIMS

First Level Appeal to the Joint Industry Board of the Electrical Industry

If your claim is denied in whole or in part and you wish to contest the denial, you must appeal the Plan's determination to the Joint Industry Board of the Electrical Industry (the "Joint Board"). Your appeal must be made in writing within 180 days after you receive notice of denial of your claim and shall set forth the reasons why you believe the Plan's decision is incorrect. In the case of urgent care claims, your appeal need not be in writing and may be made by calling the Joint Board at 1-718-591-1100.

For urgent care claims, you will be sent a notice of the Plan's decision on appeal within 72 hours of the Joint Board's receipt of the appeal. The appeal to the Joint Board is the only level of appeal for urgent care claims. If you wish to challenge any denial of an urgent care claim, you may bring a civil action under ERISA Section 502(a).

For Pre-Service claims, you will be sent a notice of the Joint Board's decision on appeal within 15 days of the Joint Board's receipt of the appeal.

For Post-Service appeals, you will be sent a notice of the Joint Board's decision on appeal within 30 days of the Joint Board's receipt of the appeal.

Second Level Appeal to the Board of Trustees

For all claims other than urgent care claims, if the Joint Board denies your first level appeal and you wish to contest the denial, you must file a second appeal to the Board of Trustees (the "Trustees"). Your appeal to the Trustees must be in writing and must be made within 60 days after you receive notice of denial of your appeal by the Joint Board and must set forth the reasons why you believe the decision is incorrect.

For appeals of denials of Pre-Service claims, the Trustees will notify you of the determination of your appeal within 15 days of the Trustees' receipt of the appeal. For appeals of denials of Post-Service claims, the Trustees will notify you of the determination of your appeal within 30 days of the Trustees' receipt of the appeal.

APPEALS PROCEDURE FOR DENTAL CLAIMS

First-Level Appeal to DDS, Inc.

If your dental claim is denied in whole or in part, or if you disagree with the decision made on a claim, your appeal should be sent to DDS, 1640 Hempstead Turnpike, East Meadow, New York 11554. Your appeal must be made in writing within 180 days after you receive notice of denial of your claim and must include your current identification number, the claim number, any pertinent information or comments you wish to make, and shall set forth the reasons why you believe the decision is incorrect. You will be sent a notice of the decision on appeal within 30 days of receipt of the appeal by DDS.

Second-Level Appeal to the Joint Industry Board of the Electrical Industry

If DDS denies your appeal in whole or in part, you may file a second appeal to the Joint Board, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, New York 11365. Your appeal to the Joint Board must be in writing and must be made within 60 days after you receive notice of denial of your appeal by DDS, and shall set forth the reasons why you believe the decision is incorrect. The Joint Board will notify you of the determination of your appeal within 30 days of its receipt of the appeal.

Optional Third-Level Appeal to the Board of Trustees

If the Joint Board denies your second-level appeal in whole or in part, you have the option of filing a third-level appeal with the Board of Trustees (the "Trustees"). If you elect to file an appeal with the Trustees, your appeal must be in writing and must be made within 60 days after you receive notice of denial of your appeal by the Joint Board, and shall set forth the reasons why you believe the decision is incorrect. The Trustees will notify you of the determination of your appeal within 60 days of the Trustees' receipt of the appeal. This third-level appeal with the Trustees is voluntary. The Plan will not assert your decision not to file a third-level appeal with the Trustees as a defense if you bring a lawsuit against the Plan instead of appealing a decision to the Trustees. If

you do file a third-level appeal, the Plan agrees that any statute of limitations or other defense based on timeliness will be suspended during the time that the appeal to the Trustees is pending. The decision of whether to appeal to the Trustees will have no effect on your rights to any other benefits under the Plan.

Review Process

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of the Plan's policy regarding the denied treatment or service. Upon request, you will be provided with the identification of medical experts, if any, that advised the Plan concerning your claim, without regard to whether the advice was relied upon in deciding your claim.

A different person will consider your first level appeal at the Joint Board (or DDS) than the one who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that you submit. Similarly, the Trustees will not afford deference to the decision by the Joint Board, nor will the Joint Board afford deference to the decision by DDS.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

NOTICE OF THE DETERMINATION OF YOUR APPEAL

The Joint Industry Board's and/or the Trustees' and/or DDS' decision on your appeal will be in writing and will include the following information:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;

- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to file a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

DESIGNATED AUTHORIZED REPRESENTATIVES

You may submit a claim and appeal a denial of a claim on your own behalf. Alternatively, you may designate another individual to act as your representative. If you choose to designate someone else to act on your behalf, you must do so in writing on a form provided by the Plan; the designation will not be effective until it is received by the Plan. You may revoke your designation of an Authorized Representative but such revocation will not be effective until received by the Plan and such revocation must be in writing in order to be effective. You may obtain a Designated Authorized Representative form by contacting the Plan. Once you have designated an Authorized Representative, all communications and notices from the Plan that would otherwise be sent to you will be sent only to your Authorized Representative.

