

SUMMARY PLAN DESCRIPTION

As Amended to January 1, 2007

**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 January 1, 2007.

GENERAL INFORMATION

Name of Plan: Employees Security Fund of the
Electrical Products Industries
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 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. Ave.
Flushing, N.Y. 11365
(718) 591-2000

Service may also be made upon any Trustee.

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.

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
221 Glenmore Avenue
Brooklyn, NY 11207

MATTHEW GOLD
Midtown Electric Supply
157 W. 18th Street
New York, NY 10011

EDWARD H. GOLLOB
MAC Power Corp.
960 Pennsylvania Avenue
S. Kearney, NJ 07032

HARVEY LIFTON
LB Electric Supply Co.
5202 New Utrecht Avenue
Brooklyn, NY 11219

DOMINIC J. PEGNATO
Atlite, Inc.
100 Andrews Road
Hicksville, NY 11801

CHRISTOPHER G. WALSH
Automatic Switch Co.
50-60 Hanover Road
Florham Park, NJ 07932

THOMAS BIANCHI
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

CAROL ANN DE ALBERO
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

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

JOHN E. MARCHELL
President
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

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

ROBERT OLENICK
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

THOMAS SCOTLAND
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

LANCE VAN ARSDALE
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

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 by having worked for a contributing employer to this Plan for at least 26 consecutive weeks, during which time contributions were received on your 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 consecutive 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.

*** The Following special eligibility rules apply:**

For the Alcoholism Confinement and Drug Addiction Benefit: The participant must have been employed or have been available for employment and one or more contributing employers must have paid 104 week of contributions for him or her in the past 130 weeks immediately prior to the date that treatment begins.

For the Maternity Benefit: Active Plan A, B and C participants are eligible for maternity coverage for themselves and their legal spouses if the Participant is employed or available for employment by a contributing employer and one or more employers have paid at least 26 weeks of contributions for them in the last 52 weeks.

New Participants in Plan A, B or C are eligible for maternity coverage for themselves and their legal spouses when a minimum of 43 weeks of contributions have been made for them by one or more contributing employers.

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 III of this booklet. This coverage ends upon the death of the participant. Retired participants, their

legal spouses and eligible children lose all other coverage including hospitalization, surgery, maternity, anesthesia, prosthesis, alcoholism and drug addiction confinement benefits 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 38-44.

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 completed the applicable enrollment forms and submitted the appropriate documents on their behalf.

Eligible dependents are:

1. Your lawful spouse. For purposes of this section, "spouse" means a man or woman who is legally married (as determined under applicable state law) to a Participant of the opposite sex.
2. Your unmarried children from birth up to their 19th birthday. However, full-time unmarried dependent students attending approved institutions of higher learning shall be covered up to age 23.

An original letter from the registrar's office of the applicable institution shall be required as proof of current college or school attendance after each spring and fall semester commences.

The term "children" shall mean natural or legally adopted children. Step-children are considered to be eligible dependents once appropriate documentation demonstrating proof of support is provided to the Plan.

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 certificate, as applicable. Coverage is effective as of the date of marriage or birth of a natural child only, provided the participant was then eligible. Dependent eligibility terminates at the same time as the participant's eligibility.

SECTION I

BENEFITS

There are three levels of health benefit plans; Plan A, Plan B, 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 (including mental health for up to 30 days per calendar year, and maternity)	\$400 per day, subject to a \$1,000 per admission co-payment. Participant is covered for up to 120 days per calendar year (30 days for mental health).
Out-patient Hospital Admission Facility Charge	\$400 per procedure.
Nursery	\$400 per day, subject to a \$1,000 co-payment.
Chemotherapy	Up to 100% of Network Fee Schedule.
Dialysis	Up to 100% of Network Fee Schedule, \$1,000 co-pay for facility charge.
Radiation Therapy	Up to 100% of Network Fee Schedule.
Anesthesia	Up to 100% of Network Fee Schedule.
Alcohol and Substance Abuse	Through Members’ Assistance Program <i>only</i> (see page 18).

Covered Plan “A” Non-Hospital Expenses

Covered Service	Benefit
Surgery	Paid at 100% of Network 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	Up to one annual diagnostic visit. Visits are paid at 100% when rendered at the Joint Industry Board Medical Center, Morristown Hospital or PEMG. Diagnostic visits rendered at other facilities or by other providers will be paid at a maximum of \$125 for patients over the age of 14 and a maximum of \$60 for patients under the age of 14.
Prosthetics	Up to \$500 per calendar year.
Dental Care	See page 23.
Optical Care	See page 27.
Prescription Drug Benefits	See page 20.
Acupuncture	Provided through the Joint Industry Board Medical Center Only.
Home Health Care	Paid at 100% of Network fee schedule for eligible participants with cancer diagnosis only. This benefit must be pre-authorized by MagnaCare.

