I.B.E.W. LOCAL 139 WELFARE PLAN

SUMMARY PLAN DESCRIPTION

July 1, 2016

Active Employees and Retirees Under Age 65

PLAN CHANGE OR TERMINATION

The Trustees reserve the right to change or discontinue (1) the Plan, (2) the types and amounts of benefits under the Plan, and (3) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Benefits provided by the Plan:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested upon retirement;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such modification or termination right is not contingent on financial necessity.

The nature and amount of plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

I.B.E.W. LOCAL 139 WELFARE PLAN

BOARD OF TRUSTEES

Union	Employer
Ernest A. Hartman	Lindsay T. Mills
Josh Fitzwater	Michael J. Sincock
Steven Spaziani	Bruce Condie

PLAN ADMINISTRATOR

The Board of Trustees is the "Plan Administrator". The Plan is administered for the Trustees by the

Welfare Fund Office
415 West Second Street
Elmira, New York 14901
(607) 732-5611

PLAN MANAGER

Ernest A. Hartman

FUND MANAGER

Kristine VanFleet

PLAN OFFICE

415 West Second Street
Elmira, New York 14901
(607) 732-5611

MEDICAL BENEFIT ADMINISTRATOR

Excellus BlueCross BlueShield
150 N. Main Street
Elmira, New York 14901
(607) 734-1551

PRESCRIPTION BENEFTIS ADMINISTRATOR

Express Scripts, Inc.
One Express Way
St. Louis, Missouri 63121
(800) 818-6602

Mail Order Refill No.: 1-800-282-2881
Mail Order Address:
Express Scripts, Inc.
P.O. Box 52150
Phoenix, AZ 85072-9954

AGENT FOR THE SERVICE OF LEGAL PROCESS

Kristine VanFleet, Fund Manager, is the Agent for the Fund on whom service of process against the Fund may be made. Service of process may be made at:
415 West Second Street, Elmira, New York, 14901.

Service may also be made on any Individual Trustee.

COLLECTIVE BARGAINING AGREEMENT

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Fund Office (a charge for copying will be made) and is available for review at the Fund Office.

LEGAL COUNSEL

Blitman & King LLP
Franklin Center, Suite 300
443 North Franklin Street
Syracuse, New York 13204-1415
(315) 422-7111

ACTUARIAL CONSULTANT

Bolton Partners Northeast, Inc.
9000 Midlantic Drive, Suite 100
Mt. Laurel, New Jersey 08054
(609) 588-9166

ACCOUNTANT

Mengel, Metzger, Barr & Co., LLP
333 East Water Street, Suite 200
Elmira, New York 14901
(607) 734-4183

MODIFICATION OF BENEFITS AND ELIGIBILITY RULES FOR EMPLOYEES, DEPENDENTS AND RETIREES UNDER AGE 65

This summary plan description includes information concerning the benefits provided by the Trustees to employees, dependents and retirees under age 65 and the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits that an employee or dependent might otherwise reasonably expect a plan to provide.

The benefits and eligibility rules applicable to employees and dependents have been established by the Trustees as part of an overall benefit plan for participants. The right to amend or modify the eligibility rules and plan of benefits for employees and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for employee and dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their responsibilities and authority contained in the Agreement and Declaration of Trust.

In accordance with the rules and regulations of the Plan and the Trust Agreement, no employee or dependent has a vested right of contractual interest in the benefits provided. In addition to the right to terminate benefits of employees and/or dependents at any time, in the event of termination of the Plan, the Trustees also reserve the right to terminate the plan of benefits for employees and/or dependents and there shall not be any vested right by any employee or dependent or beneficiary nor contractual rights after the disposition of all Plan assets and the termination of the Plan. Employees and dependents shall have no priority with respect to the disposition of Plan assets in connection with the termination of this Plan. The provision for employees and dependents' coverage shall be reviewed periodically by the Trustees.

I.B.E.W. LOCAL 139 WELFARE PLAN
415 WEST SECOND STREET
ELMIRA, N.Y. 14901
(607) 732-5611

TO: PARTICIPANTS IN THE I.B.E.W. LOCAL 139 WELFARE PLAN

FROM: TRUSTEES OF THE I.B.E.W. LOCAL 139 WELFARE PLAN

DATE: July 1, 2016

This booklet is a description of the Welfare Plan as it is in effect on July 1, 2016. You will find that the benefits are described, as well as the eligibility requirements that you must satisfy with respect to each of them. These and other matters are discussed in the major parts of the booklet as follows.

- Description of Plan and Benefits (Part A)
- Self-Pay Coverages (Part B)
- Claim and Appeal Procedure (Part C)
- Coordination of Benefits (Part D)
- Miscellaneous Provisions (Part E)
- Technical Information (Part F)

It is in your interest and that of your family to familiarize yourself completely with this booklet. If, after having gone through the booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Plan Office. If your questions are not answered to your satisfaction by the staff, you may direct them to the Fund Manager, or to the Trustees, in writing.

Sincerely,

Board of Trustees

IMPORTANT ASPECTS OF YOUR WELFARE PLAN

FAMILIARIZE YOURSELF WITH THE WHOLE BOOKLET.

ALL BENEFITS MUST BE APPLIED FOR.

MAKE SURE THAT THE PLAN OFFICE IS AWARE OF ALL YOUR DEPENDENTS AND YOUR CURRENT ADDRESS.

MAKE SURE YOUR LIFE INSURANCE BENEFICIARY DESIGNATION IS UP TO DATE.

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant

CAUTION

This booklet and the Plan Manager at the Plan Office are authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them with regard to the Plan. No employer, union representative, supervisor, or shop steward is in a position to discuss your rights under this Plan with authority.

COMMUNICATIONS

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Fund Manager or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

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PART A.
DESCRIPTION OF PLAN AND BENEFITS

INTRODUCTION

The I.B.E.W. Local 139 Welfare Plan ("Plan") has been an "individual account" type plan since 1991. The Medical Benefits under the Plan are self-funded and administered by a third-party administrator, Excellus BlueCross BlueShield. The Prescription Drug Benefits under the Plan are self-funded and are administered by a third-party administrator, Express Scripts, Inc. The Personal Account Plan (including the Health Expense Benefit) and the Disability Income Benefit are administered by the Fund Office. The Life Insurance Benefit is partially self-funded and partially insured through Union Labor Life Insurance Company ("ULLICO"). The Employee Assistance Program ("EAP") is self-funded and administered by Union Assistance Program.

The balance of this booklet describes the provisions of the Plan. Notice that the eligibility requirements that you must satisfy in order to participate in, and be entitled to, a benefit may be different for each of the benefits.

GRANDFATHERED STATUS

This group health plan is a "grandfathered health plan" under the Patient Protections and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative 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 415 West Second Street, Elmira, New York 14901, (607) 732-5611. 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.

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your Protected Health Information ("PHI") effective April 14, 2004. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the I.B.E.W. Local 139 Welfare Fund), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

(a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a participant's claim);

(b) coordination of benefits;

(c) adjudication of health benefit claims (including appeals and other payment disputes);

(d) subrogation of health benefit claims;

(e) Establishing contributions to the Plan, including, but not limited to, COBRA contributions;

(f) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) billing, collection activities and related health care data processing;

(h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m) reimbursement to the plan.

"Health Care Operations" include, but are not limited to, the following activities:

(a) quality assessment;

(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

(d) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance);

(e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(g) business management and general administrative activities of the Plan, including, but not limited to:

i. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

ii. customer service, including the provision of data analyses for policy holders, Plan sponsors, or other customers;

iii. resolution of internal grievances; and

iv. due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the I.B.E.W. Local 139 Welfare Fund who assist in the Plan's administration and the Board of Trustees of the I.B.E.W. Local 139 Welfare Fund will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by you; (d) not use or disclosure the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact Kristine VanFleet, the Fund's Privacy Official, at (607) 732-5611 if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

Effective April 20, 2006, the Plan Sponsor will:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to Plan any security incident of which it becomes aware concerning electronic protected health information.

