YOUR
HEALTH and BENEFIT
PLAN B

EFFECTIVE
PLAN YEAR 2014

I.B.E.W. Local No. 25
Health and Benefit Fund

GCC/IBT 825-C

PLAN B

I.B.E.W. LOCAL No. 25 HEALTH & BENEFIT FUND

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To All Participants:

The benefits described in the following pages have been made available to You through the joint action of the Employer and the Union Trustees.

The Trustees will continue to make every effort to maintain benefits within the limits of Fund income and assets for the greatest possible advantage of each Participant and Dependent.

On the following pages You will find a description of the principal provisions of the Plan Benefits. You should read this material carefully and become familiar with the terms of the Plan and Your rights under it.

The Trustees are responsible for the administration of the Plan. We will be happy to assist You in every way possible to make certain that You promptly receive the benefits to which You are entitled. If at any time You need information or assistance, write or call the Fund Office.

Sincerely,
The Board of Trustees

NOTICE OF GRANDFATHERED STATUS

The Trustees of the I.B.E.W. Local 25 Health & Benefit Fund believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathererd health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provisions of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (631) 434-3344. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

TABLE OF CONTENTS

Provision **Page**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS……..……27
CLAIM FILING INSTRUCTIONS..... 51
CLASSES ELIGIBLE FOR COVERAGE..... 1
CONTINUATION OF COVERAGE UNDER COBRA……...53
COMMUNICATIONS 69
CONTINUATION OF ELIGIBILITY 2
CONTINUOUS EMPLOYMENT/INSUFFICIENT CLOCK HOURS..... 2
COVERAGE – STAGE 2 (DEATH BENEFIT, DENTAL, OPTICAL AND HEARING CARE)1
COVERED EXPENSES - HOSPITAL 10
CREDIT 2
DEATH BENEFIT ……30
DEFINITIONS..... 4
DENTAL BENEFITS..... 31
DEPENDENT CHILDREN OF PARENTS NOT SEPARATED OR DIVORCED 45
DEPENDENT CHILDREN OF SEPARATED OR DIVORCED PARENTS..... 45
ELIGIBILITY FOR BENEFITS..... 1
EMPLOYEE ASSISTANCE PROGRAM 26
EXCLUSION OF BENEFITS RECOVERABLE UNDER THIRD-PARTY ACTIONS 50
EXCLUSIONS - HOSPITAL..... 15
EXTENSION OF BENEFITS 36
GENERAL EXCLUSIONS..... 8
GENERAL PROVISIONS 44
HEARING CARE BENEFIT FOR PARTICIPANTS 42
HOSPITAL REVIEW PROGRAM..... 16
HOSPITAL COVERAGE…….....10
HOW ARE BENEFITS OBTAINED? 22
INITIAL COVERAGE – STAGE 1 (HOSPITAL, MAJOR MEDICAL, PRESCRIPTION) 1
MAGNACARE..... 20
MEDICAL BENEFITS..... 18
MEDICAL REIMBURSEMENT ACCOUNT..... 43
MEDICARE..... 45
METHOD OF PAYMENT..... 2
NONASSIGNABILITY AND SPENDTHRIFT CLAUSE..... 51
NOT AVAILABLE FOR WORK 3
PLAN INTERPRETATIONS AND DETERMINATION 69
PREFERRED PROVIDER ORGANIZATION DENTAL PLAN (P.P.O.)..... 36
PRESCRIPTION DRUG COVERAGE AND MEDICARE..... 25
PRESCRIPTION DRUG PROGRAM 21
PRESCRIPTIONS BY MAIL 23
RIGHT OF RECOVERY..... 49

SCHEDULE OF BENEFITS - HOSPITAL 10
SCHEDULE OF BENEFITS - DENTAL 32
SELF-PAY 2
SPECIAL CONDITIONS 13
STATEMENT OF PRIVACY PRACTICES 58
TERMINATION OF COVERAGE 3
THE FUND'S DUTIES (HIPAA PRIVACY) 64
VISION CARE BENEFIT FOR PARTICIPANTS 37
WHOM TO CONTACT AT THE FUND FOR MORE INFORMATION 66
YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY .. 66
YOUR RIGHTS UNDER ERISA 55

CLASSES ELIGIBLE FOR COVERAGE

All Eligible Active Employees. Maintenance and Teledata Retirees eligible pursuant to the May 12, 2008 Council on Industrial Relations Decision.

ELIGIBILITY FOR BENEFITS:

Initial Coverage – Stage 1 (Hospital, Loss of Time, Major Medical, Prescription, Accidental Death and Dismemberment Benefits)

Employers are required to report employees work record and pay contributions as shown on Weekly Payroll Remittances.

An employee must work a minimum of **650** clock hours in covered employment, or its equivalent, in any consecutive six (6) month period to be eligible for the coverage provided under the Fund. Benefits will commence on the first day of the month following the completion of **650** clock hours of work. If an employee works under a Reciprocal Agreement, the 650 clock hours rule shall apply, but the hours will be determined by dividing the reciprocal contributions received on the employee's behalf by the average Residential Wiremen's contribution rate required under the Local 25 Residential Unit Collective Bargaining Agreement. Thereafter, a benefit coverage period, for the purposes of the Plan, shall be a six (6) month period commencing the first Saturday after the last Friday of December and June of each year.

Coverage – Stage 2 (Death Benefits, Dental, Optical and Hearing Care)

An employee must work a minimum of **800** clock hours in covered employment or in reciprocating employment wherein payments are received by this Fund at least equal to the Residential Wireman's average fund contribution rate as set forth in the Residential Unit Collective Bargaining Agreement in each of **three (3)** Benefit Coverage Periods, in order to be eligible for this coverage. Self-Pay as set forth in this Plan (Pages 2-3) will also qualify as a Benefit Coverage Period for this Purpose.

When Do You Qualify to File for Benefits?

An employee will become a Plan Participant on the date he/she became eligible for coverage under the Plan. His/her Dependents will become eligible also on that date, or the date he/she acquires the Dependent, whichever is later.

Eligible Dependents:

1. Plan Participant's Spouse.

2. Plan Participant's children (including stepchildren) up to age 26 years of age. Such coverage will be provided through December 31 of the year in which they attain age 26.

3. The Plan will continue coverage on unmarried mentally or physically handicapped Dependent children over the age of 26 only if they became so incapacitated while an eligible Dependent and are incapable of self-sustaining employment.

4. Eligible Dependents will not be covered for any benefits for claims arising more than 30 days prior to the Participant registering such Dependent with the Fund office.

Continuation of Eligibility

An active Plan Participant working in covered employment shall have his/her eligibility terminated on the last day of the second calendar month following, a benefit coverage period if one of the following events applies:

1. The active Plan Participant fails to accumulate at least **800** clock hours in covered employment.

2. The active Plan Participant fails to accumulate at least **800** clock hours in reciprocating employment wherein payments are received by this Fund at least equal to the Residential Wireman's average Fund contribution rate as set forth in the Residential Unit Collective Bargaining Agreement.

3. The active Plan Participant fails to self-pay for coverage as set forth below. Self-payment does not include COBRA payments.

Self-Pay

The Plan Participant shall be permitted to make payments to the Fund during the two (2) months following each Coverage Period to make up the difference between his/her total clock hours worked in covered employment and **800** clock hours at the rate of the Residential Wireman's average Fund contribution rate as set forth in the Residential Unit Collective Bargaining Agreement.

Credit

Credit up to a maximum of **eight (8)** clock hours will be allowed for each day of sickness or disability for which a Plan Participant is unable to work and is receiving State Benefits for Disability or Worker's Compensation, or No-Fault up to a maximum of one (1) year.

Method of Payment

Contributions for work in the jurisdiction of Local 25, I.B.E.W., Reciprocal Agreement Payments and MRA Payments may be used to meet all or part of the requirement for coverage cost. If sufficient funds are not available from the above sources to meet the entire requirement for coverage cost, the Plan Participant will be responsible for immediate payment of the difference.

Continuous Employment/Insufficient Clock Hours

All Plan Participants who work continuously for the same employer under a "B" Plan Collective Bargaining Agreement, shall in order to become and remain eligible for Plan Coverage, be required to have contributions made on their behalf based on a minimum of **800** clock hours in each benefit coverage period pursuant to the applicable collective bargaining agreement under which contributions are due. If such Plan Participant does not accumulate **800** clock hours, the Plan Participant will be responsible for immediate payment of the difference in clock hours which shall be

paid at the average Residential Wireman's, Residential Unit Collective Bargaining Agreement Fund contribution rate.

Further, Officers, Directors, or Stockholders of a corporation or partners and sole proprietors who are participating in this Plan must contribute to the Plan on the basis of at least **1,000** hours of contributory employment per coverage period.

If you are on the referral list of IBEW Local 25 for two consecutive benefit coverage periods, i.e., a six-month period commencing the first Saturday after the last Friday of December and June of each year, and have not worked any clock hours in covered employment during such time, your coverage by the Fund shall terminate. During periods of severe unemployment, the Trustees may extend the non-work consecutive benefit coverage periods as necessary.

Not Available for Work

An active Plan Participant who becomes classified as NOT AVAILABLE FOR WORK by Local 25, I.B.E.W., WILL CONTINUE TO BE CONSIDERED NOT AVAILABLE FOR WORK by the Plan until the Plan Participant has returned to work in the jurisdiction of Local 25, I.B.E.W., and actually works a minimum of **650** clock hours for an employer contributing to the Fund. These hours must be worked during any six month coverage period.

If the active Plan Participant becomes NOT AVAILABLE FOR WORK as determined above, the active Plan Participant's coverage shall continue until the end of the Coverage period in which the Plan Participant became NOT AVAILABLE FOR WORK on the same basis and to the same extent to which he/she would otherwise have been covered. The Plan Participant will then be offered Continuation of Health Coverage under the Federal Law (COBRA), see page 53.

If a Plan Participant retires, and is not yet eligible for Medicare, he/she is eligible for COBRA for a maximum of 18 months or until he/she becomes eligible for Medicare.

Termination of Coverage

The entire coverage of a Plan Participant shall immediately terminate:

a. On the date the Plan Participant ceases to be eligible for coverage according to the rules for eligibility established by the Trustees; or

b. On the date of death of the active Plan Participant; or

c. On the date the Plan is terminated;

Provided, however, that Your absence from work due to lay-off, leave of absence or retirement will not be treated as a termination in accordance with the Eligibility for Benefits Rules established by the Trustees.

A Dependent's coverage will terminate on the earliest of the following:

a. The date Your coverage terminates, except that if the cause was your death, in which case eligibility will be extended until the end of the then current coverage period, but not less than two months;

b. The date he/she enters the armed forces of any country;

c. The 31st of December following the date the Dependent child ceases to be a dependent as defined in this booklet.

However, if an unmarried covered Dependent child is totally and permanently disabled and;

- Incapable of self-support due to mental illness; developmental disability; mental handicap, as defined in the mental hygiene law of New York; or physical handicap; and

- Relies upon You for support and maintenance; his/her coverage will not be terminated because of age.

The Fund will require due proof of the child's incapacity within 31 days after he/she reaches the termination age for children.

The coverage for the child may be continued for as long as:

- The total and permanent disability, incapacity and reliance continues; and

- The coverage remains in force for You.

However, in any event, the coverage of the Dependent spouse or the Dependent child shall terminate on the date the Plan is terminated.

DEFINITIONS

The following is a brief listing of important definitions:

"Fund" means the I.B.E.W. Local No. 25 Health and Benefit Fund.

"You" means a Plan Participant covered under the Plan.

"He" or **"His"** means either a male or a female unless a distinction is specified.

"Dependent" means any person eligible as described in the eligibility rules.

"**Injury**" means a bodily injury caused by an accident. The accident must occur while the coverage for You or Your Dependent is in force.

"Sickness" means a disease.

"Physician" means a legally qualified and licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.), provided that such doctor is neither the Participant, the Participant's spouse, nor the child, brother, sister nor parent of the Participant. The term "Physician" shall include a duly licensed or certified practitioner, as required by state law for services which are:

a. within the scope of the license or certificate, and

b. a covered charge under this Plan.

The Trustees may require, in their sole discretion, that any physician have training as a specialist.

"Spouse" refers to a person to whom you are recognized as lawfully married under the laws of the state in which the marriage ceremony occurred.

"Medically Necessary Treatment" means medical or dental treatment which is consistent with currently accepted medical or dental practice, and which is given at the appropriate level of care. Any confinement, operation, treatment or service that is not a valid course of treatment recognized by an established medical or dental society in the United States is not considered "Necessary Treatment." No treatment or service, or expense in connection therewith, which is experimental in nature, is considered "Necessary Treatment."

The Plan may use Peer Review Organizations or other professional medical opinion to determine if health care services are:

1. Medically necessary;

2. Consistent with professionally recognized standard of care with respect to quality, frequency and duration; and

3. Provided in the most economical and medically appropriate site for Treatment.

In determining questions of medical necessity, consideration will be given to customary practices of physicians and the community where the service is provided.

A service will not be considered medically necessary if:

- the procedures are of unproven value or of questionable usefulness;

- the procedures could be deemed unnecessary when performed in combination with other procedures;

- the diagnostic procedures are unlikely to provide a physician with additional information when used repeatedly;

- the procedures are not ordered by a physician: are not documented in a timely fashion in the patient's medical records; or can be performed with equal efficiency at another type of facility (e.g., on an outpatient basis).

Services, supplies or treatment will not be considered medically necessary and no benefits will be payable if:

- the services rendered were not medically necessary;

- services were not provided at the appropriate level of care.

THE FACT THAT A PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE IT MEDICALLY NECESSARY OR MAKE THE EXPENSE A COVERED CHARGE.

"Hospital" means an establishment which:

1. Holds a license as a Hospital (if required in the state) and is accredited by the Joint Commission on Accredited Hospitals (JCAH).