NO CONFLICT OF INTEREST

Neither the Joint Board nor the Trustees stand to gain in any way from denying an appeal. No employee of the Joint Board is paid or entitled to any benefit in his or her employment based on his or her decisions on appeals. The Trustees receive no compensation from the Plan, and their decisions on appeals do not entitle them to any benefit from the Plan or their employers or the Union.

FRAUD AND PLAN'S RIGHT TO RECOVERY

The Plan reserves the right to suspend or discontinue benefits, or to deny the Claim (or appeal) of any Participant or dependent who makes or whose service provider makes a false statement material to an application, furnishes fraudulent information or proof, or otherwise fails or refuses to provide information deemed reasonably necessary to determine whether to pay a claim. The Trustees and the Joint Industry Board shall have the right to recover, or to offset against future benefits payable to or on behalf of a Participant or a Participant's dependent, any payments made as a result of false or fraudulent statements, information or proof submitted by a Participant, dependent or by a service provider. The Trustees and the Joint Industry Board shall have the right to recover, or to offset against future benefits payable to or on behalf of a Participant or a Participant's dependent, benefits paid to or on behalf of a former spouse or ineligible child for services rendered to the former spouse subsequent to divorce or the child after he or she ceased to be eligible, other than under the COBRA continuation coverage provisions described above. In addition to the foregoing, the Trustees and the Joint Industry Board shall have the right to recover, or to offset against future benefits payable to or on behalf of a Participant or a Participant's dependent any payments mistakenly paid by the Plan, and each Participant agrees, by virtue of his or her coverage hereunder, that any mistaken payments, as well as any payments made in reliance on a false or fraudulent statement or information (including a failure to provide or an omission of material information) submitted by the Participant, a dependent or a provider (collectively "Wrongful Payment") will not vest ownership in the Participant or other recipient, and the Participant agrees to repay any such Wrongful Payment to the Plan (including by the Plan's offset against future benefits payable to or on behalf of the Participant or the Participant's dependent following a demand for repayment).

EMPLOYEES SECURITY FUND OF THE ELECTRICAL INDUSTRIES HEALTH & WELFARE PLAN SUBROGATION AND RESTITUTION RIGHTS FOR PERSONAL INJURY

If you or your eligible dependent suffers an injury or illness, or requires medical treatment through the act or omission of someone else or for which a third party may be legally responsible, the Plan shall pay benefits related to such injury or illness to the extent benefits are payable under the terms of the Plan, provided that the costs have not already been

paid by the third party, only after you or your dependent (and your attorneys, if applicable) has (and have, if applicable) entered into a written subrogation and reimbursement agreement with the Plan. By accepting benefits from this Plan related to such an injury or illness, you agree to hold any reimbursement or other recovery received by you or your dependent, legal representative, or agent in trust on behalf of the Plan to cover all benefits paid by the Plan with respect to such injury or illness. You and your dependent also agree to reimburse the Plan promptly out of any recovery from any source, including the third party or the third party's insurer, for the benefits paid to you and your dependent.

The Plan's right to subrogation and reimbursement applies to all rights of recovery of you, your dependent, your parents, or to a representative, guardian or trustee of you, your parents or dependents, regardless of whether the recovery fully compensates your or your dependent's loss.

You must sign a subrogation agreement as a condition of receiving benefits for any illness or injury caused by a third party, and provide the Plan with any relevant information about the claim upon request. However, a subrogation agreement is not necessary to enforce the Plan's rights. Benefits are paid by the Plan subject to the condition that you and your dependent do not take any action that would prejudice the Plan's ability to recover benefits paid and that you will cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement.

The Plan must be reimbursed in full up to the total amount of all benefits paid by the Plan in connection with the injury or illness from any recovery you receive from a third party, as well any first-party coverage, including, but not limited to, any payments you receive from your own personal injury protection (PIP), med-pay, uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, school insurance or workers' compensation insurance, even if the recovery is not specifically identified as a reimbursement of medical expenses. All recoveries from a third party or first-party coverage (whether by lawsuit, settlement, insurance or otherwise) must be used to reimburse the Plan for benefits paid. In the event you receive an award for future medical expenses, the Plan will not pay any benefits until you demonstrate that the full award of future medical benefits has been used to treat the injury or illness. The Plan has the right of first reimbursement on a priority first-dollar basis out of any recovery obtained, even if you are not fully compensated ("made whole") for your loss, and the Plan's claim has first priority over all other claims and rights.

If you live in a state without no-fault insurance or PIP insurance coverage, the Plan will not pay medical benefits for you or your dependents if optional medical coverage was available through your automobile insurance carrier. You should purchase the maximum amount available through your automobile insurance carrier, up to \$50,000. In no event should you have less than \$25,000 in medical coverage. The Plan will not pay medical expenses for you or your eligible dependents up to the maximum amount available through your carrier or \$25,000, whichever is greater.