Kristine VanFleet shall serve as the HIPAA Security Official.

PERSONAL ACCOUNTS

Effective for your work after 1990, employer welfare plan contributions will be made to the personal account plan. A portion of such contributions will be credited to a personal account for you. The portion of the contributions on your work that will be credited to your personal account will be determined by the Trustees of the Plan, from time to time, and will be based upon the financial requirements of the whole Plan.

Once you have a personal account, you will be a participant in the Plan. If you are credited with a "Medical Benefit Allocation", you will also be a participant in this Plan.

Your account will grow with all the contributions that are made to it in the future. Your account will be decreased by any benefit distribution made from it. No more will be paid out to a plan

participant (or his beneficiary) under this Plan than has come into his personal account by way of contributions made on his work, except, perhaps, under the provisions of one of the Medical Benefit or other coverages.

Administration charges may be levied against each participant's account, on an equitable basis, if, for instance, the investment yield on the plan reserves is not sufficient to offset the costs of administration of the Plan.

Upon your death, your spouse and/or eligible dependents will be entitled to keep your personal account under the Plan and may use the balance in your account to pay for benefits provided by the Plan on behalf of your spouse and any of your eligible dependents. Upon the death of your spouse/eligible dependents, the balance remaining in your account will be forfeited.

Once your account is reduced to zero, you will stop being a participant in this Plan.

Notwithstanding anything herein to the contrary, effective September 1, 2016, if: (1) for 36 consecutive months, you are not working, or actively seeking, covered employment for reasons other than disability, or retirement under the I.B.E.W. Local 139 Pension Fund; and (2) there have been no contributions to or distributions from your Personal Account for the 36 consecutive months period, your Personal Account balance will be permanently forfeited and you will cease to be a participant in this Plan. Your availability for covered employment is determined by the Trustees.

In the following sections, you will see what is required to become eligible for the benefits that exist in the Plan for you once you are a participant. There is also a description of each of the benefits.

GENERAL ELIGIBILITY REQUIREMENTS

Before you are eligible for any of the benefits under this Plan, you must satisfy the general eligibility requirements in your current period of plan participation. In order to do this, you must work at least 300 hours in employment calling for contributions to the Plan during a period of no more than twelve consecutive calendar months (beginning with the first month of employment), with some covered employment in each of at least three months. The 300 hours will be waived for apprentices.

Once you are a participant, you will continue as a participant until your account is reduced to zero; at that time your participation stops. If you are self-paying to the Plan for your Medical Benefit coverage, you are still a participant so long as you have contributions credited to your account.

If you have once satisfied the general eligibility requirements for this Plan and your participation stops, in order to satisfy them in a future period of plan participation, you must once again satisfy the general eligibility requirements to be entitled to any benefits.

If contributions are made to the Plan for you before you satisfy the general eligibility requirements and such contributions cannot be used to satisfy the general eligibility requirements (because they were made for employment more than twelve months before you became eligible), such contributions will be forfeited and used for plan administrative costs.

If your employer fails to remit contributions to the Fund on behalf of hours worked by you, no contributions with be credited to your HRA. If and when the contributions are actually received by the Fund, the contributions will be credited to your individual HRA at that time. If the employer enters into an arrangement with the Board of Trustees for payment of the delinquent contributions (under certain terms and conditions set forth by the Board of Trustees), your HRA will be credited with the contributions due as a result of hours worked by you, regardless of whether the contributions are actually received by the Fund at the time the payment arrangement is entered into between the Fund and employer. Any negative balances will be collected in accordance with the provision stated in Part F of this booklet.

In addition to having satisfied the general eligibility requirements, you will have to satisfy special eligibility requirements depending upon which of the benefits you want to use.

Effective June 30, 2012 the Trustees terminated the "I.B.E.W. Local 139 Welfare Plan for Participants working under Small Works Addendum (Plan B)." The former participants of Plan B had personal accounts opened in their names under Plan A. Their opening account balances were equal to the account balances they had in Plan B when Plan B was terminated. These personal accounts may be used to cover medical, dental, prescription drug, hearing and optical expenses which have been determined to be deductible by the Internal Revenue Service, including co-payments, deductibles and other health insurance premiums paid on an after-tax basis. The former participants of Plan B are not eligible for any other benefit, including the Medical Benefit, offered under Plan A.

The personal accounts of former Plan "B" participants are not subject to the minimum account balance referenced in the Limitation of Benefits Section because those participants are not eligible for the Medical Benefit. Finally, contributions will not be made to the accounts and eligibility for benefits will cease once the individual's account has reached zero.

DEPENDENTS

For the purposes of the Medical Benefit, your dependents include your lawful spouse and your children who are under age twenty-six (26). Provided they have enrolled with the Plan, your children include your naturally born or legally adopted children as well as your step-children and foster children. The Plan will not cover your children's spouse or your grandchildren. Coverage for a dependent child shall terminate at the end of the month in which he or she attains age twenty-six (26).

If your child (as described above) is covered under this Plan and becomes incapable of self-sustaining employment due to a total and permanent physical or mental disability before

reaching the age limits specified above, that child will also be carried as an eligible dependent so long as that child's condition remains the same and you continue to be covered.

In any event, the Fund will make payments pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO").

Coverage for you and/or your dependents may be terminated retroactively (rescinded) if you and/or your dependents:

a. Perform an act, practice or omission that constitutes fraud;

b. Make a misrepresentation of material fact; and/or

c. Fail to remit premiums (including COBRA premiums).

The Plan will provide at least 30 days' advance written notice before coverage may be rescinded, except for rescissions due to the failure to pay premiums. Failure to provide complete, updated, and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or the existence of the spouse's other coverage constitutes intentional misrepresentation of material fact to the Plan. For purposes of the claims and appeal procedures, a rescission is deemed an adverse benefit determination of the claims. The Fund Office may refund contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Fund Office reserves the right to collect additional monies if claims are paid in excess of the contributions.

BENEFITS

There are different benefits available to you under this Plan if you are eligible. You may, during your plan participation, draw on one or more of these benefits. For example, even though you may be covered by the Medical Benefit (that is, by having insurance premiums being paid from your account each month), you are still eligible (provided you satisfy the requirements) to draw on the Health Expense Benefit for health care bills not otherwise covered. The following sections describe each of the benefits.

HEALTH EXPENSE ACCOUNTS

If you incur health care expenses as described in Section 213(d) of the Internal Revenue Code (other than insurance premiums for the Fund's Health Benefit) for yourself, your spouse, or your dependent child, and such expenses are not covered under the Fund's Medical Benefit or any other insurance program, you may apply for a distribution of a portion of your account to pay for the uncovered bills. Such expenses include, but are not limited to, payments for deductibles, copayments and co-insurance, charges by any doctor, dentist, optometrist, ophthalmologist, hospital, long-term care facility or other health facility, pharmacy, optical dispensing service, or hearing aid provider that are not covered by any health care plan under which you are covered. They may also include expenses for (1) insulin, (2) over-the-counter

medicines and drugs, but only if they are purchased with a prescription, and (3) over-the-counter medical devices and supplies.

However, if you are eligible for the insurance benefit, you are not allowed to reduce the balance in your account below the amount necessary to cover three months of family premiums by using the benefit.

In addition to those benefits, after you retire, the Board of Trustees or the Fund Manager acting on their behalf may also authorize reimbursement of your payment for medical expense you purchased for yourself, your spouse, and your other dependents. If you are an active member and you have opted out of the Medical Benefit Plan, you may use this benefit to pay post-tax medical insurance premiums. You may also use this benefit to pay for COBRA payments. You may be reimbursed only for uninsured health-related expenses that you incur on or after the date you are enrolled in the HRA. All HRA transactions are subject to substantiation. Save your receipts and documentation relating to any medical expenses paid with your HRA Account (paper claim or debit card) as you may be required to submit this information to the Plan. Debit card receipts must be accompanied by a copy of the supporting documentation from the pharmacy which includes, but is not limited to, the following information: person to whom medication was prescribed, name of medication and dosage, name of pharmacy, and date prescription was filled.