2. Operates primarily for the care and treatment of sick or injured persons as inpatients;

3. Provides around the clock nursing service;

4. Has a staff of one or more Physicians available at all times;

5. Provides organized facilities for diagnosis and surgery;

6. Is not primarily a clinic, nursing, rest or convalescent home or a Skilled Nursing Facility or a similar establishment; and

7. Is not, other than incidentally, a place for treatment of drug addiction.

8. The nursing service must be registered or graduate nurses on duty or call. The surgical facilities may be either at the Hospital or at a facility with which it has a formal arrangement.

Confinement in a special unit of a Hospital used primarily as a nursing, rest or convalescent home or Skilled Nursing Facility will not be deemed to be confinement in a Hospital.

"Hospital" also includes a licensed ambulatory surgical center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The types of procedures performed must permit discharge from the center in the same "working day." The center will not qualify as a "Hospital" if:

1. Its primary purpose is performing abortions;

2. It is maintained as an office by a Physician for the practice of medicine; or

3. It is maintained as an office for the practice of dentistry.

"Custodial Care" means care which is designed to help a person in the activities of daily living where continuous attention by trained medical or paramedical personnel is not necessary. Such care may involve:

1. Preparation of special diets;

2. Supervision over medication that can be self-administered; and

3. Assisting the person getting in or out of bed; to walk; to bathe; to dress; to eat; and to use the toilet.

"**Essential Health Benefits**" means any covered expense under the Plan that falls under the following categories, as defined under the Patient Protection and Affordable Care Act:

- Ambulatory Services;
- Emergency Services;
- Hospitalization;
- Maternity and Newborn Care;
- Mental Health and Substance Use Disorder Services, including behavioral health treatment;
- Rehabilitative and Habilitative services and devices;
- Laboratory Services;
- Prescription Drugs;
- Preventive and Wellness Services and chronic disease management;
- Pediatric Services, including oral and vision care;

"**Non Essential Health Benefits**" means any covered expense that is not an essential benefit.

"**Pediatric**" means age newborn to age 19.

"Covered Expenses" means any claim that satisfies the following conditions:

1. Is Medically Necessary Treatment as defined on page 5;

2. To the extent that it does not exceed usual, customary and reasonable charges as defined by Plan Policy;

3. Is received while covered for Medical Benefits; and

4. Is covered under the Plan.

GENERAL EXCLUSIONS

While individual benefit provisions have exclusions and limitations which pertain only to those benefits, there are some general exclusions and limitations that pertain to all benefits:

1. Declared or undeclared war

2. Any act of war

3. Injury or Sickness arising out of employment

4. Services or Supplies which are not recommended by a physician; (in the case of Dental Benefits, services or supplies which are not recommended by a Dentist)

5. Intentionally self-inflicted injury unless determined by a diagnosis to be as a result of an underlying medical condition, such as depression

6. Charges incurred in connection with cosmetic treatment, except if caused by injury. Cosmetic treatment will be considered unnecessary unless the treatment is necessary to ameliorate a (i) deformity arising from or directly related to a congenital abnormality, (ii) a disfiguring disease or (iii) if a participant or beneficiary is receiving benefits in connection with a mastectomy, the plan will also provide coverage for: Reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications at all stages of mastectomy, including lymphedemas. For this purpose, cosmetic treatment includes any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease

7. Intersex surgery or fertility treatment

8. Charges a participant would not be required to pay if there was no coverage under this Plan

9. Charges incurred in connection with any altercation or commission of a crime

10. Charges incurred prior to the date the Participant is eligible for benefits under the Plan provisions or for charges incurred after the Participant's benefits have been terminated

11. Charges for services which are eligible to be covered under the laws of a nation, state, province or local government of any country, whether or not the patient asserts his rights to obtain such coverage

12. Charges for services necessitated by a motor vehicle accident to the extent that such services are payable under the Personal Injury Protection or compulsory medical payments provisions of an automobile insurance policy pursuant to any federal or state law requiring such coverage regardless of fault, whether or not You assert Your rights to obtain such coverage

13. Charges for an accident or injury occurring at a school if the Participant and/or Dependent is covered by school insurance

14. Eye Examination for eyeglasses only, except for Vision Care Benefit on page 36.

15. Charges for glasses or contact lenses, except for Vision Care Benefit, and except contact lenses required because of surgery

16. Charges made by a relative of You or Your Dependent who is also a medical provider

17. Charges for any period of custodial care which is that type of care, wherever furnished and by whatever name called, which is designed primarily to assist an individual in meeting his activities of daily living

18. Charges for dental care except:

    a. That are required by an injury; and

    b. Expenses incurred within 6 months of the injury
    (SEE DENTAL BENEFITS PAGE 30)

19. Charges incurred in connection with the treatment of infertility. including, but not limited to, any of the following procedures:

    a. Artificial Insemination

    b. In Vitro Fertilization; or

    c. In Vivo Fertilization

20. Charges for hearing aids only, except for Hearing Care Benefit on Page 41.

21. Charges for treatment in a residential treatment center or long-term care facility

22. Charges for genetic testing

23. Charges for infant formula

24. Charges for Chiropratic Treatment

SCHEDULE OF BENEFITS

Plan Participants & Dependents

HOSPITAL COVERAGE

120 Days per 12 consecutive month period Semi-private Accommodations (See Hospital Review Program, Page 16):

		Maximum
Maternity	Paid	While medically necessary
Pre-Admission Testing	Paid	
Rehabilitation	Paid	30 days per 12 consecutive month period, charged to the 120 day maximum
Dialysis	Paid	First 30 months only, from date of first treatment
Emergency Room	$100 Copay	Unless admitted
Mental or Nervous Disorder	Paid	charged to the 120 day maximum hospital benefit
Detoxification	Paid	charged to the 120 day maximum
All Hospital Benefits	Paid	120 day per 12 consecutive month period is the sole and exclusive coverage under the Plan for Hospital Benefits.

As a registered bed patient in any general hospital, You and Your enrolled dependents are each eligible to receive the following benefits:

DAYS OF CARE

120 Days Covered in Full

Your days of care may be used during one confinement or during several

BED, BOARD AND GENERAL NURSING CARE

Semiprivate Accommodations

If You are a hospital patient in a semiprivate room, Your bed, board (including special diets) and general nursing care are covered in full for 120 days.

PRIVATE ACCOMODATIONS

If You occupy a private room, You receive for the 120 day period, a daily allowance equal to the hospital's average semiprivate room charge toward the cost of bed, board and general nursing care.

COVERED EXPENSES

You are covered in full for the following services, regardless of the class of accommodations occupied, if they are necessary for the diagnosis and treatment of the condition for which You are hospitalized:

- Use of operating, cystoscopic, recovery rooms and equipment
- Use of intensive care or special care units and equipment
- X-ray examinations
- Laboratory and pathological examinations
- Blood, use of blood transfusion equipment and administration of blood or blood derivatives when given by a hospital employee
- Use of cardiographic equipment and supplies
- Anesthesia supplies and use of anesthesia equipment
- Oxygen and use of equipment for its administration
- Dressings and plaster casts
- Any additional medical services and supplies customarily provided by the hospital
- Hospital room and board up to the semiprivate room rate charged by the Hospital in which You or Your Dependent are confined; if hospital only has private rooms, we will cover 80% of charges
- Charges for local licensed ambulance service only to a hospital, due to accident or acute illness, or from a Skilled Nursing Facility to a hospital, due to accident or acute illness
- Charges made for diagnostic testing
- Charges made for radiation and chemotherapy treatment
- Charges made for prescription drugs (except birth control drugs and vitamins), not covered under the Fund's prescription drug program; the drug must be Federal Drug Administration approved for the illness being treated
- Charges made for rental (or if cheaper, purchase) of durable medical equipment such as wheelchairs, hospital type bed, etc.

Benefits for cancer chemotherapy (including medications) will be provided when given in the hospital on an outpatient basis.

MATERNITY CARE

Maternity benefits are provided for expenses incurred in a hospital for all Participants and spouses of Participants. There are no maternity benefits provided for dependent children.

Regular hospital benefits will be provided for hospital stays involving any pregnancy-related condition. Additionally, benefits for routine nursery care of the newborn child are provided during the mother's normal covered hospital stay for delivery. There is no coverage if the pregnancy is terminated due to elective abortion.

The Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

NEWBORN CHILDREN

Under family coverage, benefits are available from birth for:

- The treatment of illness or injury, or
- Nursery care in an approved premature unit for an infant weighing less than 2,500 grams (5.5 pounds) or
- Incubator care, regardless of the infant's weight

OUTPATIENT SERVICES

Covered-in-full benefits, subject to a $100 co-payment, are provided when You are not admitted as an inpatient but receive care in the hospital's emergency room or operating room for:

Emergency Treatment/Surgery

1. Emergency first aid during the initial visit for treatment of an accidental injury within 72 hours following such injury, or
2. Emergency care during the first visit for treatment within 12 hours of the onset of sudden or serious illness, or
3. Minor surgery

PRE-ADMISSION TESTING

Diagnostic tests prescribed by Your doctor and completed in a Hospital as an outpatient, as a preliminary to admission in that hospital, if done within 7 days of admission.

OUTPATIENT CHEMOTHERAPY

Benefits for cancer chemotherapy (including medications) will be provided when given in the hospital on an outpatient basis.

HOME CARE

Home Care benefits are available, within seven (7) days following discharge from a hospital, under a physician-approved plan of treatment when the necessary services are rendered through a New York State licensed and federally certified home health agency. Benefits will be provided only if hospitalization or confinement in a skilled nursing facility would have otherwise been required.

Covered services include: part-time professional nursing; part-time home health aide services (up to 4 hours of such care is equal to one home care visit); physical, occupational or speech therapy; medical supplies, drugs and medicines prescribed by a physician; and necessary laboratory services. In no event will coverage be provided for more than 200 visits in any calendar year.

When care is rendered without prior hospitalization, or if not begun within seven (7) days from hospital discharge, after a $400 deductible, You will receive an allowance equal to 80% of the agency's reasonable charges, for up to a maximum of 40 home care visits per calendar year.

SPECIAL CONDITIONS

MENTAL OR NERVOUS DISORDERS

Regular hospital benefits are available in an accredited Joint Commission on Accreditation of Hospitals (JCAH) non-governmental general hospital, psychiatric hospital or in the separate psychiatric division of a general hospital, which is included in the 120 days hospital maximum.

PHYSICAL THERAPY, PHYSICAL MEDICINE AND REHABILITATION

Regular hospital benefits are provided in hospital for up to 30 days during a 12-consecutive month period for stays or portions of stays primarily for physical therapy, physical medicine, and rehabilitation, when such services are performed under programs approved by the New York State Department of Health. These days are included in the 120 day maximum hospital benefit.

DIALYSIS FOR KIDNEY FAILURE

Regular hospital benefits are provided for hemodialysis or peritoneal dialysis while the Participant is a registered inpatient. Benefits are also provided for outpatient dialysis, as follows:

- **In the home –** The Plan will pay the cost of all appropriate and necessary supplies required for home dialysis treatment, as well as the reasonable rental cost of the required equipment

- **In a hospital or freestanding facility –** The Plan will pay the cost of necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities

These dialysis benefits will be available until the patient becomes eligible for coverage under Medicare, but the maximum availability is 30 months from the date of the first treatment.

MASTECTOMY BENEFITS

When a participant or beneficiary receives benefits from the Plan in connection with a mastectomy, the plan will also provide coverage for:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance and
- prostheses and physical complications at all stages of mastectomy, including lymphedemas

This coverage is subject to all of the Plan's rules regarding benefits, including the Plan's annual deductibles and co-payment provisions.

INPATIENT CARE

When You are admitted to any legally constituted general hospital, You receive the benefits described in this booklet.

OUTPATIENT CARE

When You use a hospital's facilities for a surgical operation, regular hospital benefits are provided for such care.

HOSPICE CARE

A covered Participant has coverage for up to 210 days of inpatient hospice care in a hospice or hospital, and home care and outpatient services provided by the hospice as described below if:

- the Participant has been certified by his or her primary attending physician as having a life expectancy of six (6) months or less
- the hospice care is provided by a hospice organization certified pursuant; to Article 40 of the New York Public Health Law; or if the hospice is located outside of this state, under a similar certification process required by the state in which the hospice organization is located.

Typically, covered hospice and outpatient services include:

Inpatient care, either in a designated hospice unit or in a regular hospital bed, and day care services provided by the hospice organization.

Home care and outpatient services provided by the hospice and charged to You by the hospice are also covered. The services may include the following:

- intermittent care by an R.N. or Home Health Aide
- physical therapy
- speech therapy
- occupational therapy
- respiratory therapy
- social services
- nutritional services
- laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms
- medical supplies
- drugs and medications prescribed by a physician and which are approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental or investigative nature)
- medical care provided by the hospice physician
- five visits for bereavement counseling for the Participant's family, either before or after the Participant's death
- durable medical equipment (rental only)
- transportation between home and hospital or hospice organization when medically necessary

HOSPITAL EXCLUSIONS

Hospital benefits are not provided for:

- Confinement for sanitarium-type, custodial or convalescent care, or for rest cures; or for care in a hospital for long term care

- Hospital confinements or any period of hospital confinement primarily for diagnostic studies

- Workers' Compensation cases; hospitalization furnished under federal, state or other laws, or military service-related care in a veterans facility or a hospital operated by the United States

- Services of physicians, private or special nurses and or other private attendants or their board

- Any expense, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable

- Participants who have Medicare as primary coverage or are eligible for Medicare coverage; except for the Medicare deductible and any required co-payments up to the maximum hospital benefit

PRE-CERTIFICATION PROGRAM

Surgery is serious. When You have a choice, You must be pre-certified by MagnaCare for the surgery.

All infusible drugs administered in a doctor's office must be pre-certified.

To arrange for pre-certification, call 1-877-335-4725 as soon as surgery is recommended by Your physician. This does not apply to Participants on Medicare.