LIMITATIONS OF PLAN “A” BENEFITS

No coverage is provided under Plan “A” coverage for expenses incurred for any of the following (these limitations are in addition to all Plan Limitations found on pages 34).

- 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) Pre-surgical testing

- 4) Emergency Room services when patient is not admitted to the hospital.
- 5) All ancillary charges related to a hospital admission.

A \$500,000 maximum lifetime limit applies for all hospital, medical and prescription drug benefits individually to the participant and each eligible dependent.

MEDICAL SERVICES PROVIDER NETWORK

(applies to Plan B and Plan C only)

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 1-877-548-0138 or utilizing its website at www.magnacare.com.

PLAN “B” LEVEL OF BENEFITS

Covered Plan B Hospital Expenses

Covered Service	Benefit
In-patient Hospital Admission Room & Board (including mental health for up to 30 days per calendar year)	Paid at 100% of 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 MagnaCare as described on page 15.
Out-patient Hospital Procedure Facility Charge	Paid at 100% of 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 must be pre-notified through MagnaCare as described on page 15.
Emergency Room	Paid at 100% of Network Fee Schedule. Emergency Room is only paid if patient is admitted to the hospital. Admission is subject to \$500 co-payment.
Nursery	Paid at 100% of Network Fee Schedule, subject to a \$500 co-payment.
Chemotherapy	Up to 100% of Network Fee Schedule. This is covered in and out of network.
Dialysis	Up to 100% of Network Fee Schedule. This is covered in and out of network.
Radiation Therapy	Up to 100% of Network Fee Schedule. This is covered in and out of network.
Anesthesia	Up to 100% of Network Fee Schedule. This is covered in and out of network.

Covered Service	Benefit
Alcohol and Substance Abuse	Through Members' Assistance Program only (see page 18).
Pre-surgical Testing	Paid at 100% of Network Fee Schedule. Must be performed within 10 days of pre-notified surgical admission. <u>This is an in-network benefit only and must be pre-notified through MagnaCare as described on page 15.</u>

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

Covered Service	Benefit
Surgery – physicians’ charge (in hospital)	Paid at 100% of Network Fee Schedule, subject to a \$250 co-payment. <u>This is an in-network benefit only.</u>
Surgery - physician’s charge (in office)	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment. <u>This is an in-network benefit only.</u>
Pre-surgical consultation	Limit one per surgical procedure. Paid at 100% of Network Fee Schedule. <u>This is an in-network benefit only.</u>
Annual Diagnostic Medical Benefit	Up to one annual diagnostic visit. Visits are paid at 100% when rendered at the Joint Industry Board Medical Center, Morristown Hospital or PEMG. Diagnostic visits rendered at other facilities or by other providers will be paid at a maximum of \$125 for patients over the age of 14 and a maximum of \$60 for patients under the age of 14.

Covered Service	Benefit
Prosthetics	Up to \$500 per calendar year, in-network only.
Dental Care	See page 23.
Optical Care	See page 27.
Prescription Drug Benefits	See page 20.
Acupuncture	Provided through the Joint Industry Board Medical Center only.
Ancillary Charges associated with a hospital admission.	Paid at 100% of Network Fee Schedule if the hospital admission is approved.
Home Health Care	Paid at 100% of Network fee schedule for eligible participants with cancer diagnosis only. This benefit must be pre-authorized by MagnaCare.

LIMITATIONS OF PLAN “B” BENEFITS

No coverage is provided under Plan “B” coverage for expenses incurred for any of the following (these limitations are in addition to all Plan Limitations found on page 34).

- 1) Physician services, in-patient and out-patient.
- 2) Lab, pathology, radiology, x-rays, MRI/MRA, CT Scan, SPECT/PET Scans, EKG/EEG/EMG not rendered as the result of an in-patient admission at a participating facility.
- 3) Out of Network hospitals for elective admissions and surgery.
- 4) Emergency Room services when patient is not admitted to the hospital.

A \$500,000 maximum lifetime limit applies for all hospital, medical and prescription drug benefits individually to the participant and each eligible dependent.