You may not use the HRA Account to pre-pay for medical, dental, vision or other health related services. You may not receive a reimbursement for any medical expense for which you have taken a deduction on your income tax return.

You must maintain an account balance equal to at least three months of Medical Benefit family premiums ("minimum account balance") in order to be eligible for reimbursement or Health Expense Benefit. Further, any claim is invalid to the extent it would reduce your account below the minimum account balance. This provision is in the Plan to provide a reserve for you for the chief benefit of a welfare plan, namely, health insurance. Notwithstanding this general rule, you may reduce your account below the minimum account balance to pay premiums for your Medical Benefit.

Under no circumstances may any money be drawn from your account once the level of your account has reached zero. However, for the purpose of the Medical benefit you will be allowed to run a deficit of up to three months' worth of family premium if you are working in covered employment or listed as a group I applicant under the Union collective bargaining agreement.

The health expense benefit may not be used to purchase individual market coverage, even for periods during which you are no longer covered by this group health plan. Other limitations, if any, will be listed where the Individual Benefit is described in this Summary Plan Description.

Individuals enrolled in TRICARE will maintain access to their Health Expense Account through the Fund's TRICARE Health Care Expense Account. Reimbursements under the TRICARE Health

Expense Account are limited to cost sharing and excepted benefits, including unreimbursed Dental and Vision expenses and TRICARE supplemental premiums. Any reimbursement request is subject to the coverage terms of this Plan, Participant's account balance and the law as it exists at the time of the request.

MEDICAL BENEFITS

Coverages From Your Account

As long as you remain eligible for employment that calls for contributions to this Plan, each month the charges for certain medical benefit coverages will be subtracted from your account so long as your account balance is big enough to cover the total monthly charges. If your account runs out, you will be permitted to run a deficit of three months' premiums if you are working in or actively seeking work in covered employment as described above. After that you may self-pay your health care coverage charges under certain conditions. The medical benefit is available to you, as an eligible participant, your lawful spouse, and your eligible dependent children.

If your spouse and children are already covered under your spouse's employer's health care plan, you may elect that you be covered for "single" health care coverage only. If you, yourself, are also covered under your spouse's employer's health care plan, or some other employer health care plan or TRICARE, you may elect that you also not be covered under the health care coverage of the Medical Benefit or "Opt-out" of coverage.

If you become unavailable for employment covered by this Plan, for a reason other than your total disability or becoming a pensioner under the I.B.E.W. Local 139 Pension Plan (for example by moving your residence out of the local area), your entitlement to the Medical Benefit will stop at the end of the month in which you become unavailable, and you will not be eligible again for the Medical Benefit until you satisfy, again, the general eligibility requirements.

To elect "single health care" or to "opt out" of the medical coverage offered through the Fund, because you are enrolled in group health coverage through your spouse's employer, you must indicate your coverage selection on your enrollment forms distributed by the Fund Office, including the portions confirming your other coverage. If you elect to "opt out" of the Fund's medical coverage, you will continue to accumulate contributions in your personal Health Reimbursement Account (HRA) for so long as you remain "opted out" provided you have completed and returned the enrollment forms distributed by the Fund Office. Further, if you are automatically reenrolled in the Fund, the Fund will not process claims for you or your dependents until the Fund receives the necessary enrollment forms. Until all the completed forms are received by the Fund Office, the Fund's Trustees reserve the right to suspend claim payment.

The Trustees will only permit you to decline or "opt out" of coverage if you confirm for the Fund that you are enrolled with other group coverage that provides "minimum value." An

employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. To validate that you have coverage that meets the minimum value standard, you must submit annually a copy of your spouse's Group Health Plan's Summary of Benefits ("SBC") and photocopy of your Group Health Plan's Identification Card. If such other health care coverage stops (except for COBRA which is discussed later), the Plan's Medical Benefit must be started, from your account, effective with the first day of the month after 90 days from the date the other coverage stops (except for COBRA). In any event, benefit payments will be made pursuant to the terms of a QMCSO.

The decision to "opt out" of medical coverage from the Fund will not impact your eligibility for retiree health benefits, so long as you continue to accumulate contributions in your personal Health Reimbursement Account (HRA) until the date of your retirement. However, you will not be considered an "Active Participant" and you will not be eligible for retiree health benefits from the Fund if, at the time you become a pensioner with the Pension Fund, you decide to irrevocably waive all future reimbursements from your personal Health Reimbursement Account (HRA) as described in the following paragraphs.

NOTICE: You have the option to permanently "opt-out" of all medical coverage offered through the Fund and to waive all future reimbursements from your personal Health Reimbursement Account (HRA) at least annually or at the termination of your employment. Once such an election is made, it must be irrevocable for the applicable time period. Although "opting out" of and cancelling all Fund coverage is not recommended, because you will be choosing to permanently forego all medical coverage for the applicable period and personal Health Reimbursement Account (HRA) despite the contributions made to the Fund for your work in covered employment. The Fund provides this option to you in accordance with applicable law. To completely decline Fund benefits, contact the Fund Office for the pertinent documents.

By electing the Permanent "Opt-out" of medical coverage, you are agreeing to waive all future reimbursements from your Health Reimbursement Account (HRA). To completely decline Fund benefits, contact the Fund Office for the pertinent documents. You should carefully consider the consequences of declining all medical and Health Reimbursement Account (HRA) benefits, and you should discuss any such decision with your tax advisor.

<u>Special Enrollment Rights</u>

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, this group health plan will permit an employee who is eligible, but not enrolled, under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions are met:

Termination of Medicaid or CHIP Coverage – The employee or dependent is covered under a Medicaid plan or under a State child health insurance plan (CHIP) and the coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under this plan not later than 60 days after the Medicaid or CHIP coverage ends.

Eligibility for Employment Assistance under Medicaid or CHIP – The employee or dependent becomes eligible for premium assistance through Medicaid or CHIP and the employee requests coverage under this plan not later than 60 days after the employee or dependent is determined to be eligible for such assistance.

Qualified Military Service

If you leave employment for full-time Qualified Military Service, as defined by Federal law, you and your eligible dependents are permitted to elect to continue your medical benefit under the Plan's self-payment provisions, subject to certain limitations under Federal law. This coverage, subject to the rules of the Plan, may last for up to twenty-four (24) months beginning on the date of your entry into Qualified Military Service. However, the coverage will terminate before the end of the twenty-four-month period if you are discharged earlier and you fail to make a timely application for reemployment upon discharge. You will not forfeit any period of coverage for which you had previously qualified under the General Eligibility Requirement.

If you elect such continuation coverage, you will not be required to pay any premium for the first month of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan, which will be based on the self-payment premium amount.

Family and Medical Leave Coverage

Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

- To care for your newly born or adopted child;
- To care for your spouse, child, or parent who has a serious health problem; or
- If you have a serious health problem which prevents you from performing your job.

In order for you to be eligible for such a leave, your employer must have been obligated to make contributions to the Fund on your behalf for at least 1,250 hours in the preceding twelve (12) month period. You must also have worked for that employer for at least twelve (12) months immediately preceding the date your leave will commence.

However, not all employers are covered by the Family and Medical Leave Act. To be subject to the Act, an employer must have at least fifty (50) employees for each working day for each of twenty (20) work weeks in the current or preceding calendar year.

Additionally, you must:

- Work at a location where the employer has at least 50 employees; or

- Work within 75 miles of one or more work sites where the employer has 50 or more employees.

Your employer must notify the Fund that you are on leave for one of the purposes described in the act, must continue to include you on its monthly remittance report to the Fund, and must continue to make contributions on your behalf. The number of hours to be reported and for which contributions are to be made shall be those hours that would have been reported but for your exercising your right under the Act for a leave of absence.

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your employment had not stopped, unless your Employer fails to make the required contributions for you.