HOSPITAL REVIEW PROGRAM

Why is a Hospital Pre-Admission Certification Program necessary?
Costs for health care have escalated in the last decade. The majority of these expenses are for services in the hospital.

The Trustees believe that it is important that You continue to be able to obtain hospital care, when necessary, without compromising the quality of that care. By assuring You that a hospitalization is necessary and that Your hospital stay is not prolonged beyond the time medically required, You will also be helping to keep down the rising cost of health care.

What is Hospital Pre-Admission Certification (PAC) and Continued Stay Review (CSR)?
Hospital Preadmission Certification (PAC) requires You to have Your proposed hospital stay reviewed by MagnaCare professional staff **prior to** Your hospital admission. Based on information provided by Your doctor, MagnaCare will determine whether Your hospitalization is medically necessary or if the treatment might be provided in a different setting. At the same time it will assign an initial number of approved hospital days and notify You, Your physician and the hospital. This program does not apply to members on Medicare.

What happens if I need more hospital days than were initially approved? (CSR)
When the initially approved hospital days are up, MagnaCare will contact Your doctor to learn if You will be discharged or if Your physician feels that an extension of Your hospitalization is required. If the MagnaCare reviewers agree, additional days will be approved.

What should I do when my doctor recommends admission to a hospital for either myself or an eligible dependent?
You should call MagnaCare immediately (Toll Free) at 1-877-335-4725. Be sure to have the following information on hand: the name and social security number of the participant, the name and identification number of the Fund, the name and phone number of Your doctor, the name of the hospital where You will be treated, the date You are planning to enter the hospital and the planned surgical or diagnostic procedure.

What about urgent or emergency hospital admissions where there is no time to go through the Precertification process?
When You require an URGENT admission Your doctor should telephone MagnaCare at 1-877-335-4725 and give them the information so they can assign an initial approved number of hospital days.

When You are hospitalized for an EMERGENCY, the doctor or a responsible family member must call MagnaCare within 72 hours to notify them of the hospital admission.

Why should I want to use the Hospital Pre-Admission Certification Program?

You will receive maximum benefits if You use the program.

If You do not use the program, one of the following circumstances will occur:

1. If the admission would have been approved by MagnaCare as medically necessary, You will be subject to a $200 benefit reduction

2. Any admission that would not have been approved as medically necessary by MagnaCare, will not be a covered expense and You will be responsible for 100% of the non-covered charges

What is Large Case Management?
MagnaCare will also provide a special mandatory service designed to assist patients with serious illnesses or injuries. Many people who have used this kind of service have found that it provides valuable assistance and peace of mind during difficult periods of serious illness or injury. Serious medical cases include:

- Chronic illnesses
- Acute catastrophic injury
- Infectious disease
- Burns
- Terminal illnesses
- Neonatal complications
- AIDS and AIDS-related cases

A case management coordinator will contact You and Your family to discuss Your medical care needs. Your personal case management coordinator will help You by:

- Facilitating all activities and communication among the professionals involved in Your treatment plan,

- Providing information about Your treatment options,

- -Identifying any needed additional medical resources that may be available to You.

You should take advantage of this valuable case management service in order to assure that services are provided at the appropriate (and least costly) level of care.

MEDICAL BENEFITS

Private Duty Nursing Care – Annual Per Participant……..$20,000.00

All Essential Medical Benefits:

Annual per Participant incl. Hospital Benefits Unlimited

Deductible Amount

Per Person: $400 per calendar year.

The Fund will pay 80% of Covered Expenses in excess of the Deductible Amount for any covered injury or sickness.

Any Covered Expenses which You or a Dependent incur which are applied toward Your deductible during the last 3 months of a Calendar Year will be applied toward the deductible for the next Calendar Year. If You exceeded the deductible for the year, there will be no application toward the deductible for the next Calendar Year.

Benefits Payable

For Injury or Sickness:

The maximum amount of out-of-pocket expense per person per Calendar Year for those expenses payable at 80% is $3,000 including the Deductible Amount. After the $3,000 has been satisfied the Plan will pay for such person 100% of the balance of the covered expenses incurred for the remainder of the Calendar Year.

The maximum amount of out-of-pocket expense per family per Calendar Year for those expenses payable at 80% is $6,000 including the Deductible Amount. After the $6,000 has been satisfied the Plan will pay for the family 100% of the balance of the covered expenses incurred for the remainder of the Calendar Year.

If You or Your Dependent Incur Covered Expenses as the result of an accidental bodily injury or Sickness during any Calendar Year, benefits will be payable as indicated in the Schedule of Benefits.

ALCOHOLISM AND/OR SUBSTANCE ABUSE TREATMENT

Outpatient/Inpatient benefits for the diagnosis and treatment of alcoholism and/or substance abuse are available to each covered person, subject to the $400 per person per calendar year deductible and the expenses payable at 80%. Family counseling is available to all the persons covered in the patient's family. Benefits for family counseling are limited to one visit a day.

Within New York State, care for alcoholism is only covered at facilities certified by the New York State Division of Alcoholism and Alcohol Abuse and care for substance abuse is only covered at facilities certified by the New York State Division of Substance Abuse Services.

Outside of New York State, care must be provided by a facility with a treatment program approved by the Joint Commission on Accreditation of Hospitals.

Benefits are provided for covered services rendered in government facilities unless no charge would have been made in the absence of this coverage.

Covered providers are M.D., Ph.D., MSW, CFW, CAC and CFS.

ORGAN TRANSPLANT BENEFITS

Benefits are available for kidney, cornea, and some other transplants, if performed in properly qualified facilities. Coverage for heart, heart-lung, pancreas, bone marrow and liver transplant procedures includes all medically necessary hospital, medical, surgical or other services related to the transplant. Prior authorization must be obtained from the Fund, and the transplant must take place at a facility approved by the Fund for the specific transplant procedure being performed.

Under these conditions, coverage will include:

- all medically necessary care

- costs directly related to the donation of an organ used in the transplant procedure, such as the surgical procedure necessary to procure the organ, storage expenses and transportation costs, up to a maximum of $35,000 per transplant

- reasonable travel expenses if You live more than 75 miles from the transplant center, including food and lodging for the recipient and one adult family member (two, if the recipient is a minor); to the city where the transplant takes place, up to a maximum of $150 per day, $10,000 per lifetime

The benefit period begins five days prior to surgery and extends for a period of up to one year from the date of surgery.

ENDOSCOPY AND COLONOSCOPY PROCEDURES

Endoscopy and Colonoscopy procedures will be covered only if performed in a doctor's office or a free standing surgical center, unless the doctor certifies that it is medically necessary for the test to be performed in a hospital or a hospital surgical center.

ANNUAL PHYSICAL EXAM BENEFIT

Participants and dependents with primary coverage through this Fund are eligible for an annual physical exam, performed in accordance with standard medical protocol. However, the exam must be provided by a MagnaCare participating doctor and all related diagnostic tests must be performed by a MagnaCare participating provider.

When the above conditions are met, the physical exam will be considered a covered expense, subject to the MagnaCare co-payment.

WELL CHILD CARE

Well child care benefits are available for all required immunizations and well care as recommended by the American Academy of Pediatrics.

IMMUNIZATIONS

All immunizations may be subject to additional charges for giving the vaccine depending on where you receive it.

1. Influenza immunization is a covered benefit.

2. Pneumonia immunization is covered when medically necessary.

3. Shingles Vaccine is covered for Participants age 60 and over.

MAMMOGRAPHY BENEFITS

Upon receipt of satisfactory proof, benefits shall be payable for expenses incurred for mammography screening for You or Your Dependent as follows:

1. A Mammogram at any age for women having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer, whenever a mammogram is recommended by a physician

2. A single baseline mammogram for women age 35 through 39

3. A mammogram once every Calendar Year for women age 40 and older

Mammography screening means an x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

This benefit will be subject to all provisions applicable to laboratory tests or diagnostic x-ray services under the Plan.

MAGNACARE

An important benefit of the Health Plan is the MagnaCare Medical Panel. MagnaCare is a Preferred Provider Organization that has established a network of Physicians, Radiologists and Laboratories. These network providers have been screened by MagnaCare's enrollment procedures to assure quality services.

Each Participant of the Plan has been given a MagnaCare Card and a MagnaCare Directory upon request. The Directory is the list of network providers You should use to find the providers You need. When using a network provider, You must show Your MagnaCare Card. You do not need a Local 25 Health claim form for MagnaCare Providers.

Services rendered by providers that are not a MagnaCare provider will be subject to deductible and co-payment where applicable. Participants should realize that **non-panel doctors have no limit to what they can charge for any given service**. Any amount of charges billed by non-panel providers over the Fund's allowance for a given service will be the responsibility of the Participant.

If an eligible Participant chooses to use one of the over 46,000 health care providers with agreements with MagnaCare in the Metropolitan, New York, Long Island area, out-of-pocket costs will be reduced substantially by utilizing MagnaCare providers. A provider list is available on the MagnaCare website at www.magnacare.com. An example of a schedule is set forth below:

	MAGNACARE IN NETWORK	OUT OF NETWORK
Deductible	None	$400 per person
Co-Pay/Coinsurance	$25 medical office visits	20% coinsurance
	$100 Cat Scan & M.R.I.	20% coinsurance
	$25 diagnostic & lab $15 allergy treatment	20% coinsurance
Surgical	20% coinsurance; MagnaCare schedule	20% coinsurance: existing schedule
Forms	no claim forms	requires claim forms

OUT-OF-POCKET EXPENSES IN NETWORK WILL NOT BE APPLIED TO OUT-OF-NETWORK DEDUCTIBLES.

Excluded from MagnaCare are spouses covered through another health plan if the other plan is primary, and dependent children, if the other plan is primary. In addition, Participants covered by Medicare are also excluded.

PRESCRIPTION DRUG PROGRAM

You will pay a 20% coinsurance per prescription toward the cost of Your prescription drugs if generic drugs are prescribed. If non-generic drugs are prescribed, You will pay the 20% coinsurance plus the difference between the cost of the non-generic drug and a generic drug if a generic drug is available. The Fund will pay the balance, no matter what the charge, providing the prescription is

filled by a Participating Pharmacy. If a Non-Participating Pharmacy is used, reimbursement of the charges will be made in accordance with a specific schedule of allowances. When a Non-Participating Pharmacy is used, there is no assurance that the charges will not exceed the amount that the Fund allows. In such instances, payment by You may exceed the benefit provided by the Fund. The drug benefits are provided when prescribed by a licensed doctor, dentist or podiatrist and dispensed by a licensed pharmacy or the out-patient department of a hospital.

Only the following prescriptions will be accepted for payment:

1. Prescriptions which require compounding.
2. Prescriptions for legend drugs.
3. Prescriptions for Federal Legend and OTC Diabetic Medications and Supplies.

* The maximum amount of the out-of-pocket expenses per person per calendar year for those prescription expenses payable at 80% is $2,000.

HOW ARE BENEFITS OBTAINED?

Each covered Participant is issued an Identification Card authorizing any Participating Pharmacy to fill prescriptions which come within the scope of the Plan as outlined above. The Identification Card certifies the Participant's eligibility to the Participating Pharmacy.

Failure to Notify the Fund Office of a new dependent will result in disallowance of Your claim. You will sign for each prescription thus filled or refilled and pay the charges as set forth above, as applicable for each such prescription.

If a prescription is filled at a Non-Participating Pharmacy, Express Scripts, who administers the Prescription Plan for the Fund, requires a receipted bill indicating name and date of birth of patient, name of medication, NDC number (drug number), strength and quantity dispensed and the signature of a registered pharmacist. Such receipted bills must then be submitted to **Express Scripts, Attention: Commerical Claims, P.O. Box 2872, Clinton, IA 52733-2872** for payment. Reimbursement will be made in accordance with a specific schedule of allowances as established by Express Scripts. Reimbursement is determined by the price the Fund would have paid for the same drug if it had been purchased at one of the Participating Pharmacies. Such direct reimbursements will be made as soon as possible after receipt of claim.

SPECIALTY PHARMACY PRESCRIPTION DRUGS

All infusible drugs and self-injectables, except those administered in a hospital, must be obtained from Express Scripts, the Funds' prescription drug benefit manager.

Important Information for those who use Specialty Medications

As part of your prescription drug benefit, IBEW Local 25 Health & Benefit Fund has arranged for you to have access to the enhanced services of Accredo, Express Scripts' specialty pharmacy, for your specialty medication needs. Accredo is a mail-order pharmacy dedicated to providing specialty medications and delivering the high level of care and service you deserve.

Specialty medications are typically injectable medications administered either by you or a healthcare professional, and they often require special handling. These medications treat complex conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis.

The **IBEW Local 25 Health & Benefit Fund prescription drug plan REQUIRES that certain specialty medications be accessed through Accredo.** If you are currently using a retail pharmacy to obtain your specialty medications, **you may be required to transfer those prescriptions to Accredo.** If you continue to purchase your medications from a pharmacy other than Accredo or thru your physicians office, **you may be responsible for their full cost.**

If you use specialty medications, you'll appreciate the extra services offered by **Accredo,** including:

- Toll-free access to specially trained pharmacists 24 hours a day, 7 days a week
- Personalized counseling from our dedicated team of registered nurses and pharmacists
- Expedited, scheduled delivery of your medications at no extra charge
- Refill reminder calls
- Free supplies to administer your medication, such as needles and syringes

For more information about specialty medications and services or to confirm whether a medication you take is part of the specialty program, call the number on the back of your prescription drug ID card or visit **www.accredohealthgroup.com**

PRESCRIPTIONS BY MAIL

This service provides additional savings to the Participant and to the Fund. If You have a chronic condition (long term illness) and require the same medication for a long time (e.g., diabetic pills, heart condition pills, etc.) You can obtain up to a 90 day supply of medication at one time through the following procedure:

You must use the special envelope and forms supplied, and Your doctor must indicate the dosage and the number of months to be used (maximum 90 days). You will pay a 20% co-payment per prescription toward the cost of Your prescription drugs if generic drugs are prescribed. If non-generic drugs are prescribed, You will pay the difference between the cost of the non-generic drug and the generic drug if a generic drug is available. You should then mail Your prescription to:

Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

Your medicine will be delivered to You by mail or United Parcel Service at no further cost whatsoever. You should allow at least 10 days turn around time for the delivery of Your letter and the return to You of the medication. Do not leave Yourself without an adequate supply of medication during this period.