PLAN “C” LEVEL OF BENEFITS

Covered Plan C Hospital Expenses

Covered Service	Benefit
In-patient Hospital Admission Room & Board (including mental health for up to 30 days per calendar year)	Paid at 100% of Network Fee Schedule, subject to a \$500 co-payment. <u>This is an in-network benefit only for non-emergency admissions. All hospital admissions must be pre-notified through MagnaCare as described on page 15.</u>
Out-patient Hospital Procedure Facility Charge	Paid at 100% of Network Fee Schedule, subject to a \$250 co-payment. <u>This is an in-network benefit only for non-emergency procedures. All hospital services must be pre-notified through MagnaCare.</u>
Elective out-patient testing (hospital-based pre-surgical testing performed within 10 days of an admission)	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment. <u>This is an in-network benefit only.</u>
Emergency Room	Paid at 100% of Network Fee Schedule. Emergency Room co-payment is waived if patient is admitted to the hospital.
In-Patient Physician Visit	Paid at 100% of the Network Fee Schedule. Covered only if a follow-up visit is by a physician whose services are deemed necessary to patient condition.
Nursery	Paid at 100% of Network Fee Schedule, subject to a \$500 co-payment.

Covered Service	Benefit
Chemotherapy	Up to 100% of Network Fee Schedule. This is covered in and out of network.
Dialysis	Up to 100% of Network Fee Schedule. This is covered in and out of network.
Radiation Therapy	Up to 100% of Network Fee Schedule. This is covered in and out of network.
Anesthesia	Up to 100% of Network Fee Schedule. This is covered in and out of network.
Alcohol and Substance Abuse	Through Members' Assistance Program <i>only</i> (see page 18).
Mental & Nervous Disorder	Paid at 100% of Network Fee Schedule, subject to a \$500 co-payment. Covered up to 30 days per calendar year. <u>This is an in-network benefit only.</u> All hospital admissions must be pre-notified through MagnaCare as described on page 15.
Hospice	Paid at 100% of Network Fee Schedule, subject to a \$500 co-payment. <u>This is an in-network benefit only and must be pre-notified through MagnaCare as described on page 15.</u>
Out-Patient Physical Rehabilitation	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-certified through MagnaCare as described on page 15.

PRE-NOTIFICATION REQUIREMENTS

Plans “B” and “C” require pre-notification of certain services, as described below:

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:

- Hospital admissions (emergency room visits should be authorized within 24 hours of admission for Plan C participants only);
- 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.

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, severe breathing difficulty such as asthma, shock, hemorrhaging or other acute conditions. This benefit is subject to a \$100 co-payment.

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

Covered Service	Benefit
Surgery – physician’s charge (in hospital)	Paid at 100% of Network Fee Schedule, subject to a \$250 co-payment. In-Network Benefit only.
Surgery - physician’s charge (in office)	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment. In-Network Benefit only.
Pre-surgical consultation	Limit one per surgical procedure. Paid at 100% of Network Fee Schedule. In-Network Benefit only.
Physician’s Office Visit (non-preventative care only. Well-care and routine visits are not covered under this benefit)	Paid at 100% of Network Fee Schedule, subject to a maximum of \$75 co-payment.
Immunization	Paid at 100% of Network Fee Schedule. Children covered up to 18 years of age. In-Network Benefit only.
Annual Diagnostic Medical Benefit	Up to one annual diagnostic visit. Visits are paid at 100% when rendered at the Joint Industry Board Medical Center, Morristown Hospital or PEMG. Diagnostic visits rendered at other facilities or by other providers will be paid at a maximum of \$125 for patients over the age of 14 and a maximum of \$60 for patients under the age of 14.

Plan C - Continued

Covered Service	Benefit
Prosthetics	Up to \$500 per calendar year. This service must be pre-authorized through MagnaCare by calling 1-877-335-4725
Diagnostic – Radiology (x-rays) – not hospital based.	Paid at 100% of Network Fee Schedule, subject to a \$50 co-payment. In-Network Benefit only.
Diagnostic – Lab & Pathology – not hospital based	Paid at 100% of Network Fee Schedule, subject to a \$30 co-payment. In-Network Benefit only.
MRI (not hospital based)	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment. In-Network Benefit only.
CT Scan (not hospital based)	Paid at 100% of Network Fee Schedule, subject to a \$75 co-payment. In-Network Benefit only.
Ambulance	Paid at 100% of Network Fee Schedule, subject to a \$100 co-payment.
Well-Care Mammography (effective January 1, 2006)	Paid at 100% of Network Fee Schedule, subject to a \$50 co-payment. In-Network Benefit only. This benefit is available one time per year
Dental Care	See page 23
Optical Care	See page 27
Prescription Drug Benefits	See page 20
Acupuncture	Provided through the Joint Industry Board Medical Center only.
Home Health Care	Paid at 100% of Network Fee Schedule for eligible participants with cancer diagnosis only. This benefit must be pre-authorized by MagnaCare.