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any of the following events:

- Your employer fails for any reason to make the required contributions to the Fund on your behalf while you are on leave; or

- You exhaust the twelve (12) weeks of leave which you are entitled to under federal law; or

- You or your employer notifies the Fund that you do not intend to return to the employer's employment. (NOTE: If you do not return to work for your employer at the end of your leave, you may be responsible for repaying the employer contributions made for you during the leave.)

In the event your employer ceases to make contributions on your behalf, you may be provided an opportunity to elect continuation coverage in accordance with the provisions of the section of the Summary Plan Description entitled Continued Coverage By Self-Payment (COBRA).

LIFE INSURANCE BENEFIT

$60,000 Benefit

If you die from any cause while you are covered under this Plan as (1) as an active participant or (2) a retired participant up to age 65 who retired on or after February 1, 2003, $60,000 in life insurance will be paid to your beneficiary. The terms of the ULLICO policy are set forth in the Certificate issued by the Insurance Carrier. That Certificate is incorporated herein by reference.

For those covered by the $60,000 benefit, $10,000 of such benefit is provided through a policy with ULLICO, the terms of which are set forth in the Certificate issued by the insurance carrier. That Certificate is incorporated herein by reference. The remaining $50,000 of the Life Insurance Benefit is provided directly by the Fund as a self-insured benefit.

The Life Insurance Benefit, including the premiums paid to the insurance company, is provided out of the Fund's unallocated pooled assets.

$7,500 Benefit

If you die from any cause while you are covered under this Plan as a retired participant up to age 65 who retired before February 1, 2003, $7,500 in life insurance will be paid to your beneficiary.

For those covered by the $7,500 benefit, $2,000 of such benefit is provided through a policy with ULLICO, the terms of which are set forth in the Certificate issued by the insurance carrier. That Certificate is incorporated herein by reference. The remaining $5,500 of the Life Insurance Benefit is provided directly by the Fund as a self-insured benefit.

The Life Insurance Benefit, including the premiums paid to the insurance company, is provided out of the Fund's unallocated pooled assets.

Beneficiary

You may name anyone you wish as your beneficiary for life insurance. You may change your beneficiary at any time by filling out the proper form. Beneficiary forms are available at the Plan Office. Conversion Privilege

If your Life Insurance Benefit terminates while the ULLICO policy is in effect, you are entitled to buy an individual policy directly from ULLICO.

You may convert to an individual life policy within 31 days after termination. Medical examination is not required. The amount of your converted policy will not exceed the amount provided under the group plan. You may choose any type of individual policy then being written by ULLICO except term insurance. However, at your option, you may choose a policy of

life insurance in any one of such forms, preceded by single premium term insurance for a period of not more than one year. The premium cost to you will be based on your age and class of risk at the time you convert.

If you die within the 31-day period, ULLICO will pay your beneficiary as though you were still covered under the welfare plan.

DISABILITY INCOME BENEFIT

Under this benefit you will receive a daily allowance (paid weekly) of $100 (weekly maximum $500) for each regular work day during which you are disabled by an illness, pregnancy, or injury that prevents you from working, provided you are not receiving a similar benefit directly from your employer. Also, you must be under the care of a doctor to receive this benefit. You must submit to the Fund proof of disability from your doctor concerning the extent of the disability and the estimated time you are expected to be out of work.

Benefits will be paid to you from the first day of your disability if it is due to an accidental bodily injury or from the eighth day of your disability if it is due to an illness or pregnancy.

The maximum number of weeks payable under this benefit for any one period of disability is twenty-six.

Successive periods of disability due to the same or related causes not separated by return to full-time active employment for two weeks will be considered one period of disability.

The Disability Income Benefit is provided out of the Fund's unallocated pooled assets.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

For You and Your Covered Dependents

The Fund's Employee Assistance Program (EAP) helps members solve their problems so they can balance work and family life. The EAP provides a confidential referral service for you and your immediate family. The program is available to all participants and their dependent family members. It has been developed to aid you or your dependent family members find solutions to family problems so that those problems do not seriously threaten your health, home life, and job performance. The cost of the EAP is paid from the unallocated pooled assets of the Fund and not from your personal account.

How the Program Works

You may call 24 hours a day, 7 days a week. After a participant calls Union Assistance Program at (800) 252-4555, an interview with a trained employee counselor is arranged. At the interview with the counselor, the nature of the problem is discussed and an approach to its solution is outlined. Short-term counseling is available at convenient times and locations.

Following an appraisal of the interview by the counselor, the participant is given a recommended course of action. A referral to an appropriate facility or helping agency for follow-up treatment or counseling is provided, if necessary. Such follow-up treatment or counseling is not paid for by EAP. The cost of some treatment services are covered by your Medical Benefit. Check with the Fund Office if you have any questions about what services are covered.

Types of Problems the Program Covers

The most common problems include alcoholism and drug abuse, financial difficulties, family tensions, and conflicts with co-workers. Assistance is also available for other types of behavioral or emotional concerns to help you balance work and family life. And if you have legal matters you need assistance with, the EAP can help you with legal concerns by referring you to an attorney.

Importantly, the EAP is strictly confidential. All records of a participant are the property of the EAP. Except in the case of a governmental agency or court order, records held by Union Assistance Program will not be released without the express written authorization of the client.

To get in touch with the
Union Assistance Program
Call
(800) 252-4555
Or on the Web
www.unionap.com

PART B.
PROVISIONS OF COVERAGE
UNDER THE MEDICAL BENEFIT

Each month premiums will be taken from your account (if you are eligible for the Medical Benefit) to pay for your health care coverage. The charge to be made for your health care benefit will depend upon just who in your family unit is to be protected.

MEDICAL BENEFIT

The Medical Benefit is administered by Excellus BlueCross BlueShield, a third-party administrator. The following is a brief description of the benefits provided by the medical Benefit. Please note that the Medical Benefit covers expenses, not illnesses, and the Trustees reserve the right to eliminate or modify covered expenses, in their discretion. Although the Plan may cover a particular expense relating to an illness at one point in time, coverage of different or substantially similar or same expenses related to the same illness will be determined based upon whether, at the time incurred, the different or subsequent expense is a covered expense and whether the Participant is eligible at that time for benefits.

COVERAGE FOR ACTIVE PARTICIPANTS AND THEIR DEPENDENTS

Active participants, i.e. not retired or Medicare recipients, and their dependents are covered by the Hospital, Surgical, Prescription Drug and Major Medical Benefits of the Medical Benefit. These benefits are explained later in this section.

DEFINITIONS

CONVALESCENT NURSING HOME "Convalescent Nursing Home" means an institution licensed as a nursing home pursuant to the New York Public Health Law or as a skilled nursing facility as defined in title XVIII of the Federal Social Security Act.

DOCTOR "Doctor" means a duly licensed doctor of medicine authorized to perform a particular medical or surgical service within the lawful scope of his practice, and also includes any other health care provider or allied practitioner as mandated by state law.

EXPERIMENTAL OR INVESTIGATIONAL Services, supplies, or treatment will be considered "experimental or investigational" as follows: if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; if "Reliable Evidence" shows that the drug, device, or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or if "Reliable Evidence" shows that the consensus of opinion among experts regarding the drug, device, or

medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

HOME HEALTH CARE "Home Health Care" means the care and treatment of a covered person if such care and treatment is in place of confinement in a hospital or skilled nursing facility as defined in title XVIII of the Social Security Act and the plan of such care and treatment is established and approved in writing by a doctor, and rendered by a licensed home Health Care Agency. Home Health Care will consist of one or more of the following:

(a) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.);

(b) part-time or intermittent home health aide services which consist primarily of caring for the patient; and

(c) physical, occupational, or speech therapy.