Neither you nor your dependent is compelled to pursue any right of recovery from a third party whose conduct caused the injuries for which benefits were paid by the Plan. The Trustees strongly recommend, however, that if you are injured as a result of the negligence or wrongful act of a third party, you should contact an attorney for advice and counsel. The Plan cannot and does not pay for the legal fees your attorney may charge.

You are required to notify the Plan promptly of any third-party claim you may have for an injury or illness for which the Plan has paid or may pay benefits and any demand made or suit filed against any third party. You are required to notify the Plan of any third-party recovery, whether in or out of court, that you, your dependent, or your parents or any agent, representative or trustee or any of them obtains.

The Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of the Plan's claim is subject to prior written approval by the Trustees in their sole discretion.

If you choose not to pursue the liability of a third party, the Plan will be subrogated to your right of recovery and may pursue your claims against the third party. You agree to cooperate with the Plan with respect to any attempt to recover Plan benefits payable to you or your eligible dependent related to an injury or illness caused by the act or omission of a third party.

You must forward any recovery to the Plan within 10 days of receipt or notify the Plan why you are unable to do so. The Plan shall have an equitable lien by agreement on any recovery until you reimburse the Plan

for the amount of its claim. The Plan may offset its subrogation claim against any other Plan benefits otherwise due or payable to you or your dependents.

Note that other provisions of this Plan may exclude or limit coverage under certain circumstances where the injury or illness may have been the result of the act or omission of a third party (e.g. Workers' Compensation cases, certain automobile accidents, etc.). Please review carefully the specific limitations and exclusions set forth above.

The Plan has contracted with *NexClaim Recoveries* to administer all subrogation cases.

“GRANDFATHERED” PLAN STATUS

The Employees Security Fund of the Electrical Products Industries Health and Welfare Plan, believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the Joint Industry Board of the Electrical Industry at 718-591-1100. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

AMENDMENT AND TERMINATION

The Trustees, acting pursuant to the Trust Agreement, may at any time and from time to time modify this Plan and all benefits provided hereunder in any of its terms, with respect to all Participants, including active and retired Participants, and their eligible dependents, including

benefits for which individuals have already established eligibility, provided, however, that no such modification or termination shall cause or permit any property held subject to the terms of the Trust Agreement to be diverted to purposes other than for the exclusive benefit of Participants and their dependents and/or for the administrative expenses of the Plan's Trust Fund (the "Trust Fund").

Neither the promulgation of this Plan nor the creation of the Trust Fund by the Trust Agreement shall be construed as giving any Participant or any person whatsoever any legal or equitable right against the Union, any Employer, Employer Association, the Trustees, the Plan Administrator and/or the Trust Fund, except such right as is specifically provided for herein, or given by action of the Trustees duly taken in accordance with the provisions hereof.

The Plan may be terminated when there is no longer in force any collective bargaining agreement requiring contributions to the Plan. The Plan and Trust Agreement may likewise be terminated by the unanimous vote of the Trustees with the consent of the Employers and the Union.

In the event of a termination of the Plan, the Trustees shall apply the Trust Fund to pay or provide for the payment of any and all obligations of the Plan and Trust Fund and distribute and apply any remaining surplus in the Trust Fund in such manner as will, in their opinion, best effectuate the purposes of the Plan and Trust Agreement; provided, however, that no part of the corpus or income of the Trust Fund shall be used or diverted to purposes other than the exclusive benefit of Participants and their dependents or the reasonable administrative expenses of the Plan and Trust Fund.

The Trustees shall give written notice to all Participants, Employers, and the Union of all amendments to or the termination of the Plan.

ALIENATION OF BENEFITS

No Participant or eligible dependent may assign, sell, dispose or transfer any rights he or she may have under the Plan to receive benefits. If they do so, their actions will have no effect.

The Plan will, however, allow a Participant or eligible dependent to assign the payment of benefits directly to a hospital as a result of a hospital stay. In addition, a Participant or eligible dependent may assign

the payment of benefits directly to a provider who accepts the reimbursement from the Plan as payment in full.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Benefits may become payable directly or indirectly to an eligible dependent of a Participant if the Plan is served with a Qualified Medical Child Support Order (QMCSO). A QMCSO is a medical child support order issued pursuant to a state domestic relations law or a state medical child support law that provides child support or health coverage with respect to an eligible dependent of a Participant covered by the Plan.

A medical child support order is “qualified” if it meets certain criteria set forth in Section 609 of ERISA. If the order is qualified, the Plan is required by federal law to comply with it. The Plan has written procedures relating to its determination whether a medical child support order is qualified. The procedures require the Plan to notify the Participant and each alternate recipient of the receipt of a medical child support order and of the procedures for the determination of its qualified status. The Plan will also notify all appropriate parties as to the determination of the Plan.

STATEMENT OF ERISA RIGHTS

As a Participant in the Employees Security Fund of the Electrical Products Industries Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including provider contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan

Description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description on the rules governing your COBRA continuation coverage risks.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied, or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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