A \$500,000 maximum lifetime limit applies for all hospital, medical, and prescription drug benefits individually to the participant and each eligible dependent.

SECTION II

The benefits described in this section apply to all eligible active Plan A, B and C Plan participants and their covered dependents.

ALCOHOLISM OR DRUG ADDICTION CONFINEMENT 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 all of the following conditions are met:

- 1) The participant has been employed or has been available for employment and one or more contributing employer has paid 104 week of contributions for them in the past 130 weeks immediately prior to the date that treatment begins.
- 2) The facility is approved in advance of the admission by the Members' Assistance Program to an approved facility. Admissions to unapproved facilities will not be covered under any circumstances. If the participant is an employee of a contributing employer located in New Jersey, and it is not possible because of distance for the covered person to visit the Members' Assistance Program, approval of a treatment facility must be obtained from the Fund Office before the covered person is admitted to a facility.
- 3) In order to be approved, the admission must be for "effective treatment" only, and the Members' Assistance Program must approve the course of treatment in advance. The goal of the treatment is to control fully the disease and not merely to intervene in a crisis. For example, emergency treatment for an overdose is not covered, while a program of detoxification and therapy aimed at total abstinence may be covered.

After the facility is designated or approved by the Members' Assistance Program, the Plan will make a benefit payment to the facility of up to \$400 per day or the facilities charges, whatever is less.

The Alcoholism Confinement Benefit and Drug Addiction Confinement Benefit Coverage can each be used once per covered person per lifetime, for a period of up to (30) days each.

The Members' Assistance Program is located at :
Electric Industry Center
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

Contact the Members' Assistance Program at 718-591-2000, ext. 1396 for pre-notification.

LIMITATIONS OF THE ALCOHOLISM OR DRUG ADDICTION CONFINEMENT BENEFITS:

No coverage is provided by the Alcoholism Or Drug Addiction Confinement Benefits for any of the following (these limitations are in addition to all Plan Limitations found on pages 34-37).

- Alcohol or drug treatments lasting beyond 30 days.
- Additional substance abuse treatment or services.
- Alcoholism confinement or drug addiction confinement made after you voluntarily leave employment with a contributing employer and take a position in a non-covered employment, or after you retire from covered employment.
- Charges made by a substance abuse confinement center or facility not approved by the Fund Office prior to entry.
- Charges covered by any other insurance policy or health plan.

MENTAL OR NERVOUS DISORDER BENEFITS:

Regular hospital benefits provided through the Plan are available for up to 30 days in any 12-month period for mental or nervous disorder confinements, provided such hospitalization is pre-notified by the MagnaCare Pre-notification Department at 1-877-335-4725, as described on page 15. You must contact MagnaCare's Pre-notification Department to obtain advance approval for any such outpatient care. In no instance shall the total benefit exceed the annual limitation. **This is an in-network benefit only for Plan B and Plan C participants.**

SECTION III

The Following Benefits Apply to all eligible Plan A, B and C participants and all Eligible retirees.

PRESCRIPTION DRUG BENEFITS

A Prescription Drug Plan administered by Medco is part of the benefits provided to participants and eligible dependents. The Plan will issue a separate identification card which, when presented to pharmacists who participate in the Medco Network, will cover the cost of the prescription except for the applicable co-payment. You should call Medco at 1-800-413-7402 for any questions on the Prescription Drug Plan. **Effective January 1, 2007 a \$3,500 annual limit applies for all prescription drug benefits per family per calendar year.**

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, ext. 1800 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 Medco "*Preferred Prescriptions Member Guide*" or contact Medco directly at 1-800-413-7402 or visit the Medco website at www.medco.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 Medco by Mail Pharmacy Service or **pay the entire cost** of the medication yourself at the retail pharmacy. For more information on the Medco 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.

PRE-AUTHORIZATION OF CERTAIN MEDICATION

Prior authorization is required for certain drugs. In an effort to promote safety and health, certain drugs may require a Medco pharmacist to discuss the medical appropriateness with the prescribing physician before approval is given to dispense the medication. Included in this category of drugs managed by Medco are drugs relating to growth hormones, multiple sclerosis, migraines, sleeping disorders, arthritis, high blood pressure and stimulants.

If you receive a new prescription for one of the medications that require pre-authorization, the local pharmacist will advise you of the need to obtain a coverage review and will provide the toll-free number for Medco's 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 Medco, and Medco will contact the physician directly. If the coverage is approved, Medco 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 Medco 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 pages 48-58.