HOME HEALTH CARE AGENCY "Home Health Care Agency" means an organization which meets each of the following requirements:

(a) it is primarily engaged in and is federally certified as a Home Health Care Agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services;

(b) its policies are established by a professional group associated with such organization, including at least one doctor and at least one registered nurse to govern the services provided;

(c) it provides full-time supervision of such services by a doctor or by a registered nurse;

(d) it maintains a complete medical record on such services; and

(e) it has an administrator.

HOME HEALTH CARE VISIT "Home Health Care Visit" means each visit by a member of a team from a licensed Home Health Care Agency shall be considered one visit. Four hours of home health aide services is considered one visit.

HOSPITAL "Hospital" means an institution which:

(a) is primarily engaged in providing, by or under the supervision of doctors, to in-patients, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(b) maintains clinical records on all patients;

(c) has bylaws in effect with respect to its staff of doctors;

(d) has a requirement that every patient be under the care of a doctor;

(e) provides a 24-hour nursing service rendered or supervised by a registered professional nurse;

(f) has in effect a hospital utilization review plan;

(g) is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and

(h) has accreditation under one of the programs of the Joint Commission on Accreditation of hospital.

Unless specifically provided, "Hospital" does not mean institution or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged or for the care and treatment of drug addicts or alcoholics, except as mandated by state law, or any institution that makes a charge that the covered person is not required to pay.

MEDICALLY NECESSARY "Medically Necessary" or "Medical Necessity" means health care services, supplies or treatment that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(a) in accordance with generally accepted standards of medical practice;

(b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;

(c) not primarily for the convenience of the patient, physician or other health care provider; and

(d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer review medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the view of prudent physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

The fact that a physician or health care practitioner may order, recommend, or approve a service, supply or treatment does not in itself make it medically necessary. The Plan Administrator or its designee has the discretion and authority to determine if a service, supply or treatment is medically necessary.

MISCELLANEOUS EXPENSES "Miscellaneous Expenses" include services and supplies furnished by the hospital; local ambulance to and from hospital; services of an anesthesiologist; services of a radiologist and or pathologist; and pre-admission testing. Pre-admission testing means diagnostic treatment (x-rays, and lab examinations, etc.) performed on an outpatient basis within 5 days before hospital confinement and must be ordered by a doctor and performed in connection with hospital confinement.

NECESSARY, USUAL, AND REASONABLE CHARGE – means the lowest of:

1. The actual charge for the service or supply;
2. The usual charge by the doctor or other provider for the same or similar service or supply; or
3. The usual charge of other doctors or other providers in a similar geographic area for the same or similar service or supply (prevailing fee).

In the determination of benefits for a claim, the usual level of charges may be modified by a relative value study, where appropriate, to model actual claims experience in a given area across a range of percentiles. The term "area" as it would apply to any particular service, medicine, or supply means a zip code, county, or such greater area as is necessary to obtain a representative cross section of level charges. The part of the cost that exceeds that of any other services that would have been sufficient to safely and adequately diagnose or treat an individual's physical or mental condition will not be deemed as usual or reasonable charges. The determination of the Necessary, Usual, and Reasonable Charge for a service or supply is made by the Trustees.

Under the health care benefits, it is intended that the welfare plan make reimbursement for necessary and reasonable charges for the care of a covered person as the result of an illness, pregnancy, or injury. Reimbursement is for specific expenses only and not for illnesses.

Any services not prescribed by a Doctor as medically necessary (except for services for voluntary abortion or voluntary sterilization) under the health care benefits of the welfare plan, for the covered person, will not be considered for reimbursement.

RELIABLE EVIDENCE “Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental or investigational.

SCHEDULE OF BENEFITS FOR ACTIVE PARTICIPANTS

Applies to: Active participants, non-Medicare Retirees and their dependents. Claims must be filed within one year following the year the claim is incurred or the claim will be denied.

TYPE OF SERVICE	COVERAGE ALLOWANCE The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Hospital (also see Mental Illness, Substance Abuse, and maternity care for inpatient benefits)		
• **Inpatient** – Pre-Certification Required(1)	100% up to the semi-private room rate(ICU to 2x semi-private room rate)	*Deductible does not apply.*
• **Outpatient Hospital**		
-Emergency room (2) (Does not include Emergency room physician)	100%	*Deductible does not apply.*
-Emergency room physician	80%	*Subject to deductible.*
-Outpatient surgical center	100%	*Deductible does not apply.*
-Clinic	80%	*Subject to deductible.*
-Laboratory	80%	*Subject to deductible.*
-X-rays	80%	*Subject to deductible.*
-Diagnostic tests	80%	*Subject to deductible.*
-Radiation	80%	*Subject to deductible.*
-Chemotherapy	80%	*Subject to deductible.*
-Respiratory therapy	80%	*Subject to deductible.*
-Physical/speech therapy	80%	*Subject to deductible.*
-Occupational therapy	80%	*Subject to deductible.*
-Dialysis or hemodialysis	80%	*Subject to deductible.*
-Cardiac rehabilitation	80%	*Subject to deductible.*
Freestanding Surgical Facility	100%	*Deductible does not apply.*
Urgent Care Facility	100%	*Deductible does not apply.*
Ambulance	80%	*Subject to deductible.*
Preadmission Testing (3)	100%	*Deductible does not apply.*
Convalescent/Skilled Nursing and Rehabilitation Facility (1)		
-Inpatient **(4)**	80% up to semi-private room rate	*Subject to deductible.*
-Outpatient	80%	*Subject to deductible.*

(1) Pre-Certification is required for all Inpatient Hospital and Skilled Nursing Facility Admissions. Post-Admission Certification is required within 24 hours if a maternity stay exceeds 48 hours for a normal delivery or 96 hours for a cesarean delivery.

(2) Services in the Emergency room must be rendered within 72 hours of an accidental Injury or within 12 hours of the sudden onset of a Sickness. For Non-Emergencies, Emergency Room and Emergency Room Physician are covered as major medical at 80% after deductible.

(3) Preadmission testing must be performed within five days of the planned admission.

(4) Limited to 30 days per year.

TYPE OF SERVICE	COVERAGE ALLOWANCE The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Home Health Care (5)	80%	*Subject to deductible.*
Hospice Care • Inpatient • Home	Not Covered Not Covered	
Private Duty Nursing (not covered if the patient is receiving home health care services)	80%	*Subject to deductible.*
Mental Illness Services		
• Inpatient (Hospital or behavioral health care facility) (1)	100% of the semi-private room rate	*Deductible does not apply.*
• Inpatient Physician	80%	*Subject to deductible.*
• Outpatient (Hospital clinic, facility, office)	80%	*Subject to deductible.*
• Emergency room treatment (2) (Does not include Emergency room physician)	100%	*Deductible does not apply.*
• Emergency room physician	80%	*Subject to deductible.*
Substance Abuse Treatment		
• Inpatient (Hospital or behavioral health care facility) (1)	100% of the semi-private room rate	*Deductible does not apply.*
• Inpatient Physician	80%	*Subject to deductible.*
• Outpatient (Hospital clinic, facility, office)	80%	*Subject to deductible.*
• Emergency room treatment (2) (Does not include Emergency room physician)	100%	*Deductible does not apply.*
• Emergency room physician	80%	*Subject to deductible.*

(1) Pre-Certification is required for all Inpatient Hospital and Skilled Nursing Facility Admissions. Post-Admission Certification required within 24 hours if a maternity stay exceeds 48 hours for a normal delivery or 96 hours for a cesarean delivery.

(2) Services in the Emergency room must be rendered within 72 hours of an accidental Injury or within 12 hours of the sudden onset of a Sickness. For Non-Emergencies, Emergency Room and Emergency Room Physician are covered as major medical at 80% after deductible.

(5) Limited to a maximum of 40 visits per 2 consecutive months.