LIMITATIONS (RETAIL)

Prescriptions may not exceed a 34 day supply. You are entitled to two (2) maintenance medications at retail. On the third fill you will be charged a 40% copay instead of 20% unless you use Express Scripts By Mail.

The second time you purchase certain long-term drugs (such as those used to treat high blood pressure or high cholesterol) at a participating retail pharmacy, you will pay your retail co-payment. After that, you will pay an additional 20% higher copay for these long-term drugs unless you choose to order them through Express Scripts By Mail. You should continue to purchase short-term drugs such as antibiotics at a participating retail pharmacy. You'll still pay your participating retail pharmacy co-payment for short-term drugs.

EXCLUSIONS

The following are exclusions from coverage unless specifically listed as a benefit:

- Contraceptives, oral or other, whether medication or devices, regardless of intended use.

- Therapeutic devices or appliances, including all needles and syringes, support garments, and other non-medical substances, regardless of intended use, except for diabetic supplies.

- Prescriptions for which an eligible person is entitled to receive without charge due to Workers' Compensation law, or any municipal, state or federal program.

- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.

- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

- Any prescription filled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

If you have any questions or need assistance, please call Member Services toll free at 1-800-251-7689. Express Scripts is there for you around the clock (except Thanksgiving and Christmas).

You can also view Plan information and compare prices online: Register at www.ExpressScripts.com to quickly refill your mail-order prescriptions, locate participating retail pharmacies, and use My Rx Choices to vew potential lower-cost options, such as generics, for your long-term medications. Express Scripts, with your approval, will contact your doctor to arrange for you to get a new prescription for the lower cost option you select.

PRESCRIPTION DRUG COVERAGE AND MEDICARE

The Fund has determined that Your prescription drug coverage with the Fund is, on average for all Plan Participants, expected to pay out at least as much as the standard Medicare prescription drug coverage will pay. You can choose to join a Medicare prescription drug plan. Each year You will have the opportunity to enroll in a Medicare prescription drug plan between November 15th and December 31st.

If You enroll in a Medicare prescription drug plan Your coverage with I.B.E.W. Local 25 Health & Benefit Fund will be terminated and You will not be able to obtain this coverage later. You should compare Your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in Your area.

Furthermore, Your current coverage pays for other health expenses, in addition to prescription drugs, and You will not be eligible to receive all of Your current health and prescription drug benefits if You choose to enroll in a Medicare prescription drug plan.

You should also note that if You drop or lose Your coverage with the Fund and do not enroll in Medicare prescription drug coverage after Your current coverage ends, You may pay more to enroll in Medicare Prescription drug coverage later.

More detailed information about Medicare plans is available in the "Medicare & You" handbook. You should have received a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also obtain more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help.
- Call Your State Health Insurance Assistance Program (see Your copy of the Medicare & You handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

EMPLOYEE ASSISTANCE PROGRAM

The Trustees have contracted with National EAP, Inc., a confidential assistance program that is available to Participants and their dependents who may be experiencing work/life issues that could interfere with overall productivity.

Solution Focused Consultation and Counseling Services to Address Concerns or Issues with:

- Balancing Work & Family;
- Stress Management;
- Adoption;
- Crisis Management;
- Grief & Loss;
- Anxiety & Depression;
- Workplace & Mental Illness;
- Marital & Family Relationships.

Work/Life Referral

- Child & Eldercare
- Legal & Financial
- Debt & Credit Counseling

How EAP works:

You simply pick up the phone and call 1-800-624-2593 to speak with our Client Coordinator. Private, telephone, face-to-face sessions are available for personalized assistance and solution-focused counseling. All EAP services are pre-paid by the Fund.

You may also reach National EAP, Inc., via the web at www.nationaleap.com.

What if additional treatment is needed?

An EAP clinician can help You secure longer treatment; if necessary, and can make a referral. Plan benefits may be available to help offset the cost of such care. Please review this Summary Plan Description, or call the Fund Office for assistance.

NATIONAL EAP - EMPLOYEE ASSISTANCE PROVIDERS, INC. Established 1982
Corporate Headquarters: 490 Wheeler Road, Suite 102, Hauppauge, NY 11788
www.nationaleap.com

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Accidental Death and Dismemberment Benefits are payable on behalf of all covered Participants under an insurance policy with American International Life Insurance Company of New York (the "Company").

BENEFITS

Principal Sum. As applicable to each insured Participant, Principal Sum means the amount of $100,000.

Reduction Schedule. The amount payable for a loss will be reduced if an Insured Person is age 70 or older on the date of the accident causing the loss with respect to any Benefit provided by this Policy where the amount payable for the loss is determined as a percentage of his or her Principal Sum. The amount payable for the Insured Participant's loss under this Benefit is a percentage of the amount that would otherwise be payable, according to the following schedule:

AGE ON DATE OF ACCIDENT	PERCENTAGE OF AMOUNT OTHERWISE PAYABLE
70-74	65%
75-79	45%
80-84	30%
85 and older	15%

"Age" as used above refers to the age of the Insured Person on the Insured Person's most recent birthday, regardless of the actual time of birth.

Limitation on Multiple Benefits. If an Insured Participant suffers one or more losses from the same accident for which amounts are payable under more than one of the following Benefits provided by this Policy, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the larger of the Accidental Death Benefit or the Accidental Dismemberment Benefit.

Accidental Death Benefit. If Injury to the Insured Participant results in death within 365 days of the date of the accident that caused the Injury, the Company will pay 100% of the Principal Sum.

Accidental Dismemberment Benefit. If Injury to the Insured Participant results, within 365 days of the date of the accident that caused the Injury, in any one of the Types of Losses specified below the Company will pay the percentage of the Principal Sum shown below for that Loss:

Schedule For Insured

Type of Loss	Percentage of Principal Sum
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and index Finger of Same Hand	25%

If more than one Loss is sustained by an Insured Participant as a result of the same accident, only one amount, the largest, will be paid.

Exposure and Disappearance. If by reason of an accident occurring while an Insured Participant's coverage is in force under the Policy, the Insured Participant is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If the body of an Insured Participant has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the Participant was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured Participant has suffered accidental death within the meaning of the Policy.

"Loss" of a hand or foot means complete severance through or above the writs or ankle joint. "Loss of sight of an eye" means total and irrecoverable loss of the entire sight in that eye. "Loss of hearing" in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss of speech" means total and irrecoverable loss of the entire ability to speak. "Loss of the thumb and index finger" means complete severance through or above the metacarpophalangeal loss of both digits.

EXCLUSIONS

No coverage shall be provided under this Policy and no payment shall be made for any loss resulting in whole or part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily injury.

1. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self- inflicted Injury.

2. sickness, or disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these, unless specifically provided by this Policy.

3. travel or flight in or on (including getting in or out, on or off of) any vehicle used for aerial navigation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline whether as a passenger, pilot, operator or crew member, unless specifically provided by this Policy.

4. declared or undeclared war, or any act of declared or undeclared war.

5. infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.

6. service in the Armed Forces or units auxiliary thereto of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded).

7. the Insured Person being under the influence of drugs unless taken under the advice of and as specified by a Physician.

8. the Insured's Person's participation in a felony, riot, or insurrection.

9. the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment.

DEATH BENEFITS (Stage 2)

(Active Plan Participants and I.B.E.W. Local 25 Disability Pensioners up to age 62 Only)

BASED ON ATTAINED AGE AT TIME OF DEATH AND AMOUNT OF DEATH BENEFIT PER ACCUMULATED YEARS OF PLAN B OR PLAN A COVERAGE FOR DEATH BENEFIT:

AGE AT TIME OF DEATH	YEARS OF PLAN COVERAGE FOR DEATH BENEFIT			
	1-4	5-9	10-14	15 & over
50 and under	$10,000	$20,000	$30,000	$40,000
51	10,000	20,000	29,000	38,000
52	10,000	20,000	28,000	35,000
53	10,000	20,000	26,000	32,000
54	10,000	20,000	24,000	28,000
55	10,000	20,000	22,000	25,000
56	9,000	17,000	20,000	22,000
57	9,000	14,000	17,000	19,000
58	8,000	11,000	14,000	16,000
59	7,000	9,000	12,000	13,000
60	6,000	7,000	10,000	12,000
61	5,000	6,000	9,000	11,000
62	5,000	5,000	8.000	8,000
63	5,000	5,000	7,000	8,000
64	5,000	5,000	6,000	8,000
65 and over	5,000	5,000	5,000	8,000

The Amount of Death Benefit for Plan participants who retire and qualify for retiree coverage, including Disability Pensioners age 62 and older: $5,000

LIMITATIONS FOR ALL DEATH BENEFITS

There is no coverage for loss caused by or resulting from:

Suicide or any attempt thereat.

DENTAL BENEFITS (Stage 2)

Maximum Amount Payable:

Per Person per Calendar Year except for Pediatric.	$2,000
Per Family per Calendar Year except for Pediatric:	$4,000

Benefits Payable:

All other Dental Services:	100% of the usual and customary charge, not to exceed the Maximum Covered Charge stated in the List of Covered Dental Procedures. (page 32)

If You or Your Dependent incur expenses for a service in the "List of Covered Dental Procedures," benefits will be payable to the extent that they:

1. Are usual and customary
2. Constitute necessary treatment
3. Are incurred while You or Your Dependents are covered for this benefit

The Plan will pay the amount of eligible expenses indicated in the Schedule of Benefits. The maximum amount allowed for dental services is also found in the Schedule of Benefits.

LIMITATIONS

There is no coverage for loss caused by or resulting from:

1. A service furnished to You or Your Dependent for:
    a. Cosmetic purposes, unless needed as the result of an injury
    b. Dental care of congenital or developmental malformation except for Orthodontic services
2. Replacement of a lost or stolen appliance
3. A service not furnished by a Dentist, except:
    a. Services of a dental hygienist, and
    b. X-rays ordered by a dentist
4. Appliances, restorations or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing structure lost as a result of abrasion or attrition or treatment of disturbances of the temporomandibular joint.

5. The replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within 5 years of the date of the last placement, unless replacement is needed as a result of injury.

6. An initial placement of a partial or full removable denture or fixed bridgework which involves the replacement of one or more natural teeth, unless the teeth are extracted while covered for this benefit.

7. Services performed for the teeth, nerves of the teeth, gingivae or alveolar process except for tumors or cysts, or because of accidental injury, while covered, to sound natural teeth. This includes the initial replacement of these teeth and any necessary dental x-rays resulting from an accident occurring while covered, provided You receive treatment within twelve months of the accident.

8. All claims must be submitted within twelve (12) months of the date of service.

9. There is a lifetime maximum benefit of $500 per implant, payable for 1 implant per jaw lifetime, (total of 2) for implant codes 6010, 6020, 6040 and 6050. Panel dentists do not have to accept these fees as payment in full; it is an allowance towards the full implant fee.

SCHEDULE OF COVERED DENTAL PROCEDURES

The following is a listing of dental procedures covered under Your dental plan. Only procedures listed in the following schedule are eligible for coverage:

PROCEDURE	MAXIMUM PLAN ALLOWANCES
I. DIAGNOSTIC AND PREVENTATIVE	
Comprehensive Oral Examination (once every six (6) months)	$25.00
X-Rays Complete Series	$50.00
X-Ray Periapical 1st Film	$4.00
X-Ray Periapical Each Addl.	$4.00
X-Ray Occlusal Film	$16.00
X-Ray Extraoral Film	$25.00
X-Ray Bitewing	$4.00
X-Rays 2 Bitewings	$8.00
X-Rays 4 Bitewings	$16.00
X-Ray Sialography	$40.00
X-Ray Temporomandibular Joint	$25.00
X-Ray Panoramic Film	$45.00
X-Ray Cephalometric Film	$35.00
Dental Prophylaxis Adult (once every six (6) months)	$45.00
Dental Prophylaxis Child to 16 (once every six (6) months)	$40.00
Fluoride Treatment to Age 19 (once per year)	$16.00

Sealant Per Tooth to Age 19	$20.00
Space Maintainer Fixed Unilate	$150.00
Space Maintainer Fixer Bilater	$150.00
Space Maintainer Remove Unilate	$150.00
Space Maintainer Remove Bilater	$150.00
Recement Space Maintainer	$30.00

II. RESTORATIVE

Amalgam Fillings	
Amalgam 1 Surface, Amalgam 2 Surfaces, Prim., Perm	$60.00
Amalgam 3 Surfaces, Prim., Perm	$65.00
Amalgam, Prim., Perm	$50.00
4+ Surfaces, Prim., Perm	$75.00
Resin Fillings	
Composite 1 Surface Anterior	$60.00
Composite 2 Surfaces Anterior	$65.00
Composite 3 Surfaces Anterior	$70.00
Composite 4+ Surfaces/Incisal Anterior	$75.00
Composite 1 Surface Posterior	$70.00
Composite 2 Surfaces Posterior	$85.00
Composite 3 Surfaces Posterior	$95.00
Composite 4+ Surfaces Posterior	$95.00
Inays/Onlays	
Inlay Metallic 1 Surface	$150.00
Inlay Metallic 2 Surfaces	$180.00
Inlay Metallic 3 or more Surfaces	$210.00
Onlay Metallic 2 Surfaces	$180.00
Onlay Metallic 3 Surfaces	$210.00
Onlay Metallic 4+ Surfaces	$210.00
Inlay Porce/Ceramic 1 Surface	$150.00
Inlay Porce/Ceramic 2 Surfaces	$180.00
Inlay Porce/Ceramic 3+ Surfaces	$210.00
Onlay Porce/Ceramic 2 Surfaces	$180.00
Onlay Porce/Ceramic 3 Surfaces	$210.00
Onlay Porce/Ceramic 4+ Surfaces	$210.00
Crowns	
Crown Resin (Indirect)	$175.00
Crown Resin High Noble Metal	$300.00
Crown Porcelain High Noble Metal	$400.00
Crown Porcelain Noble Metal	$400.00
Crown 3/4 Cast Noble Metal	$300.00
Crown Full Cast High Noble Metal	$300.00
Recement Inlay	$40.00
Recement Crown	$40.00
Stainless Steel Crown-Primary	$100.00
Stainless Steel Crown Primary	$100.00
Pin Retention Per Tooth	$25.00