MAIL ORDER PHARMACY

The Prescription Drug Plan requires the use of a mail order service program that is administered by Medco by Mail for all maintenance medications. If you are using a maintenance medication to treat an on-going illness, you can have your doctor prescribe the initial prescription for a 1-month supply that can be filled at a local pharmacy and a second prescription for up to a 90-day supply. It takes up to 14 days for delivery from the mail order service facility, once the prescription is mailed. 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. In that case, you are responsible for paying the difference in cost, plus the co-payment.

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

- Diabetes • Anemia • Arthritis • Tuberculosis • Emotional Instability
- Nervous Tension • Epilepsy • High Blood Pressure • Constipation
- Heart Disorders • Thyroid Disease • Ulcers

The Plan will allow only the initial prescription and one refill of a maintenance medication to be filled at a local pharmacy. ***Any subsequent prescription or refill relating to the same maintenance medication must be filled through the Medco by 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 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
- Fertility drugs
- Anti-obesity drugs
- Erectile dysfunction drugs
- Smoking deterrents
- Vitamins

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 1-718 591-1100, ext. 1800 to obtain a form, which you and your doctor must submit.

Additional exclusions are set forth on pages 34-37.

DENTAL BENEFITS

You, your legal spouse and eligible children may obtain dental treatment through the Dental Benefit provision of this Plan. You may use the Dental Benefit 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 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 pre-authorization ***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 34-37 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 the Medical Department of the Pension Committee, Joint Industry Board of the Electrical Industry, located at:

Electric Industry Center
158-11 Harry Van Arsdale Jr. Avenue, Room 201
Flushing, NY 11365

For information on how to arrange an appointment, please see the section on the Medical Center on page 26.

- 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 973-971-7098 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. If you use this method, you must file a claim form. The Plan will reimburse you or your doctor up to a maximum of \$125 for a person age 14 and over and up to a maximum of \$60 for a child under age 14.

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

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

SMOKING CESSATION PROGRAM

The Smoking Cessation Program is part of the Diagnostic Medical Benefit. This program enables you and your legal spouse only, to receive acupuncture treatment to stop smoking. All acupuncture treatment is administered by a physician at the Medical Department of the Pension Committee of the Joint Industry Board located at:

Electric Industry Center
158-11 Harry Van Arsdale Jr. Avenue, Room 201
Flushing, NY 11365

A full course of treatment consists of two visits. You and your legal spouse are entitled to a full course of treatment twice in your lifetime. To arrange an appointment, please see the section on the Medical Center below.

Note: Children are not eligible for this benefit.

THE MEDICAL CENTER

All eligible active and retired participants and their eligible dependents are entitled to the services provided by the Medical Center at the Electric Industry Center, located at 158-11 Harry Van Arsdale Jr. Ave., Flushing, New York. The Medical Center offers expanded diagnostic programs at no cost. The diagnostic procedures provided are:

Annual physicals

Mammograms (covered only when provided within the Medical Center, except as provided to active Plan C participants.)

Lab Tests

Chest X-Rays

EKGs

Pap Smears

P.S.A. Tests

Proctology Exams

To schedule a medical appointment, contact the Medical Center at (718) 591-2014 from Monday - Friday, 8:00 A.M. to 8:00 P.M. and Saturday from 8:00 A.M. to 3:00 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 the Medical Department of the Pension Committee of the Joint Industry Board located at:

Electric Industry Center
158-11 Harry Van Arsdale Jr. Avenue, Room 201
Flushing, NY 11365

To schedule an optical appointment, contact the Medical Center at (718) 591-2014 from Monday - Friday, 8:00 A.M. to 8:00 P.M. and Saturday from 8:00 A.M. to 3:00 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 the Medical Department

- 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.

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 related to mental health care except as provided herein;
4. Charges for eye refractions and eyeglasses except as provided herein;
5. Charges the insured individual is not required to pay;
6. 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;
7. 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;
8. Charges for services or supplies that any school system is required to provide under any law;
9. Charges for services and supplies that are provided or required under any law of government;
10. 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;
11. Charges for services and supplies not prescribed, recommended and approved by the covered person's attending physician;
12. Charges for services of a resident physician or intern rendered in that capacity;
13. 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;
14. 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;
 15. Charges for mammographies unless provided through the Medical Department located at the Electric Industry Center, or as provided herein;
 16. Charges for dentistry, except as described on page 23 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.
 17. Chiropractic services;
 18. Charges in connection with Temporomandibular Joint Disorder/Disease (“TMJ”);
 19. Charges, as determined by the Plan, for maintenance or custodial care;
 20. Charges related to the treatment of obesity or for diet or weight control;
 21. Charges related to liposuction;
 22. Charges related to sexual dysfunctions or inadequacies, including but not limited to surgery, therapy, supplies or counseling;
 23. Charges related to sex change surgery or any treatment as to gender identity;
 24. Charges related to artificial insemination, invitro fertilization or embryo transfer procedures;
 25. Charges in connection with any birth control device; except as provided under the Prescription Drug Plan;
 26. Abortions;
 27. Charges for the reversal of a sterilization procedure;