TYPE OF SERVICE	COVERAGE ALLOWANCE The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Maternity Care – Mother ***(Excludes Dependent Children)***		
• Inpatient Hospital (1)	100% of the semi-private room rate	*Deductible does not apply.*
• Physician for prenatal care and delivery	100%	*Deductible does not apply.*
Newborn Care (Prior to discharge)		
• Hospital	100% of the semi-private room rate	*Deductible does not apply.*
• Physician	80%	*Subject to deductible.*
• Newborn circumcision	100%	*Deductible does not apply.*
Physician (except for routine care and delivery, Emergency room physicians, or treatment of Mental Illness or Substance Abuse)		
• Inpatient visit	80%	*Subject to deductible.*
• Office visit	80%	*Subject to deductible.*
• Home visit	80%	*Subject to deductible.*
• Consultation by a Specialist		
Inpatient	80%	*Subject to deductible.*
Outpatient	80%	*Subject to deductible.*
Office	80%	*Subject to deductible.*
• Surgery		
Inpatient	100%	*Deductible does not apply.*
Outpatient	100%	*Deductible does not apply.*
Office	100%	*Deductible does not apply.*
Assistant surgeon	25% of allowance for surgeon	*Deductible does not apply.*
Assistant Physician	80%	*Subject to deductible.*
• Second surgical opinion	100%	*Deductible does not apply.*
Anesthesia		
• Inpatient	90%	*Deductible does not apply.*
• Outpatient	90%	*Deductible does not apply.*
• Office	90%	*Deductible does not apply.*
Allergy Care		
• Treatment and serum	80%	*Subject to deductible.*
• Testing – laboratory	80%	*Subject to deductible.*
Autism	80%	*Subject to deductible.*

(1) Pre-Certification is required for all Inpatient Hospital and Skilled Nursing Facility Admissions. Post-Admission Certification required within 24 hours if a maternity stay exceeds 48 hours for a normal delivery or 96 hours for a cesarean delivery.

TYPE OF SERVICE	COVERAGE ALLOWANCE The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Chiropractor	80%	*Subject to deductible.*
Podiatrist (6)		
• Visit	80%	*Subject to deductible.*
• Orthotics	80%	*Subject to deductible.*
• Surgery	100%	*Deductible does not apply.*
Preventative/Well Care (7)		
• GYN office visit	80%	*Subject to deductible.*
• Pap smear	80%	*Subject to deductible.*
• Mammogram	80%	*Subject to deductible.*
• Well child care to age 19	80%	*Subject to deductible.*
• Routine adult physicals	80%	*Subject to deductible.*
• Routine PSA test	80%	*Subject to deductible.*
• Routine colonoscopy	80%	*Subject to deductible.*
Pap Smear (Medically Necessary)	80%	*Subject to deductible.*
Mammogram (Medically Necessary)	80%	*Subject to deductible.*
Outpatient Diagnostic Tests		
• Independent Laboratory **Laboratory/diagnostic tests, x-rays**	80%	*Subject to deductible.*
• Physician's Office/ Freestanding Facility Laboratory/diagnostic tests, x-rays	80%	*Subject to deductible.*
Home	80%	*Subject to deductible.*

(6) Plan limitations and exclusions apply.

(7) The following procedures must be performed in the doctor's office, if the doctor's office provides the following services, unless medically necessary to be performed elsewhere: infusion therapy, colonoscopies and endoscopies.

TYPE OF SERVICE	COVERAGE ALLOWANCE The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule or the Reasonable and Customary amount.	
Outpatient Treatments		
• **Freestanding Facility**		
Chemotherapy	80%	*Subject to deductible.*
Radiation therapy	80%	*Subject to deductible.*
• **Physician's Office**		
Chemotherapy	80%	*Subject to deductible.*
Radiation therapy	80%	*Subject to deductible.*
Durable Medical Equipment, Prosthetics, Medical Supplies, and Oxygen	80%	*Subject to deductible.*
Diabetic Treatment	80%	*Subject to deductible.*
Diabetic Supplies and Equipment (Includes Insulin and prescription medications used to control blood sugar)	Covered under Prescription Drug Plan through Express Scripts	
Outpatient Services & Therapy		
• **Freestanding Facility**		
Blood and blood products	80%	*Subject to deductible.*
Dialysis or hemodialysis	80%	*Subject to deductible.*
Respiratory therapy	80%	*Subject to deductible.*
Physical therapy	80%	*Subject to deductible.*
Occupational therapy	80%	*Subject to deductible.*
Speech therapy	80%	*Subject to deductible.*
Cardiac rehabilitation	80%	*Subject to deductible.*
• **Physician's Office**		
Blood and blood products	80%	*Subject to deductible.*
Dialysis or hemodialysis	80%	*Subject to deductible.*
Respiratory therapy	80%	*Subject to deductible.*
Physical therapy	80%	*Subject to deductible.*
Occupational therapy	80%	*Subject to deductible.*
Speech therapy	80%	*Subject to deductible.*
Cardiac rehabilitation	80%	*Subject to deductible.*
CALENDAR YEAR DEDUCTIBLE	$250 Individual $750 Family* *Three individuals must meet their deductible in order for the family deductible to be met.	
COINSURANCE MAXIMUM (Does not include deductible)	$3,000 Individual	
Dental	None	
Vision	None	
PRESCRIPTION DRUGS (8) **Express Scripts**	Mail / Maintenance Active and Non Medicare retirees – 20% co-insurance up to $3,000; then $0 co-insurance	

(8) Prior authorization is required for infusion therapy and all special pharmacy drugs must be through the Medco step program. All injectable drugs must be ordered through the Express Scripts specialty pharmacy program unless medically necessary to be administered at a hospital.

Note: This Schedule of Benefits is intended to be a general summary only. Some limitations, conditions, or exclusions may apply. Refer to the sections of this booklet entitled "Detailed Description of Benefits" and "Plan Exclusions" for more specific information regarding coverage.

Maternity Benefits

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Common Accident

Two or more members in a family may sustain injuries in the same accident. If this happens, only one deductible has to be met during that calendar year and the next following calendar year. The deductible will be applied only for those covered charges incurred due to the common accident.

Coinsurance Maximum on Major Medical Benefits

The Plan pays 80% of the first $15,000 of covered charges in excess of the deductible that you incur in a calendar year. After that, the Plan will pay 100% of the covered charges for the remainder of that calendar year.

PRE-ADMISSION CERTIFICATION

Hospital Pre-Admission Certification

Prior to being admitted to the hospital, you should have your proposed hospital stay reviewed by Excellus BlueCross BlueShield. You or your physician must call the telephone number listed on your identification card for pre-certification (1-800-363-4658) as soon as you are scheduled for admission, or at least two (2) days prior to an elective admission and provide the following information:

- Name and Social Security Number of the member
- The name of the Fund and policy number from your identification card
- Hospital name and telephone number of the hospital where you will be treated
- Date(s) you are planning to enter the hospital
- Reason for admission to the hospital

You are required to call Excellus BlueCross BlueShield before admission or within 72 hours of an emergency admission. If you do not obtain approval for admission, your benefits may be reduced or forfeited.

Urgent or Emergency Hospital Admissions

In the case when you or your eligible dependent require urgent or emergency admission to a hospital, your physician, the hospital or family member should contact Excellus BlueCross BlueShield within 72 hours and provide them with the information so they may assign an initial approval for the number of days allowed for your hospital stay.

PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit is administered by Express Scripts, Inc. You may purchase medications and pay only a co-payment when you use a participating pharmacy or the mail service pharmacy. You may obtain prescriptions at participating pharmacies by presenting your identification card and paying co-payments, without submitting a paper claim. You may receive up to a 30-day supply from a participating retail pharmacy, or up to a 90-day mail service pharmacy supply from Express Scripts, Inc. [RO1] Information regarding the Home Delivery Pharmacy Service can be found in the brochure provided to you by Express Scripts, Inc. If you need assistance, please call the Member Services phone number, 1-800-818-6602, found on the back of your identification card. Representatives are available to help you 24 hours a day, 7 days a week, except Thanksgiving and Christmas, with any questions on using this benefit.

The Plan is a co-insurance plan, which means your co-payment is a percentage of the cost of each medication. Your co-insurance is 20% of the cost of each covered medication. The maximum amount of co-insurance you will be required to pay per year is $3,000.