Cast Post and Core	$125.00
Prefabricated Post and Core	$95.00
Labial Veneer-Laboratory	$200.00

III. ENDODONTICS

Pulp Cap Direct	$20.00
Pulp Cap Indirect	$20.00
Therapeutic Pulpotomy	$60.00
Root Canal Anterior	$350.00
Root Canal Bicuspid	$400.00
Root Canal Molar	$450.00
Apicoectomy Anterior	$200.00
Apicoectomy Bicuspid 1st Root	$200.00
Apicoectomy Molar 1st Root	$200.00
Apicoectomy Each addl. Root	$100.00
Retrograde Filling Per Root	$85.00
Root Amputation Peer Root	$150.00
Hemisection	$150.00

IV. PERIODONTICS

Gingivectomy/Plasty-Per Quad	$150.00
Osseous Surgery Per Quad	$400.00
Bone Replacement Grft- 1st Site	$150.00
Bone Replacement Grft Each Addl	$250.00
Pedicle Soft Tissue Graft	$200.00
Free Soft Tissue Graft	$200.00
Perio Scaling Rt. Planning Quad	$50.00
Periodontal Maintenance	$60.00

V. PROSTHODONTICS

Complete Denture Maxillary	$600.00
Complete Denture Mandibular	$600.00
Immediate Denture Maxillary	$600.00
Immediate Denture Mandibular	$600.00
Prtl. Dent. Max w/Clasps Resin	$375.00
Prtl. Dent Mand w/Clasps Resin	$375.00
Prtl. Dent Max w/Clasps Cast	$600.00
Prtl. Dent Mand w/Clasps Cast	$600.00
Removable Unilateral Prtl. 1 Tooth	$175.00
Adjust Complete Denture Max	$35.00
Adjust Complete Denture Mand	$35.00
Adjust Partial Denture Max	$35.00
Adjust Partial Denture Mand	$35.00
Repair Brkn Complete Dent Base	$90.00
Replace Miss/Broken Tth Comp. Dnt	$85.00
Repair Prtl. Resin Denture Base	$90.00
Repair Prtl. Cast Framework	$100.00

Repair or Replace Broken Clasp	$85.00
Replace Broken Tth. Per Tooth	$85.00
Add Tooth To Partial Denture	$85.00
Add Clasp to Partial Denture	$85.00
Reline Complete Dent Max Chair	$75.00
Reline Complete Dnt Mand. Chair	$75.00
Reline Partial Dent Max Chair	$70.00
Reline Partial Dent Mand Chair	$70.00
Reline Complete Dent Max Lab	$125.00
Reline Complete Dent Mand Lab	$125.00
Reline Dent Max Lab	$100.00
Reline Partial Dent Mann Lab	$100.00
Tissue Conditioning Maxillary	$40.00
Tissue Conditioning Mandibular	$40.00
Precision Attachment	$100.00
Surg. Placement Implant Endosteal, see limitations page 30	$500.00
Abut. Placement Substitution End, see limitations page 30	$500.00
Surg. Placement Eposteal Implant, see limitations page 30	$500.00
Surg. Placement Transosteal Impl, see limitations page 30	$500.00
Pontic Cast High Noble Metal	$350.00
Pontic Porcelain High Noble	$400.00
Pontic Porcelain Prenom, Base Metal	$400.00
Pontic Porcelain Noble Metal	$400.00
Pontic Resin High Noble Metal	$350.00
Retainer Cast Metal For Resin	$200.00
Abutment Resin High Noble Metal	$350.00
Abutment Porcelain High Noble	$400.00
Abutment Porce. Predom. Base Metal	$400.00
Abutment Porcelain High Noble	$400.00
Abutment Full Cast High Noble	$350.00
Recement Fixed Partial Denture	$60.00

VI. ORAL SURGERY

Extraction Erupted Tth Exposed	$90.00
Surgical Removal Erupted Tooth	$90.00
Removal Impacted Tth Soft Tissue	$150.00
Removal Impacted Tth Prtl. Bony	$235.00
Removal Impacted Tth Full Bony	$300.00
Surgical Removal Residual Root	$90.00
Surgical Access Unerupted Tth	$160.00
Surg. Exposure Impacted Tth Aid.	$80.00
Biopsy Of Oral Tissue Hard	$75.00
Biopsy Of Oral Tissue Soft	$75.00
Alveoloplasty w/Ext Per Quad	$125.00
Alveoloplasty w/out Ext Quad	$125.00
Removal Benign Odonto. Cyst < 1.25 CM	$75.00
Removal Benign Odonto Cyst >1.25 CM	$125.00

Incision & Drainage Intraoral	$50.00
incision & Drainage Extraoral	$50.00
Frenectomy	$95.00

VII. ADJUNCTIVE SERVICES

Palliative Treatment	$30.00
Deep Sed. Gen. Anesthesia 1st 30 Mm	$100.00
Deep Sed. Gen Anesthesia Each Addl. 15	$50.00
Consultation by Specialist	$50.00

EXTENSION OF BENEFITS

The Dental Benefit will continue to be payable for a period not to exceed 90 days after termination. Dental Benefits will continue to be payable only as follows:

1. In the case of appliances or modification of appliances: If the master impression was taken while coverage was in force and the appliance was delivered or installed within 2 calendar months after termination;

2. In the case of a crown, bridge, or inlay or onlay: If the tooth or teeth were prepared while coverage was in force and such crown, bridge, or cast restoration was installed within 2 calendar months after termination;

3. In the case of root canal therapy: If the pulp chamber was opened while coverage was in force and the root canal therapy is completed within 2 calendar months after termination;

All coverage will stop when the earliest of the following happens:

1. The Maximum Benefit payable is reached;

2. 90 days after termination;

3. You or Your Dependent become eligible under another group plan.

PREFERRED PROVIDER ORGANIZATION DENTAL PLAN (P.P.O.)

DDS

DDS has a panel of participating dentists that accept full or partial assignment for all covered services. This means there are limited out-of-pocket expenses when You or a family member visits one of DDS's participating dentists.

Simply call 1-800-255-5681, identify Yourself as a member of Local 25, I.B.E.W., and ask for the dentist nearest to You. You will be given the dentist's name, address and telephone number, which You can use to make an appointment. Participating dentists, co-payments (if any) and plan design is available on the web at www.ddsinc.net; use code number 25-b for your specific plan information.

VISION CARE BENEFIT FOR PARTICIPANTS (Stage 2)

The benefit is available to You and Your dependents. This benefit entitles You and Your family to vision care services if You are eligible pursuant to the requirements of the Plan.

What are the Plan benefits?

Annually (every January 1) You are entitled to:

- a comprehensive eye examination (including dilation), and:
- spectacle lenses, or:
- contact lenses (in lieu of eyeglasses):
- safety eyeglass (in lieu of eyeglasses):

Biannually (every other January 1) You are entitled to:

- an eyeglass frame.

Who are the in-network doctors?

They are licensed doctors who are extensively reviewed and credentialed to ensure that standards for quality service are maintained. Davis Vision's extensive network of nearly 11,000 doctors nationwide makes it possible for the majority of active and retired Fund Participants to receive services from a doctor in the network. To locate the in-network doctors nearest to You, just call 1-800-999-5431 or access the Davis Vision website at www.davisvision.com and utilize the "Find a Doctor" feature. Davis Vision Retail's name changed to Visionworks but, the benefit of Davis Vision will remain the same.

How do I receive services from an in-network doctor?

- Call the in-network doctor of Your choice and schedule an appointment;
- Identify Yourself as a Participant or Dependent of the I.B.E.W. Local 25 Health & Benefit Fund vision plan;
- Provide the office with the Participant's Identification number and the year of birth of any covered children needing services.

The doctor's office will verify Your eligibility for services - no claim forms are required.

What types of eyewear may I select?

- any frame from the special Fashion and Designer selections displayed on the "Davis Vision Collection of Frames" in each in-network doctor's office, or $55 retail credit plus an additional 20% discount off any overage will be applied toward the purchase of a frame from the doctor's private selection: and

- any spectacle lens type; many are included at no additional cost; or

- contact lenses; in lieu of eyeglasses; standard, soft, daily-wear and disposable/planned replacement; types are available for most prescriptions with a minimal co-payment (see below). A $105.00 credit will be applied toward other types of contact lenses (i.e., toric, gas permeable) from the doctor's private selection.

  Please note: contact lenses can be worn by most people, but not by all. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

- safety eyeglasses; in lieu of eyeglasses; choose frames from specified Designer Safety Collection or use your own frame. In- network , a $40 credit will be applied toward a safety frame from the providers selection of safety frames. Out- of Network safety eyewear must be received from an in-network provider. There is no out-of network reimbursement for safety eyewear.

What are my costs for services?

- **EYE EXAMINATIONS**……Every January 1, including dilation as professionally indicated.

  In-Network Copayment…….$10

  Out-of-Network…….Reimbursed up to $20

- **EYEGLASSES**

  Frame……...Every other January 1

  Spectacle Lenses……..Every January 1

  You may choose any Fashion or Designer level frame from Davis Vision Frame Collection, covered in full. Or, if you select another frame in the network provider's office, a $55 credit, plus a 20% discount off any overage will be applied. This credit would also apply at retail locations that do not carry the Frame Collection. Members are responsible for the amount over $55 (less the applicable discount).

Out-of-Network……..Reimbursed up to $20 for frames, up to $20 for single vision lenses, up to $30 for bifocals, up to $40 for trifocals.

- **CONTACT LENSES** ……every 12 months
  In-Network Copayment……$35

  In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision Contact Lens Collection will be covered in full per the number indicated below, and your evaluation, fitting and follow up care will also be covered.

  Davis Vision Contact Lens Collection (includes evaluation, fitting, follow-up):

  Disposable…….Four boxes/multi-packs

  Planned Replacement……Two boxes/multi-packs

  In lieu of the Davis Vision contact lenses, members may use their $105 credit to go toward the provider's own supply of contact lenses, evaluation, fitting and follow-up care. This credit would also apply towards all contact lenses received at participating retail locations.

What lenses/coatings are included?

- plastic or glass single vision, bifocal or trifocal lenses, in any prescription range
- glass grey #3 prescription lenses
- oversize lenses
- post-cataract (lenticular) lenses
- fashion, sun or gradient tinted plastic lenses
- polycarbonate lenses (for dependent children and monocular patients)

Are there any optional frames, lenses or lens coatings available?

Yes, You can pay the low, discounted fixed fees indicated and receive these optional items:

	Dress	**Safety**
• Premier Frame	**$20**	**$20**
• Anti- relective coating		
Standard	**$35**	**$35**
Premium	**$48**	**$48**
Ultra	**$60**	**N/A**
• Glass photochromic lenses	**Included**	**N/A**
• Blended invisible bifocals	**Included**	**Included**
• Double segment lenses	**N/A**	**$60**
• Plastic Photosensitive lenses	**$40**	**$40**

• High-Index lenses	**$55**	**$55**
• Scratch-Resistant coating	**Included**	**Included**
• Ultraviolet (UV) coating	**$12**	**$12**
• Intermediate-Vision lenses	**$30**	**$30**
• Polycarbonate lenses (adult)	**$30**	**$30**
• Polarized lenses	**$75**	**$75**
• Progressive addition multifocal lenses.***		
Standard types	**$50**	**$50**
Premium	**$90**	**$90**

**** These lens are options and copays apply to in-network benefits only.**

*****Progessive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses, however, the copayment is not refundable.**

More special features:

- membership and access to a mail order replacement contact lens service, Lens 1-2-3, providing a fast and convenient way to purchase replacement contact lenses at significant savings. Call 1-800-LENS-123 (1-800-536-7123) for more information

- a one year unconditional breakage warranty is provided for all eyeglasses completely supplied by Davis Vision

What about out-of-network provider benefits?

You may receive services from an out-of-network provider; however, You will receive the greatest value and maximize Your benefit dollars if You select an In-network doctor.

If You choose an out-of-network provider, You must:

- pay the provider directly for all charges

- submit Your claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, New York 12110

Services will be reimbursed up to the following:

eye examinations	$20.00	
single vision lenses	$20.00	(per pair)
bifocal lenses	$30.00	(per pair)
trifocal lenses	$40.00	(per pair)
a frame	$20.00	
contact lenses	$105.00	

Claim forms are available by calling: 1-800-999-5431

Remember, You can claim reimbursement for an eye examination and lenses (if Your prescription has changed) every January 1, but only claim reimbursement for a frame every other January 1.

May I use the benefit at different times?

All available services must be obtained at one time from either one in-network or one out-of-network location.