28. Charges relating to primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy;
29. Charges relating to counseling services including but not limited to marriage, family, child, career, social adjustment, pastoral and financial;
30. Charges in connection with speech therapy unless such therapy is expected to restore speech to a person who has lost an existing speech function as the result of a disease or injury, and the therapy is pre-notified;
31. Charges in connection with occupational or physical therapy;
32. Charges in connection with developmental delay or learning disabilities;
33. 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;
34. Charges for services rendered in a skilled nursing facility;
35. Charges incurred for the acquisition of donor organs in the case of an organ transplant;
36. Charges for infant formula, regardless of medical condition of infant;
37. Charges for behavioral therapy or biofeedback;
38. Charges for acupuncture unless provided through the Medical Department located at the Electric Industry Center;

39. Charges for genetic testing;
40. Charges for Laser surgery and Lasik eye surgery;
41. Charges for transcendental medication;
42. Charges for the treatment of Attention Deficit Disorder or Adult Attention Deficit and Hyperactivity Disorder, unless the treatment is by a psychiatrist;
43. Charges for services by assistant surgeons in teaching hospitals where residents are available;
44. Charges for preventive immunizations for adults, including but not limited to flu shots;
45. Charges for full-body screening CT scans and virtual colonoscopies;
46. Charges for hearing aids;
47. Charges for hair prosthesis;
48. 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. 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 on the claim form submitted for reimbursement of medical expenses.

The order in which various plans will pay benefits is as follows:

- 1) A plan with no rules for coordination with other benefits will be deemed to pay its benefits 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. If a plan does not have this provision regarding birthdays, then the rule set forth in that plan will determine the order of benefits. 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.
- 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.

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.

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.

Note that if you are the spouse of a participant who dies, you will receive 18 months of coverage at no expense (or until the date of your remarriage if sooner). See page 7 for a description of the Plan's coverage of surviving spouses and children following the death of a participant.

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

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than his or her gross misconduct;
- The parents become divorced; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Again, as with the surviving spouse coverage, the Plan provides up to 18 months of continued coverage (or until the surviving spouse remarries, if sooner) at no expense to dependent children of a participant who dies. See page 7 for a description of these provisions.

The Plan will make the determination that a qualifying event involving a reduction in the employee's hours, termination of employment or death has occurred.

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 event pertains to the divorce of the employee and spouse or a dependent child's loss of coverage, the participant or a family member must notify the Joint Industry Board in writing within 60 days after the date of the divorce or loss of eligibility as a dependent child. You must provide this notice to: Members' Records Department of 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 losing eligibility for coverage as a dependent child, you must identify the child's date of birth and the last date that the child was a full-time student.

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 loss of eligibility status has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. 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 due to 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 losing eligibility as a dependent child, 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 Plan Administrator 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 would have to have started at some time 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 18-month period of continuation coverage expires. 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 your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family 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. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent 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 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 your continuation coverage is not paid on a timely basis.
3. You become covered for medical benefits under another group health plan that does not have a pre-existing condition exclusion. If the new plan includes a pre-existing conditions limitation or exclusion, coverage will cease under this Plan once the pre-existing conditions limitation or exclusion has been satisfied or once eligibility for continuation coverage otherwise terminates.
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.

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., within 30 days after the birth, placement or marriage and provide the birth certificate, adoption papers or marriage certificate, as applicable.

Special Notice for TAA Eligible Individuals

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("TAA eligible individuals"). Under the new tax provisions, TAA eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage.

TAA eligible individuals who did not previously elect continuation coverage during the original 60-day COBRA election period related to the TAA-related loss of coverage may elect continuation coverage during a second 60-day election period. This second 60-day election period begins on the first day of the month in which he or she is determined to be a TAA eligible individual, provided that such election may not be made later than 6 months after the date of the TAA-related loss of coverage. TAA eligible individuals may elect continuation coverage for themselves and their eligible family members. Any continuation coverage elected will begin with the first day of the second 60-day election period, and not on the date the coverage originally was lost. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has a 63-day break in coverage under HIPAA.