EXCLUSIONS

The welfare plan will not consider, for reimbursement, expenses incurred for services, supplies, or treatment:

1. unless such services, supplies, and treatment were prescribed as necessary (except for services for voluntary abortion or voluntary sterilization) by a Doctor practicing within the scope of his license. This exclusion includes services rendered by individuals or entities other than qualified hospitals, physicians, and other medical providers (unless explicitly authorized by other provisions of this Plan Booklet); medical summaries, invoice preparation, completion of claim forms, or fees for missed appointments, telephone consultations, charges for standby services; services or supplies not actually received by the patient or incurred by someone other than the patient unless specifically included in this Plan such as coverage limits for organ donors; care and treatment for which there would not have been a charge if no coverage had been in force; charges incurred for which the Plan has no legal obligation to pay; care,

treatment, services or supplies not recommended, prescribed and approved by a physician; treatment, services or supplies when the Covered Person is not under the regular care of a physician; regular care means ongoing medical supervision or treatment which is appropriate care for the injury or sickness; care and treatment billed by a hospital for non-emergency condition admissions on a Friday or a Saturday; this does not apply if surgery is performed within 24 hours of admission.

2. during confinement in a hospital owned or operated by the Federal Government unless there is a legal obligation to pay charges without regard to the existence of any insurance. This exclusion includes care, treatment, or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by law. This exclusion applies to services or supplies received in an institution owned or operated by state or local governments. However, benefits will be available for covered expenses for the following exceptions:

    a. Veterans Hospital for services and supplies that are unrelated to conditions resulting from military service in the USA armed forces;

    b. State or local government owned acute care Hospital or Skilled Nursing Facility that customarily bills for its services;

    c. State or local government owned mental health facility;

    d. Government owned facility that otherwise meets Plan limitations for coverage as an outpatient alcohol or substance use disorder treatment facility;

    e. USA military acute hospital or skilled nursing facility for treatment of retired or inactive military personnel or their dependents or for the dependents of active military personnel; and

    f. Any government facility, if the patient with a sudden and serious illness or injury is treated immediately at a government facility, because of its closeness, and the confinement is only as long as the emergency care is necessary or it is impossible to transfer the patient to another facility.

3. that the individual is not required to pay or for which someone else is responsible. This exclusion includes amounts reimbursable because of claim settlement or legal action (third party claim or actions). This exclusion does not include conditional payments shown in the section entitled Recovery of Certain Payments.

4. incurred on account of war or any act of war, declared or undeclared, or participation in a felony, riot, or insurrection.

5. developed from or directly attributed to accidental bodily injury arising out of and in the course of the individual's employment for which coverage exists under the applicable Workers' Compensation or Occupational Disease Law; or otherwise incurred on account of occupational disease and, for the purpose of this Plan, the term "occupational disease" will mean a disease for which the individual with regard to whom a claim is submitted is entitled to benefits under the applicable Worker's Compensation Law, Occupational Disease Law, or similar legislation;

6. incurred on account of services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, except for tumors or cysts or except as required because of accidental injury to natural teeth occurring while covered hereunder (subject to the HIPAA rules regarding preexisting conditions). This exclusion includes services or supplies related to care or treatment of the teeth, gums or alveolar process, such as dental caries (tooth decay), extractions whether simple or surgical, periodontics, bridges, crowns, orthodontia, implants or other services considered to be dental, rather than medical, in nature. Adjustments, services or supplies related to appliances for treatment of Temporomandibular Joint disorders (TMJ) or similar disorders. The exclusion does not include charges by a Dentist or Physician for care otherwise considered medical and limited dental care given for Accidental Injury to Sound Natural Teeth. In no event will the Plan pay for the repair or replacement of dentures, crowns or other dental devices. Benefits are available for Hospital or other facility charges for dental-related services that require a Hospital inpatient or outpatient admission due to an underlying medical condition. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures: excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; emergency repair due to Injury to Sound Natural Teeth; surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth; excision of benign bony growths of the jaw and hard palate; external incision and drainage of cellulitis; incision of sensory sinuses, salivary glands or ducts; and reduction of dislocations and excision of Temporomandibular Joints (TMJs). No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

7. incurred on account of cosmetic surgery, except as required because of accidental injury, and except reconstructive surgery following a mastectomy or when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, and except reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. This exclusion includes services or supplies connected with elective cosmetic surgery or treatment. Reversal of elective, cosmetic surgery will not be covered unless found to be Medically Necessary according to Plan provisions. The exclusion does not include care required to significantly restore tissue damaged by an Illness or Injury or for

reconstruction surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a Dependent Child that has resulted in a functional defect.

8. incurred on account of eye refractions, eyeglasses, hearing aids, or the fitting thereof. This exclusion includes Radial keratotomy or other eye surgery to correct refractive disorders and routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Services and supplies related to vision therapy not specified as covered under shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

9. for repairing or removal of corn, calluses, or toenails (other than partial or complete removal of nail roots) except when prescribed by a doctor who is treating the covered person for a metabolic disease such as diabetes mellitus, or a peripheral vascular disease, such as arteriosclerosis. This exclusion includes treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral vascular disease) and Orthopedic shoes, foot Orthotics or other supportive foot devices. Coverage is available for care of the feet related to services or supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet. Charges for routine foot care are covered for patients with severe systemic disorders, such as diabetes. Services or supplies for foot Orthotics, orthopedic shoes or shoe inserts are not covered and Diabetic shoes are not covered.

11. charges for services for artificial insemination or in vitro fertilization as well as charges for fertility drugs.

12. genetically engineered drugs.

13. that are not medically necessary. This exclusion includes services, supplies, or treatment. This exclusion includes disallowed expense benefits, services, or supplies to the extent such expenses were disallowed by a primary health plan due to failure by the Participant to follow the requirements of the primary health plan including, but not limited to, its managed care program, pre-admission reviews, second surgical opinion, or any other reason, including failure to abide by the primary care physician network established by the primary health plan. However, the Plan will pay as a secondary payer if the primary plan had allowed the claim or benefit.

14. that are experimental or investigational.

15. associated with an attempt at suicide or from a self-inflicted illness or injury or illness and complication thereof, unless deemed as the result of a physical or mental medical

condition. In accordance with the source of injury rules established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the self-inflicted exclusion shall not be interpreted to exclude coverage related to injuries incurred as a result of domestic violence and/or self-inflicted injuries that are the result of depression or mental illness.

16. associated with illness or injury as a result of a person operating a vehicles with a blood alcohol level which exceeds the motor vehicle or state operation legal limit.

17. associated with injuries or illness arising from an automobile, motorcycle or related accident if personal injury protection coverage or no-fault benefits are recoverable under state law. This exclusion includes No-Fault Auto Insurance for which, an eligible person is entitled to receive benefits through mandatory No Fault or fault automobile insurance, an uninsured motorist insurance law, or any other motor vehicle liability insurance policy, including under-insured individuals. This applies whether or not a claim is for payment under that coverage. Benefits under this Plan will automatically be denied if the No-Fault Auto Insurance or other payer of motor vehicle liability coverage denies benefits due to its DWI or DUI exclusion, felony exclusions, as not Medically Necessary, or for late filing. Charges for services or supplies not paid by the No-Fault coverage due to its deductible or maximum payment limits will be covered under this Plan to the extent Allowable Fees would have otherwise been payable by this Plan. Note: No-Fault and motor vehicle liability coverage is considered another plan under the Coordination of Benefits provision of this Plan.

18. associated with illness or injury as a result of an Illegal Act. No benefits or plan assets will be paid or expended from this Plan to cover expenses related to an injury, condition, or disease resulting from directly or indirectly being engaged in, or incurred while committing, an Illegal Act. For the purpose of this exclusion, the term "Illegal Act" means any action or omission that is contrary to, or in violation of, any statute, rule, regulation, ordinance, court order, or other established custom having the force and effect of law. The Plan's Trustees reserve the exclusive right to determine, in their sole discretion, whether an action or omission is an Illegal Act based upon the facts and circumstances involved in the case and regardless of whether a criminal prosecution or conviction resulted. In accordance with the source of injury rules established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the term "Illegal Act" shall not be interpreted to exclude coverage related to injuries incurred as a result of domestic violence and/or self-inflicted injuries that are the result of depression or mental illness.