EXCLUSIONS - VISION

The following items are not covered by this vision program:

- medical treatment of eye disease or injury
- visual therapy
- special lens designs or coatings, other than those previously described
- replacement of lost eyewear
- non-prescription (plano) lenses
- two pair of eyeglasses in lieu of bifocals
- contact lenses and a frame in the same 12-month period
- services not performed by licensed personnel

Need more information? Please feel free to call Davis Vision **at 1-800-999-5431 to:**

- locate an in-network doctor in Your area
- verify eligibility for Yourself or a family member
- request an out-of-network provider reimbursement claim form

- speak with a Participant Service Representative
- ask any questions about Your vision benefits

Participant Service Representatives are available:

- Monday through Friday, 8:00 A.M. to 11:00 P.M., Eastern Time, and
- Saturday, 9:00 AM. to 4:00 P.M., Eastern Time
- Sunday, 12:00 P.M. to 4:00 P.M., Eastern Time

T.D.D. (Telephone Device for the Deaf) services are available by calling:
1-800-523-2847

HEARING CARE BENEFIT FOR PARTICIPANTS (Stage 2)

The benefit is available to You and Your dependents. This benefit entitles You and Your family to hearing care services if You are eligible under the requirements of the Plan.

THE HEARING CARE PROGRAM PROVIDES:

Basic Hearing Evaluations

A basic hearing screening will be provided once every 36 months at no cost to You if You receive services from a participating audiologist. A hearing screening is appropriate if You are uncertain whether or not Your hearing is normal. If the screening results indicate that Your hearing falls outside of the normal range, a comprehensive audiological evaluation would be recommended.

Hearing Aid Services

Based on the findings of the audiological evaluation, hearing aid(s) may be recommended. Following medical clearance for use of hearing aids, Your audiologist can fit and dispense the aids which best accommodate Your hearing impairment based on the most recent comprehensive evaluation results, as well as input from You regarding Your lifestyle and listening needs. You are responsible for payment (in excess of the $500.00 allowance) for all hearing aids which are dispensed to You (see discounted fee schedule).

Preferred Provider Organization Hearing Service Plans

The Fund has selected two (2) Preferred Provider Organizations (PPOs) to provide hearing care services to eligible participants and their dependents.

EPIC Hearing Health Care

- To schedule a hearing screening, contact the EPIC Call Center, toll free at 866-956-5400 or visit their website at www.epichearing.com;
- An EPIC Hearing Counselor will issue a referral to a local participating provider;
- You will be sent a Hearing Service Plan Booklet outlining plan process, products and pricing.
- All hearing aid purchases will be coordinated and processed by EPIC, you will not pay the provider directly. EPIC will coordinate your eligible benefit up front, at time of payment. Any amount exceeding your hearing aid allowance will be payable to EPIC at the time of the order. Financing options are available.

HearUSA

HearUSA is a participating provider with MagnaCare with locations in the metro area. Additional information, such as the actual address and phone number for the locations can be obtained by contacting HearUSA by calling toll free at 1-877-664-9353, or visiting the MagnaCare website at www.magnacare.com.

If you see an in-network provider, all claims will be submitted by the provider. If you use an out-of-network provider, your claims should be sent to MagnaCare. Any amount charged over the benefit allowance will be billed directly to you.

MEDICAL REIMBURSEMENT ACCOUNT

Any person employed under a Collective Bargaining Agreement which contains a fringe benefit provision for medical reimbursement contributions shall have the contributions credited to his/her individual Medical Reimbursement Account (MRA).

Any eligible Participant's MRA will grow with solely the contributions that are made to it. The account will be decreased by any benefit distribution made from it. No more will be paid out to a Participant (or his beneficiary) under this benefit than has come into his MRA by way of contributions made on his work or initial allocation.

Once a Participant's MRA is reduced to zero, a Participant will cease to be considered a Participant in this benefit.

LIMITATION ON BENEFITS

Under no circumstances may any money be drawn from an MRA once the balance of an MRA has reached zero.

BENEFITS

If You incur health care expenses, including payment made for COBRA coverage or other payments required to continue Your Fund coverage for Yourself, Your spouse or Your dependent children, and such expenses are not covered under one of the other coverages of the Fund, You may apply for a distribution from Your MRA to pay for the uncovered bills.

Claims may be submitted only in the months of November and December.

FORFEITURE OF MRA

In the event a Participant has satisfied the general Fund eligibility requirements, Your participation in the MRA benefit will stop two (2) years after termination of a Participant's health and benefit coverage from the Fund.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

In the event the covered person has coverage under another plan that provides health care benefits, there will be coordination of benefits regarding the health care reimbursement under this Plan.

This coordination will apply in the event a covered expense is incurred under this Plan which also is covered under another plan or plans. A determination will be made as to which plan is the "primary" plan. The rules for determining which plan is primary are as follows:

1. If the other plan does not have a coordination of benefits provision with regard to the particular expense, that plan is primary regardless of the following rules for such determination.

2. The plan that covers the patient as an active employee is primary and the plan that covers the patient as a dependent is secondary.

3. If the other plan has a provision that it is always secondary, then this plan will be secondary in coordination with such plan.

4. If none of the above rules establishes which plan is the primary plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the primary plan.

If this Plan is the primary plan, it will pay its benefits as if there were no other plan.

If this Plan is not the primary plan, it will pay its benefits as if there were no other plan, except that this Plan will pay no greater part of a charge covered by this Plan and other plan(s) than that which when added to the part(s) payable by the other plan(s) equals 100% of such allowed charges.

This Plan will coordinate up to the Plan allowed charge not the billed charge.

DEPENDENT CHILDREN OF PARENTS NOT SEPARATED OR DIVORCED

1. Birthday Rule: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan covers the parent longer pays first. The plan that covered the other parent for a shorter time pays second. A person's year of birth is not relevant in applying this rule.

2. The Transition Rule: Provides that if one coordinating plan uses the Birthday rule and the other uses the Male/Female rule, both plans will follow the birthday rule.

DEPENDENT CHILDREN OF SEPARATED OR DIVORCED PARENTS

When parents are separated or divorced, neither the Male/Female nor the Birthday rule apply. instead:

1. The plan of parent with custody pays first

2. The plan of the spouse of the parent with custody (the step Parent) pays next

3. The plan of the parent without custody pays last

4. The plan will comply with a Qualified Medical Child Support order

MEDICARE

1. If You are 65 years or over, or if You qualify at an earlier age under one of the special provisions of the Medicare law (such as Social Security Disability pensioners), You are eligible for Social Security health benefits - Medicare. The same rules apply to Your spouse.

2. To be sure that You are eligible for Medicare benefits as soon as You reach age 65, You must register for Medicare Benefits at Your local Social Security Office within the 3 months before Your 65th birthday, whether or not You expect to continue to work after 65. No benefits will be paid for expenses incurred to the extent those expenses would have been reimbursable through Medicare Part A. If you are retired, no benefits at all will be paid for under the Fund unless You are covered under Part B of Medicare.

3. Medicare Hospital Insurance (Part A) is provided without cost to You and helps pay Your hospitalization services.

Medicare Medical Insurance (Part B) is provided at a monthly premium cost to You and helps pay for doctor's services and many other health care services. Medicare does not provide nor was it designed to accomplish total and complete protection.

THE FOLLOWING ARE MODIFICATIONS TO THE PLAN OF BENEFITS SPECIFICALLY FOR THE MAINTENANCE AND TELECOMMUNICATIONS JOURNEYMEN AFFECTED BY THE MAY 12, 2008 CIR DECISIONS. THE FOLLOWING BENEFITS ARE IN ADDITION TO ALL OTHER PREVIOUSLY STATED PLAN B BENEFITS:

CLASSES ELIGIBLE FOR COVERAGE

As per the May 12, 2008 Council on Industrial Relations Decision (CIR), all Eligible Retired Maintenance and Teledata Journeymen who have earned 15 or more years of IBEW Local 25 Pension Fund eligibility prior to April 30, 2011.

CLASSES NOT ELIGIBLE FOR COVERAGE

As per the May 12, 2008 Council on Industrial Relations Decision, retirees, other than Retirees receiving a Disability Pension, who have been disabled prior to retirement, are not eligible for Dental coverage. Disability pensioners will receive Dental Coverage only up to age 62.

QUALIFICATIONS FOR RETIREE COVERAGE

Upon retirement, those eligible Teledata and Maintenance Journeyman wireman shall be entitled to the health care benefits available at that time.

In order to qualify for such retiree coverage, a Plan Participant who retires must have **twenty-five (25)** years of pension eligibility time in the I.B.E.W. Local 25 Pension Fund (Pension Fund). However, an active Plan Participant age 61 or older must have **twenty (20)** years of pension eligibility. Participants who receive a Social Security Total Disability Award dated October 1, 2008 or thereafter must also have **twenty (20)** years of pension eligibility to be eligible for retiree coverage.

In addition, a retired Plan "B" Participant must have five (5) or more years of Fund Coverage under Plan "A" and/or Plan "B" within the jurisdiction of I.B.E.W. Local 25 within the 10-year period immediately prior to retirement and five (5) or more years of Continuous Fund Coverage under Plan "A" and/or Plan "B" immediately prior to retirement, For the purpose hereof, Continuation of Coverage (COBRA) payments will not be considered Fund Coverage.

RETIRED PENSIONERS - MAINTENANCE OF COVERAGE

The continuation of coverage charge for those eligible Teledata and Maintenance Journeymen is determined by the Trustees based on an annual review of expenses and income. As of January 1, 2008, the charge is set at 30% of the cost as determined by the Fund actuary.

RETIREE'S RETURNING TO COVERED EMPLOYMENT

In the event that a retiree makes himself available for work under the referral procedures of I.B.E.W. Local 25, such Plan Participant, in order to maintain his Fund coverage, must pay to the Fund during the two months following each Benefit Coverage Period to make up the difference between his total clock hours worked in covered employment and **800** clock hours or a number of clock hours worked as determined by the Trustees at the rate of the Journeyman's average Fund contribution rate, as set forth in the applicable Local 25 Collective Bargaining Agreement.

WORKING RETIREES

In the event that a retiree becomes employed in reciprocal employment whereby he is eligible to continue to receive his I.B.E.W. Local 25 Retirement Benefits, such Plan Participant, in order to maintain his Fund coverage, must pay to the Fund during the two months following each Benefit Coverage Period to make up the difference between his total clock hours, which will be determined by dividing the reciprocal contributions received on the employee's behalf by the average Journeyman's contribution rate required under the applicable Local 25 Collective Bargaining Agreement, and **800** clock hours or a number of clock hours worked as determined by the Trustees at the rate of 100% of the Journeyman's average Fund contribution rate, as set forth in the applicable Local 25 Collective Bargaining Agreement.

CHIROPRACTIC EXPENSE BENEFIT

Chiropractic Visits:	
Maximum payable per Calendar Year	$ 400.00
Maximum payable per visit (1 per day)	20.00
Therapeutic Modality:	
Maximum payable per Calendar Year	500.00
Maximum payable per modality	10.00
Diagnostic Treatment or Nuclear Medicine	
Diagnostic Tests on Spinal Column	
Per Calendar Year	150.00
All of the above are Subject to a Combined Maximum per Calendar Year:	
Per Covered Person	$ 1,050.00
Per Family	$ 2,000.00

TERMINATION OF COVERAGE, SPOUSE AND DEPENDENT CHILDREN

As per the May 12, 2008 Council on Industrial Relations Decision, if a retired Plan Participant, who retired on or after May 1, 2009, and was married at least five (5) years prior to retirement, coverage will be extended until;

- The surviving spouse remarries; or
- The Dependent child ceases to be eligible.

MEDICARE

FOR ELIGIBLE RETIREES ONLY

ALL PARTICIPANTS, SPOUSES AND COVERED DEPENDENTS MUST SUPPLY THE FUND OFFICE WITH A COPY OF THEIR MEDICARE CARD WITHIN 30-DAYS OF RECEIPT OF SAME.

1. Coverage for medical procedures for retirees eligible for Medicare shall be restricted to those procedures approved by Medicare.

2. If You are 65 years or over, or if You qualify at an earlier age under one of the special provisions of the Medicare law (such as Social Security Disability pensioners), You are eligible for Social Security health benefits - Medicare. The same rules apply to Your spouse.

3. To be sure that You are eligible for Medicare benefits as soon as You reach age 65, You must register for Medicare Benefits at Your local Social Security Office within the 3 months before Your 65th birthday, whether or not You expect to continue to work after 65. No benefits will be paid for expenses incurred to the extent those expenses would have been reimbursable through Medicare Part A. If you are retired, no benefits at all will be paid for under the Fund unless You are covered under Part B of Medicare.

4. Medicare Hospital Insurance (Part A) is provided without cost to You and helps pay Your hospitalization services.

   Medicare Medical Insurance (Part B) is provided at a monthly premium cost to You and helps pay for doctor's services and many other health care services. Medicare does not provide nor was it designed to accomplish total and complete protection.

5. No benefits will be paid for expenses incurred to the extent those expenses would have been reimbursable through Medicare Part A. If You use a physician who does not participate in Medicare, reimbursement will be based on the Medicare approved amounts rule.

6. A Medicare eligible participant who wishes to terminate coverage under the Fund in order to participate in a Medicare Advantage Plan of his/her choosing, will be allowed one year from the date of termination to return to Fund coverage. However, after this one year anniversary date, a terminated participant will no longer be eligible to return to Fund coverage.

In addition, when a participant, eligible for retiree health coverage, chooses to terminate coverage in order to enroll in a Medicare Advantage Plan, the participant will be entitled to keep the death benefit as provided for in the current Plan.

RIGHT OF RECOVERY

CLAIMS WHERE THIRD PARTY IS LIABLE

This provision applies to all Participants (and retirees) and their covered Dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "You" and "Your" refer to all Participants, retirees and covered Dependents.

Occasionally, a third party may be liable for Your medical expenses. This may occur when a third party is responsible for causing Your illness or injury or is otherwise responsible for Your medical bills. The Trustees, in their sole discretion, may determine to not provide benefits under the Plan for any Participant who may have a third party responsible for the payment of medical benefits until a determination is made by the proper and final decision maker regarding the third party's responsibility to the Participant. The rules in this section govern how the Fund pays benefits, if at all, in such situations.

This provision has two purposes. First, this provision ensures that Your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. This provision permits this Fund to pay Your covered expenses until Your dispute with the third party is resolved.