Health Insurance Portability and Accountability Act

If you are or expect to be covered by another employer-sponsored group health plan (including a plan of your spouse's employer), federal law guarantees you certain rights under that plan, which you should consider when making your decision about COBRA Continuation Coverage.

Under the Health Insurance Portability and Accountability Act (HIPAA), the period during which a group health plan may exclude or limit coverage for pre-existing conditions is reduced or eliminated if the person had previous health coverage under another group health plan. However, credit is not given for earlier coverage if you allowed that coverage to lapse, without replacement, for at least 63 days. If there will be some delay before you can enroll in a new plan,

a break in health coverage can be avoided by maintaining COBRA continuation coverage in the meantime.

You should also consider whether other available coverage has a pre-existing condition exclusion that applies to you. You can contact the plan administrator of the other plan to determine whether that plan has a pre-existing condition exclusion that applies to you.

CERTIFICATE OF CREDITABLE COVERAGE

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

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

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

Please address all requests for certificates of creditable coverage to:

Joint Industry Board of the Electrical Industry
158-11 Harry Van Arsdale Jr. Ave.
Flushing, NY 11365
Attention: Members' Records Department

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.

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 for up to two years under this Plan (18 months for elections made prior to December 10, 2004) from the date of the employee's absence due to military service begins or the day after the date on which the employee fails to apply for or return to a position of employment. 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. If the period of military service exceeds 31 days, the employee can elect to pay the applicable COBRA premium to continue his/her coverage. If the employee does not elect COBRA coverage during the period of military service, the employee will be entitled to have coverage reinstated on the date he/she returns to covered employment with a contributing employer. No exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted under USERRA are dependent upon uniformed service that ends honorably.

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Joint Industry Board. For more information about your rights under ERISA, including COBRA, 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.)

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 Plan Administrator.

Plan Contact Information

If you have any questions about continuation coverage or about the Plan, please communicate with the Joint Industry Board, who is the Plan Administrator at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, 1-718-591-2000, Monday through Friday between the hours of 8:30 A.M. and 4:30 P.M.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Eligible participants who properly notify their employer of their election to take up to 12 weeks of unpaid 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 in order to extend the participant's health coverage. Coverage under the Plan during the participant's leave shall continue at the same level it would have been if the participant had continued to be employed.

Upon return to active employment, the participant shall not be subject to any restrictions, waiting periods or pre-existing condition exemptions.

If the participant does not return to work after the leave or upon the participant's determination that he or she will not return to employment, if earlier, such date will be considered a qualifying event under COBRA, and the participant will be eligible for continuation coverage.

WOMENS' 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 includes reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prosthesis and physical complications of all stages of mastectomy, including lymphedmas.

Coverage for these services will be subject to the applicable co-payment if rendered by a Network provider. If such services are provided by non-Network providers, reimbursement will be based on the Plan's schedule of surgical fees.

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 precertify 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 refiled 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 refiled 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 6-month period will be denied as untimely.

HOW CLAIMS MUST BE FILED

Medical and Hospitalization 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.

Pre-Approval Through The Fund Office

For pre-service claims that require pre-approval through the Fund Office as described above, you must contact the Members' Records Department, 1-718-

591-1100, Monday through Friday between the hours of 8:30 A.M. and 4:30 P.M.

Pre-Approval Through Members Assistance Program

For pre-service claims that require pre-approval through the Members Assistance Program (alcoholism or drug addiction confinement) you must contact the Members' Assistance Program at the Joint Industry Board, 1-718-591-2000, ext. 1396.

Post-Service Medical and Hospitalization 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., 825 East Gate Boulevard, Garden City, New York 11530.

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 718-591-2000. Send your completed claim form to MagnaCare, with an attached itemized bill to 825 East Gate Blvd., Garden City, NY 11530.

Prescription Drug Claims

Pre-Service Prescription Drug Claims

For prescription drugs that require pre-approval as described above, you or your pharmacist must contact Medco's 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 ext. 1800 to obtain a form.

Post-Service Prescription Drug Claims

In-Network Claims

If you obtain a prescription from a participating Medco 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 the Medical Department, 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 1-718-591-2000.

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.

SUBROGATION AND RESTITUTION RIGHTS FOR PERSONAL INJURY

If you or your eligible dependent suffers an injury or illness through the act or omission of someone else, 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 benefits have not already been paid by the third party. 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 eligible 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 also agree to reimburse the Plan promptly for the benefits paid.