Second, this provision protects this Fund from bearing the full expense in situations where a third party is liable. Under this provision, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Fund must be reimbursed for the relevant benefits it has advanced to You out of any recovery whatsoever that You receive that is directly or indirectly related to the event which caused You to incur the medical expenses.

RIGHTS OF SUBROGATION AND REIMBURSEMENT

If You incur covered expenses for which a third party may be liable, You are required to advise the Fund of that fact.

In addition to its subrogation rights, the Fund has the right to be reimbursed for payments made on Your behalf under these circumstances. The Fund must be reimbursed from any settlement, judgment or other payment that You obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment. The Fund has the right to full reimbursement even if, as a result of the Fund's reimbursement, You are not made whole. The Fund has the right to full reimbursement from any recovery You make regardless of how such recovery may be characterized, including but not limited to, for medical expenses, pain and suffering and/or lost earnings.

The Trustees may, in their sole discretion, require the execution of this Fund's subrogation forms by You (or Your authorized representative if You are a minor or if You cannot sign) before this Fund pays You any benefits related to such expenses and before this Fund provides any documents. If the Trustees have required execution of the Fund's subrogation agreement, no benefits will be provided unless You sign the form. You must also notify the Fund before You retain another attorney or an additional attorney. In no event shall the failure of the Trustees to require execution of the

subrogation agreement diminish or be considered a waiver of the Fund's rights of subrogation and reimbursement.

RIGHTS OF FUTURE SUBROGATION AND REIMBURSEMENT

In addition to satisfaction of the existing lien from any recovery by the Participant and/or Dependent, the Fund is also entitled to a credit for future related Fund expenses equal to the net monies received by the Participant and/or Dependent. As such, the Participant and/or the Dependent must spend the net recovery on related Fund expenses until the amount of said net recovery is exhausted. It is only at that point that the Participant's and/or Dependent's further related Fund benefits will again be the responsibility of the Fund.

ASSIGNMENT OF CLAIM

The Trustees, in their sole discretion, may require You to assign Your entire claim against the third party to this Fund. If this Fund recovers from the third party any amount in excess of the benefits paid to You, plus the expenses incurred in obtaining the recovery, then the excess will be paid to You.

FAILURE TO DISCLOSE

If You fail to advise this Fund that You have a claim against a third party; if You fail to assign Your claim against the third party to this Fund when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if You and/or Your attorneys fail to reimburse this Fund out of any payment You obtain from the third party; and/or if You fail to fully reimburse the Fund (out of any settlement You receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then You are personally liable to this Fund for the reimbursement owed to this Fund by the third party. This Fund may offset the amount You owe from any future benefit claims, or if necessary, take legal action against You.

NO-FAULT BENEFITS

If You have a claim which involves a motor vehicle accident covered by the "no-fault" insurance law of any state, the no-fault insurance carrier must reimburse health care expenses first. Only when You have exhausted Your health care benefits under the "no-fault" coverage will You be entitled to receive health care coverage under this Fund. If there are expenses for services which are covered by this Fund and which are not completely reimbursed by the "no-fault" carrier, this Fund will entertain claims for the difference up to the Fund maximums and subject to all the provisions hereof. No benefits will be payable under this Fund where a Participant is not covered under a no-fault policy in violation of state law.

EXCLUSION OF BENEFITS RECOVERABLE UNDER THIRD-PARTY ACTIONS

If You require medical care treatment as a result of an automobile accident, all claims for service must be submitted to Your car insurance carrier. In the event that Your car insurance carrier does not pay the total medical expense due to the automobile accident, a claim may then be submitted to the Fund Office for the amount not covered by the car insurance carrier, together with a denial or letter of exhaustion of benefits.

NONASSIGNABILITY AND SPENDTHRIFT CLAUSE

To the extent permitted by law, the benefits or payments under the Plan shall not be assignable or otherwise transferable, nor subject to any claim of any creditor of any individual covered under the Plan or to legal process by any creditor of any individual covered by the Plan except pursuant to a Qualified Medical Child Support Order.

CLAIM FILING INSTRUCTIONS

Under the Fund Rules, the issuance and submission of a claim form does not constitute acceptance of an individual's eligibility by the Fund, or a guarantee of benefit payment. The determination of eligibility and the amount of any benefits payable are subject to the terms of the Plan at the time a claim occurs. In-network claims do not require a form.

MEDICAL - DENTAL

There is a separate claim form for each type of benefit

Medical Dental

Be sure to request the proper claim form so You may receive the benefits to which You are entitled. Follow these steps:

Step 1 - Obtain the proper claim form from:

I.B.E.W. Local 25 Health & Benefit Fund
372 Vanderbilt Motor Parkway
Hauppauge, New York 11788
www.eibofli.com

Step 2 - Complete the Plan Participant's Statement on all claims. If the claim is for a Dependent, complete the Dependent information.

Important: If You fail to provide complete details in the Participant or Dependent sections of the claim forms, it will be necessary to return the form to You, which will delay settlement of Your claim.Step 3 - Have Your Physician or Dentist fill in his/her portion of the claim form.

Step 4 - Attach all related bills to Your form. It is important that they contain the right information. Related bills received late may be sent separately.

Step 5 - Review all forms for completeness. Make sure You sign the claim form.

Step 6 - Mail the completed and signed claim form, including all related bills, promptly to:

MagnaCare TPA
P.O. Box 1001
Garden City, New York 11530-2124

MAGNACARE LABORATORY CLAIM INFORMATION

The following steps are recommended to prevent potential problems:

1. In order to ensure that the proper information is transmitted to the lab, present Your MagnaCare identification card at Your doctor's office and make sure that the doctor's staff enters the member's identification number and "MagnaCare" on all forms and that a copy of the card is placed in Your file. The member is the active participant with the Fund, not the spouse or dependent

2. If Your physician orders tests, ask the person who handles the specimen to indicate on the lab requisition form that You are a MagnaCare participant, and mention that the plan will pay 100% of covered expenses, after the in-network $25 co-payment, if a MagnaCare lab is used.

3. If You go to a drawing station instead of a doctor's office, make sure that the specimen is sent to a participating lab by following steps 1 and 2 above

4. If You receive a bill for services rendered at a participating MagnaCare laboratory, this means that the lab is missing the information necessary to identify You as a MagnaCare participant. DO NOT IGNORE THE BILL. On the bill, write the identification number of the member and "I.B.E.W. Local 25 Health & Benefit Fund," and if possible, attach a copy of Your MagnaCare card. Mail the bill to:

   MagnaCare
   P.O. Box 1001
   Garden City, NY 11530
   Attn: Laboratory Unit

   Once MagnaCare receives Your bill, they will contact the lab to have Your claim submitted for processing and place Your account on hold.

NOTES ON FILING YOUR CLAIM FOR BENEFITS

Claim forms must be fully completed and submitted with related bills within one year from the date of treatment.

Benefits will be paid for the period covered by the statement on the claim form. If a disability or confinement continues beyond that point, an additional claim form must be requested and filed. Proper consideration of a claim for benefits can be given only when the completed claim form and all supporting documents are received. **The Fund will not accept claims which are more than one year old**.

COMMON CLAIM DELAY PROBLEMS AND CAUSES

Incomplete Participant and Dependent information:

1. Regarding whether You or Your spouse has other insurance coverage: name of group, name of insurance company, address, policy number, etc.

2. Regarding accidental injuries: how occurred, where, when, etc.

3. Regarding dates of birth or age to determine whether You or Your spouse are eligible for Medicare

4. Regarding date of birth of Dependent

What is needed if You or Your spouse has other health benefit coverage:

1. Information on Your Claim Form with name of other policyholder, name and address of insurance company, or other group health plan and whether group or individual coverage. This information is necessary to process any claim

2. Copies of all bills must be submitted to both plans

3. If lump-sum receipts are submitted, these must be itemized

4. Copies of payments from Your primary coverage must be submitted before a claim can be considered

MagnaCare is not guaranteeing the payment of some portion or all of the Plan's health benefits. MagnaCare is only providing claims administrative services.

DEATH BENEFIT

Notify the Fund Office of the death of a Plan Participant.

Claim forms will be sent to the designated beneficiary for completion and should be returned to the Fund Office with one certified copy of the death certificate.

IMPORTANT NOTICE TO ELIGIBLE PARTICIPANTS ON CONTINUATION OF COVERAGE (COBRA) LAW

Federal law requires most Group Health Benefit Plans to offer employees and their families the opportunity for a temporary extension of health coverage called "continuation coverage" at group rates in certain instances where the person's eligibility for coverage under the Plan would otherwise end. You may also be eligible for access to coverage through the State Exchanges (Marketplace).

This notice is intended to inform You, in summary fashion, of Your rights and obligations under the continuation coverage provision of the law.

1. Eligible Plan Participants will have the right to choose continuation coverage if he loses his health coverage because his eligibility is terminated.

2. The lawful spouse of a Plan Participant will also have the right to choose continuation coverage if the spouse loses his health coverage for any of the following reasons:

    a. The death of the Plan Participant; or

    b. The termination of the Plan Participant's eligibility under the Plan; or

    c. The termination of the spouse's eligibility under the Plan by reason of divorce or legal separation from the Plan Participant: or

    d. The Plan Participant becomes covered by Medicare.

3. In the case of a Dependent child of an eligible Plan Participant, he has the right to choose continuation coverage if the Dependent child loses his health coverage for any of the following reasons:

    a. The death of the Plan Participant; or

    b. The termination of the Plan Participant's eligibility under the Plan; or

    c. Parents divorce or legal separation; or

    d. The Plan Participant becomes covered by Medicare; or

    e. The child ceases to be a "Dependent Child" under the Plan.

Under the law, the Plan Participant is directly responsible for promptly notifying the Fund Office of a divorce, legal separation, or a child losing Dependent status under this Benefit Plan. We will in turn notify the person that he has the right to choose continuation coverage.

The law requires that You be afforded the opportunity to pay all the contribution costs to maintain continuation coverage for 36 months unless the Plan Participant lost his health coverage because of a termination of employment and/or failure to work the required hours to maintain eligibility. In that case, the required continuation coverage period is 18 months. Coverage may be maintained for up to 29 months if the Plan Participant is disabled under Title II or XVI of the Social Security Act at the time employment ended or his work hours were reduced or he became disabled at any time during his COBRA continuation coverage. In the case of a dependent child whose coverage has been terminated due to the plan age limit eligibility rules, the Trustees have authorized an additional 24 months over and above the required 36 months, to a maximum of 60 months of continuation coverage. However, the law also provides that Your continuation coverage may be cut short for any of the following reasons:

1. The contribution required for continuation coverage is not paid as due; or

2. You become an employee or are otherwise covered under another group health plan, if that plan does not include any pre-existing limitations or exclusions with respect to You; or

3. You become covered by Medicare; or

4. You were divorced from a Plan Participant and subsequently remarry and are covered under Your new spouse's group health plan.

If You have any questions about this law, contact the Fund Office.

YOUR RIGHTS UNDER ERISA

The following section contains information provided to You by the Fund Manager of Your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974. It does not constitute a part of the Plan or of any insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to Your Fund Manager.

SUMMARY PLAN DESCRIPTION

NAME OF PLAN

The Plan for which this Summary Plan Description is provided is known as the I.B.E.W. Local 25 Health & Benefit Plan.

MAINTENANCE OF PLAN

The Plan is maintained by I.B.E.W. Local 25 Heath & Benefit Fund located at 372 Vanderbilt Motor Parkway, Hauppauge, New York, 11788.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The employer identification number (PIN) assigned by the Internal Revenue Service to the plan sponsor is 11-1630810. The Plan number assigned by the Plan sponsor is 501.

TYPE OF WELFARE PLAN

The Plan is a Plan Participant and Dependents Death Benefit, Medical, Dental, Optical, Hearing, Prescription, Supplemental Unemployment Benefit and Medical Reimbursement Account Plan.

ADMINISTRATION OF PLAN

The Plan is administered by the Board of Trustees of I.B.E.W. Local 25 Health & Benefit Fund.

FUND MANAGER

Name of Fund Manager: John W. Gilday

Address: 372 Vanderbilt Motor Pkwy.
Hauppauge, New York 11788

Telephone Number: (631) 434-3344

Fax Number: (631) 434-3397

AGENT FOR SERVICE OF LEGAL PROCESS

The person designated as agent for service of legal process upon the Fund is Archer, Byington, Glennon & Levine, LLP.

The address at which process may be served on such entity is One Huntington Quadrangle, Suite 4C10, Melville, NY 11747. In addition, service of process may be made upon the Fund Manager or any Trustee.

TRUSTEES

The name, title and address of the principal place of business of each Trustee of the Fund are:

EMPLOYER	**ADDRESS**
Steven Cadieux	Roland's Electric Co., Inc. 307 Suburban Avenue Deer Park, NY 11729
Paul Dunn	Mainline Electric Corp. 295 Broadway Huntington Station. NY 11746
Clifford Seaman	Gordon L. Seaman, Inc. 29 Old Dock Road Yaphank, NY 11980
Pat Santoro	Com-Bell Systems 561 Acorn Street, Unit C Deer Park, NY 11729
UNION	**ADDRESS**
Kevin M. Harvey	Local 25, I.B.E.W. 370 Vanderbilt Motor Pkwy. Hauppauge, NY 11788
James P. Malley	Local 25. I.B.E.W. 370 Vanderbilt Motor Pkwy. Hauppauge, NY 11788
Sean Meehan	Local 25, I.B.E.W. 370 Vanderbilt Motor Pkwy. Hauppauge, NY 11788

Sean Plant — Local 25, I.B.E.W.
370 Vanderbilt Motor Pkwy.
Hauppauge, NY 11788

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to Local 25, I.B.E.W. Collective Bargaining Agreements. A copy of such agreement(s) may be obtained upon written request to the Fund Manager, who may make a reasonable charge for the copies, and is available for examination by Plan Participants and beneficiaries at the Fund Office.

ELIGIBILITY AND BENEFITS

The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits, and description or summary of the benefits are included in this booklet.

SOURCES OF PLAN CONTRIBUTIONS

Contributions to the Fund are made by contributing employers and in certain instances by Plan Participants of the Fund.

MEDIUM FOR PROVIDING BENEFITS

Benefits under the Plan are self-insured by the Fund, except for insured Death Benefits.

DATE OF END OF PLAN'S FISCAL YEAR

The date of the end of each year for purposes of maintaining the Plan's fiscal records is December 31.

CLAIM PROCEDURES

a. Presenting Claims for Benefits:

Claim forms may be obtained from:

I.B.E.W. Local 25 Health & Benefit Fund
372 Vanderbilt Motor Parkway
Hauppauge, New York 11788
(631) 434-3344
www.eibofli.com

Please see page 51 of this booklet for the requirements as to notice of claims.

b. Claims Denial Procedure:

Any denial of a claim for benefits will be provided by MagnaCare and shall consist of a written explanation which will include:

1. Specific reasons for the denial;

2. Reference to the pertinent Plan provisions upon which the denial is based;

3. A description of any additional information You might be required to provide and explanations of why it is needed; and

4. An explanation of the Plan's claim review procedure.

You, Your beneficiary (when an eligible claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the Fund. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed within 180 days after receipt of the written notice of denial of a claim. The full review will be held and a decision rendered by the Fund, no later than 60 days after receipt of the request for review. If there are any special circumstances, they will be made as soon as possible, but not later than 120 days after the receipt of the request for review. If such an extension of time is needed, You will be notified in writing prior to the beginning of the extension period. The decision after review will be in writing and will include specific reasons for the decision, as well as specific references to the pertinent Plan provisions on which the decision is based.

STATEMENT OF PRIVACY PRACTICES

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protections. HIPAA requires that the Fund maintain the privacy of your protected health information (PHI). PHI is information the Fund has or receives that can identify an individual and that relates to any medical, prescription, dental, vision and/or Employees Assistance Program benefits that you receive from the Fund, regardless of the form in which it is provided.

The Fund also is required by HIPAA to provide you with this description of the privacy policies and practices adopted by the Fund to safeguard PHI. The Fund must follow these policies and practices but, as permitted by law, the Fund reserves the right to amend or modify them. Revisions to these policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material change to the Fund's privacy policies and practices within sixty (60) days of the change.

Does HIPAA permit the Fund to disclose my PHI to my employer? Under HIPAA, the Fund generally cannot disclose your PHI to your employer without your written authorization. It is important to note, however, that HIPAA does permit the Fund to disclose your PHI without your authorization to workers' compensation carriers, or others involved in the workers' compensation system, to the extent the disclosure is required by law as described below in further detail.

The privacy policy of the Fund is broken down into the following categories:

I. The Fund's uses and disclosures of PHI;

II. Your privacy rights with respect to your PHI;

III. The Fund's duties with respect to your PHI;

IV. Your right to file a complaint with the Fund and to the Secretary of the U.S. Department of Health and Human Services; and

V. The person or office to contact for further information about the Fund's privacy practices.

I. The Fund's Uses and Disclosures of PHI

Permitted PHI Uses and Disclosures that do not require your permission to use or release.

The use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Fund's compliance with the privacy regulations. The Fund is also allowed to use and disclose your PHI without your permission under the following circumstances:

(1) For treatment, payment and health care operations.

How may the Fund use my PHI with respect to payment for my treatment, payment and health care operations? The Fund may use your PHI for the broad range of actions needed to make sure that the Fund can make payments for the services that you and your family are eligible to receive. The Fund may use your PHI for making payments to providers for services or treatment that you receive, for making arrangements for payments through one of the networks of providers through which the Fund provides benefits to you, and for coordinating payments to providers through other health Funds under the Fund's coordination of benefit rules.

a. *Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Fund may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

b. *Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorization). For example, the Fund may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

c. *Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business Funding and development, business management and general administrative activities. However, no genetic information can be used or

disclosed for underwriting purposes. For example, the Fund may use information to project future benefit costs or audit the accuracy of its claims processing functions

How may the Fund use my PHI with respect to health care operations? HIPAA allows the Fund to disclose an individual's PHI, without an authorization, to help the Fund assess the quality of the Fund's benefits as well as to monitor the Fund's administration and operations. These disclosures include, but are not limited to, disclosures to ensure that participants or their beneficiaries are eligible for benefits prior to making payments; disclosures to recover overpayments; disclosures to assess health Fund performance; disclosures to review the Fund's benefits and determine whether a reduction in costs is possible; disclosures to pursue case management and coordination of care; disclosures for actuarial studies relating to the cost of benefits and management studies relating to the operation and administration of the Fund; disclosures to resolve internal grievances; and disclosures as part of medical review, legal, and auditing functions. For example, the Fund may use PHI to determine the most cost-effective manner of providing vision benefits to its participants and beneficiaries. The Fund and its business associates (and any health insurers providing benefits to Fund participants) may also disclose the following to the Fund's Board of Trustees: (1) PHI for purposes related to Fund administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Fund; and (3) enrollment information (whether an individual is eligible for benefits under the Fund). The Trustees have amended the Fund to protect your PHI as required by federal law.

(2) Enrollment information provided to the Trustees.

(3) Summary health information provided to the Trustees for the purposes of treatment, payment, and health care operations.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform a minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(7) To a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Fund may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Fund is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Fund's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

PHI Use and Disclosures that require you the opportunity to object prior to its use or release.

There are instances where uses and disclosures of your PHI require that you be given an opportunity to agree or disagree prior to the use or release. Unless you object, the Fund may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Fund will disclose PHI (as the Fund determines) in your best interest. After the emergency, the Fund will give you the opportunity to object to future disclosures to family and friends.

Because I am always working, my spouse often calls to find out the status of my health claims and to get other information about me or my benefits. Can the Fund release information relating to payment of my claims to my spouse? The Fund will **not** provide claims payment or other PHI about you to your spouse **unless** you file a written authorization form with the Fund office, as described later in this Notice.

May I call the Fund to get information about my children's health claims? The Fund will provide a minor child's parent, guardian (or person standing *in loco parentis* with respect to the child) with payment information about the child's claims.

The Fund will carefully consider your written request for information other than claims payment information, and will respond as permitted by its privacy policies and applicable state law.

If your child is **not** a minor, the Fund cannot provide you with the child's PHI, even if the child is still covered under the Fund as your dependent, unless the child files an authorization form with the Fund office, as described later in this Notice.

PHI Use and Disclosures that you must give us authorization to use or release.

Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Fund will not use or disclose your psychiatric notes; the Fund will not use or disclose your PHI for marketing; and the Fund will not sell your PHI, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Fund receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

II. Rights of Individuals

Do I have rights under the federal privacy standards? Yes. Your rights to information under HIPAA include:

- *The right to request restrictions on the use and disclosure of your PHI.* You may request the Fund to restrict the uses and disclosures of your PHI. However, the Fund is not required to agree to your request (except that the Fund must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket). You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Fund's Privacy Official.

- *The right to receive confidential communications concerning your medical condition or treatment if you believe that disclosure of this information could endanger you.* For example, you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential. You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Fund's Privacy Official. The Fund will attempt to honor reasonable requests for confidential communications.

- *The right to inspect and copy your PHI.* The Fund may charge a reasonable fee for copying, assembling and mailing your requested PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual. *"Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Fund; or other information used in whole or in part by or for the Fund to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Fund's Privacy Official. If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Fund's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services. The Fund may charge a reasonable, cost-based fee for copying records at your request.

- *The right to receive an electronic copy of your electronic medical records.* The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format.

- *The right to receive notice of a breach of your unsecured PHI.*

- *The right to amend or submit corrections to your PHI.* If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, for example, you do not include the reason that you wish to correct your records or if the records were not created by the Fund. You have the right to request the Fund to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set. The Fund has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If the request is denied in whole or part, the Fund must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Such requests should be made to the Fund's Privacy Official. You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

- *The right to receive an accounting of how and to whom you're PHI has been disclosed, if it was disclosed for reasons other than payment or health care operations.* At your request,

the Fund will also provide you an accounting of disclosures by the Fund of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Fund's privacy practices. In addition, the Fund need not account for certain incidental disclosures. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

- *The right to file a complaint that your privacy rights have been violated, with the Fund and with the Secretary of U.S. Department of Health & Human Services*. You will **not** be penalized or otherwise retaliated against for filing a complaint.

- *The right to receive a printed copy of this Notice.*

To exercise these rights, you may file requests with the Fund office, to the attention of the Fund's Privacy Officer, whose name, address, and telephone number appear below. The Fund office will let you know if the Fund accepts or rejects your request (and why) in writing within the time set by law.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Fund retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

III. The Fund's Duties

The Fund is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Fund's legal duties and privacy practices. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Fund still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other

permissible manner. If the revised version of this Notice is posted on the Fund's website you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Fund's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Fund's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Fund or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Fund will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Fund's compliance with legal regulations.

De-Identified Information
This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information
The Fund may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Fund. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach
The Fund is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Fund will notify affected individuals of the breach.

IV. Your Right to File a Complaint With the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Fund. Such complaints should be made to the Fund's Privacy Official. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Fund will not retaliate against you for filing a complaint.

V. Whom to Contact at the Fund for More Information

The Fund has designated Andrew Bub as the Privacy Officer. If you wish to file an authorization, request information to which you have a right, or file a complaint with the Fund, or if you have any questions regarding this Notice, you should address them to:

Mr. Andrew Bub
HIPAA Privacy Officer
372 Vanderbilt Motor Parkway
Hauppauge, NY 11788

CONCLUSION

PHI use and disclosure by the Fund is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code Federal Regulations Parts 160 and 164. The Fund intends to comply with these regulations. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

Please remember that the Fund can assess reasonable charges for copying, assembling and mailing to you any documents that you request.

STATEMENT OF ERISA RIGHTS

This Statement of ERISA rights is required by federal law and regulation.

As a Participant in the Fund, 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:

1. 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.

2. 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 Fund's annual financial report. The Fund Administrator is required by law to furnish each Participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

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's rules covering Your COBRA continuation coverage rights.

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 the other group health plan or health insurance issuer when You lose coverage under that 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 this Plan's coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in Federal court. In such a case, the court may require the Fund 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 which 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 Fund'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 Fund fiduciaries misuse the Fund's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs

and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Fund Administrator, You should contact the nearest office of the Employee Benefits Security, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 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, U.S. Department of Labor.

FUTURE OF THE PLAN AND PLAN TERMINATION

This Summary Plan Description includes information concerning the circumstances which may result in disqualification, ineligibility, or denial of benefits that a Fund Participant or beneficiary might otherwise reasonably expect the Fund to provide. This Plan Description booklet details the eligibility rules, benefits, limitations and exclusions for coverages.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend or modify the plan is reserved by the Board of Trustees, in accordance with the Declaration of Trust. In addition, the continuance of the Plan is subject to the maintenance of collective bargaining agreements which provide for Employer contributions to the Fund.

If it ever becomes necessary to terminate the Plan, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of Fund Participants and to defray the cost of reasonable administration and termination expenses. In no event will any of the assets revert to any Employer or to the Union. In the event of termination of the Fund, the Trust Assets are to be used exclusively to continue the payment of benefits provided to eligible Plan Participants, their Dependents, beneficiaries, or their estates, to defray reasonable administration and termination expenses and to otherwise effectuate the purpose of the Trust Fund. Upon the necessity for termination, the Trustees shall establish a plan to be applied to the balance of assets in the Fund so that the assets will be applied solely for these purposes.

Upon final liquidation of the Plan, Plan Participants and beneficiaries would have no further rights or interest in the Plan.

MODIFICATION OF BENEFITS AND RULES FOR RETIRED PARTICIPANTS

This Summary Plan Description includes information concerning the benefits provided by the Trustees to retired Plan Participants and their Dependents and the circumstances which may result in disqualification, ineligibility, or denial of benefits that a retired Plan Participant or Dependent might otherwise reasonably expect the Plan to provide.

The benefits and eligibility rules applicable to retired Plan Participants and their Dependents have been established by the Trustees as part of an overall benefit program. The right to amend, terminate or modify the eligibility rules and plan of benefits for retired Plan Participants and their Dependents is reserved by the Board of Trustees, in accordance with the Declaration of Trust. The continuance of benefits for retired Plan Participants and their Dependents and the eligibility rules relating to a qualification therefor are subject to termination, modification and revision by the Board of Trustees in accordance with their responsibilities and authority contained in the Trust Agreement.

In accordance with the rules and regulations and the Trust Agreement, no person has a vested interest in the benefits provided for retired Plan Participants and their Dependents. In the event of termination of the Plan, as stated above, the Trustees reserve the right to terminate the program of benefits for retired Plan Participants, and there shall not be any vested right by any retired Plan Participant or Dependent or beneficiary, nor contractual rights after the disposition of all Plan assets and the termination of the Plan. Retired Plan Participants and their Dependents shall not have any priority with respect to the disposition of assets in connection with the termination of this Plan.

COMMUNICATIONS

If You have any questions about any aspect of Your participation in the Plan, You should, for Your own permanent record, write to the Fund Office. You will then receive a written reply, which will provide You with a permanent reference.

PLAN INTERPRETATIONS AND DETERMINATION

This booklet describes the main features of our Plan.

The Board of Trustees is responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out their responsibility, the Board of Trustees, or their designee, shall have exclusive authority and discretion to: determine whether an individual is eligible for any benefits under the Plan; determine the amount of benefits, if any, an individual is entitled to from the Plan; interpret all of the provisions of the Plan; and interpret all of the terms used in the Plan.

All such determinations and interpretations made by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits under the Plan; be given deference in all courts of law, to the greatest extent allowed by applicable law; and not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith.

CAUTION

This booklet and written material from the Trustees and the Fund Office personnel are Your only authorized sources for Plan information.

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