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 other relevant information about the claim if we ask you to do so. 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 eligible 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, even if the recovery is not specifically identified as a reimbursement of medical expenses. All recoveries from a third party (whether by lawsuit, settlement, insurance or otherwise) must be used to reimburse the Plan for benefits paid. The Plan has the right of first reimbursement 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.

Neither you nor your eligible dependent is compelled to pursue any right of recovery from a third party whose conduct caused the injuries which were the basis for the claim of benefits or who is responsible for payment. The Board of Trustees strongly recommends, 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 or your eligible dependent 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 Plan Administrator in its 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 paid 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 a lien 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 eligible dependents.

Note that 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 refer to the balance of this booklet for information on specific limitations and exclusions.

AMENDMENT AND TERMINATION

The Board of Trustees, acting pursuant to the Trust Agreement, may at any time and from time to time modify this Plan in any of its terms, with respect to all participants, including active participants and retirees and their eligible dependents, or terminate the same in its entirety, and 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 Board of Trustees, the Plan Administrator and/or the Trust Fund, except such right as is specifically provided for herein, or given by action of the Board of Trustees duly taken in accordance with the provisions hereof, provided, however, that no such modification or termination shall:

- (A) cause or permit any property held subject to the terms of the Trust Agreement to be diverted to purposes other than the exclusive benefit of participants, retired participants and their dependents and/or for the administration expenses of the Trust Fund; or,
- (B) increase the duties or liabilities of the Board of Trustees without their written consent.

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 may likewise be terminated by the unanimous vote of the Board of Trustees with the consent of the Employers and the Union.

In the event of a termination of the Plan, the Board of Trustees shall apply the Trust Fund to pay or provide for the payment of any and all obligations of the Plan and Trust and distribute and apply any remaining surplus 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 shall be used or diverted to purposes other than the exclusive benefit of participants, retired participants and dependents of either or the reasonable

administrative expenses of the Plan and Trust.

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

ALIENATION OF BENEFITS

No participant or dependent may assign, sell, dispose or transfer any rights you may have under the Plan to receive benefits. If you do so, your actions will have no effect.

The Plan will, however, allow an eligible participant to assign the payment of benefits directly to a hospital as a result of a hospital stay. In addition, an eligible participant 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 a 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 enforces 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 indicated 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 (name of 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:

Examine, without charge, at the plan administrator’s office and at other

specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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.

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.

**JOINT PENSION COMMITTEE
EMPLOYEES SECURITY FUND
OF THE ELECTRICAL PRODUCTS INDUSTRIES
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365
(718) 591-1100**

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May 1, 2009

Established 1944

HARRY VAN ARSDALE JR.
Founder

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IMPORTANT NOTICE:

TO ELIGIBLE PARTICIPANTS OF THE EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRY HEALTH AND WELFARE PLAN

The Trustees of the Employees Security Fund of the Electrical Products Industries Health and Welfare Plan ("the Plan") have amended the Plan, effective May 1, 2009, to eliminate three provisions set forth in the Summary Plan Description ("SPD").

This notice constitutes a Summary of Material Modification of the Plan, and should be kept in a safe place along with your copy of the SPD.

1. Maternity Expenses (Page 4 of the SPD).

Effective May 1, 2009, initial and ongoing eligibility for maternity expenses will be the same as the eligibility rules for the Plan and any other reimbursable expenses. Thus, Active A, B and C participants will be initially eligible for maternity coverage (and all other coverage provided by the Plan) for themselves and their legal spouses, once the Participant has worked for a contributing employer to the Plan for at least 26 consecutive weeks, during which time contributions were received on the Participant's behalf. Thereafter, prior to incurring a reimbursable maternity (or any other) expense, at least 26 weeks of contributions out of the past 52 must be received by the Plan on behalf of the participant, or if the participant is unemployed, during all or any portion of such period, the participant must have been registered as available for employment.

2. Cosmetic Surgery (Page 35 of the SPD)

Exclusions 14 and 16 set forth on page 35 of the SPD exclude coverage for cosmetic surgery and dentistry, respectively, unless the surgery or dentistry resulted from an accident that occurred while the participant (or family member) was covered by the Plan. The Trustees have agreed to eliminate the requirement that the accident giving rise to the surgery occur while the participant is covered by the Plan. The surgery or dentistry must still take place within 90 days of the accident.

Please note that the Trustees of the Plan reserve the right to make additional changes to the Plan at any time. The Board also reserves the right, in its sole and absolute discretion, to amend, modify, or terminate the Plan or any benefits provided under the Plan, in whole or in part, at any time and for any reason.

If you have any questions regarding these changes, please contact the Fund Office at 718-591-1100.