EXTENDED BENEFITS ON TERMINATION

Benefits are payable for Covered Expenses incurred within twelve months from the date an individual's medical coverage is terminated provided the medical expenses are incurred with respect to an accidental bodily injury or sickness on account of which the individual is totally disabled at the time his coverage is terminated and is continuously disabled to the date each medical expense is incurred, and provided that the individual is not entitled to benefits for such expenses under any other policy of group insurance or any group BlueCross or BlueShield plan on the date each medical expense is incurred.

The words totally disabled, as used in the preceding paragraph, means, with respect to an employee, that the employee is prevented, solely because of disease or accidental bodily injury, from engaging in his regular or customary occupation, and, with respect to a Dependent, that the Dependent is prevented, solely because of disease or accidental bodily injury, from engaging in substantially all of the normal activities of a person of like age and sex and in good health.

PART C.
SELF-PAY COVERAGES

CONTINUED COVERAGE BY SELF-PAYMENT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. (If you do elect COBRA coverage, you will also be covered under the Plan's Employee Assistance Program benefit.) As discussed in preceding sections, you may use your Health Reimbursement Account ("HRA") to pay for COBRA premiums. For your dependents, this is not available as discussed below.

Qualifying Events for Employees

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of Medical Benefit coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff, or a loss of eligibility due to reduction of personal account. ***You may elect COBRA continuation coverage for the Medical Benefit only or for both the Medical Benefit and Health Expense benefit.***

You are NOT required to elect COBRA continuation coverage for the Health Expense Benefit to continue to receive reimbursements under the Health Expense Benefit. Even if you reject COBRA continuation coverage for the Health Expense Benefit, you will continue to have access to the Health Expense Benefit and can receive reimbursements under such coverage so long as the account balance is sufficient to cover your claims.

If you elect COBRA continuation coverage, the amount of your monthly COBRA premium attributable to your Medical Benefit will not be available under the Health Expense Benefit for other expenses.

Spousal Eligibility for COBRA Coverage

Your spouse may elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following events:

1. Your death.

2. Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in

hours worked including a strike, walkout or layoff, or a loss of eligibility due to reduction of personal account.

3. Divorce or judicial order of legal separation.

4. Your enrollment in Part A or Part B of Medicare.

If your spouse has a COBRA Qualifying Event as a result of your death, your spouse may elect COBRA continuation coverage for the Medical Benefit only or for both the Medical Benefit and the Health Expense Benefit. In this case, your spouse is NOT required to elect COBRA continuation coverage for the Health Expense Benefit to receive reimbursements under the Health Expense Benefit. Even if your spouse rejects COBRA continuation coverage for the Health Expense Benefit, your spouse will have access to the Health Expense Benefit and can receive reimbursements under such coverage so long as the account balance is sufficient to cover the claims.

If your spouse has a COBRA Qualifying Event because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your spouse may elect COBRA continuation coverage for the Medical Benefit only or for both the Medical Benefit and the Health Expense Benefit. In this case, your spouse is not required to elect COBRA continuation coverage to remain covered by your Health Expense Benefit. However, if your spouse does not elect COBRA coverage, only you can submit claims for reimbursement, and only you can receive reimbursements, under your Health Expense Benefit.

If your spouse has a COBRA Qualifying Event as a result of divorce or judicial order of legal separation, your spouse may elect COBRA continuation coverage only by electing such coverage for both the Medical Benefit and the Health Expense Benefit.

If your spouse elects COBRA continuation coverage, the amount of the spouse's monthly COBRA premium attributable to the Medical Benefit will not be available under the Health Expense Benefit for other expenses.

<u>Dependent Eligibility for COBRA Coverage</u>

Your dependent children can elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following events:

1. Your death.

2. Your dependent child's loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or loss of eligibility due to reduction of personal account.

3. Divorce or judicial order of legal separation of the child's parents.

4. Your enrollment in Part A or Part B of Medicare.

5. The child ceases to qualify as an "eligible dependent" as described in Part A on page 2.

If your dependent child has a COBRA Qualifying Event as a result of your death, your dependent child may elect COBRA continuation coverage for the Medical Benefit only or for both the Medical Benefit and the Health Expense Benefit. In this case, your dependent child is NOT required to elect COBRA continuation coverage for the Health Expense Benefit to receive reimbursements under the Health Expense Benefit. Even if your dependent child rejects COBRA continuation coverage for the Health Expense Benefit, your child will have access to the Health Expense Benefit and can receive reimbursements under such Health Expense Benefit so long as the account balance is sufficient to cover the claims.

If your dependent child has a COBRA Qualifying Event because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your dependent child may elect COBRA continuation coverage for the Medical Benefit only or for both the Medical Benefit and Health Expense Benefit. In this case, your child is not required to elect COBRA continuation coverage to remain covered by your Health Expense Benefit. However, if your child does not elect COBRA coverage, only you can submit claims for reimbursement, and only you can receive reimbursements, under your Health Expense Benefit.

In the event your dependent child has a COBRA Qualifying Event as a result of your divorce or judicial order of legal separation or because your child ceases to qualify as an "eligible" dependent, your child may elect COBRA continuation coverage only by electing such coverage for both the Medical Benefit and the Health Expense Benefit.

If your child elects COBRA continuation coverage, the amount of your child's monthly COBRA premium attributable to the Medical Benefit will not be available under the Health Expense Benefit for other expenses.

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

<u>Notifications to the Fund Office</u>

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed

to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Fund Manager using the Fund's "Participant's Notice to Fund Manager" form which can be obtained from the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent, or of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Fund Manager within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, you have the responsibility to inform the Fund in the event that the Social Security Administration has determined you or one of your qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Notification of COBRA Rights

After the Fund Manager receives notice of the occurrence of one of the above qualifying events, the third-party administrator will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the third-party administrator will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverage has terminated

Election of COBRA Coverage

The employee, spouse and dependent children each have independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the third-party administrator that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60-day period described above as long as the completed COBRA Election Form is received by the third-party administrator on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form is received by the third-party administrator.

You may elect COBRA continuation coverage for the Medical Benefit only or for both the Medical Benefit and the Health Expense Benefit. You (meaning the participant) are NOT required to elect COBRA continuation coverage for the Health Expense Benefit to continue to receive reimbursements under the Health Expense Benefit. Even if you reject COBRA continuation coverage for the Health Expense Benefit, you will continue to have access to the Health Expense Benefit and to receive reimbursements under such coverage, so long as the account balance is sufficient to cover your claims.

Benefits Provided Under COBRA Coverage

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance (death benefits) or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included. Benefits available from your Personal Account include health care expenses not covered under the health care insurance of the Insurance Benefit or any other insurance program, including medical, dental, prescription drug, hearing and optical expenses which have been determined to be deductible by the Internal Revenue Service, including co-payments, deductibles and other health insurance premiums paid on an after-tax basis.

Consequences of Failing to Elect or Waive COBRA Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Duration and Termination of COBRA Coverage

If the election is due to termination of your employment or a reduction in hours worked or a loss of eligibility due to reduction in personal account, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations, such coverage is available

for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions.

4. The individual enrolls in Part A or Part B of Medicare.

5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

If any of these events occur, the third-party administrator will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

Cost and Payment of COBRA Coverage

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the third-party administrator to continue COBRA continuation coverage. The first payment must be made within 45 days of the date written election of coverage is made. After the first payment is made, future payments must be made within thirty (30) days after the first day of the month.

The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan. The monthly COBRA premium will usually be more than the monthly premium charged to self-pay participants described below.

Additional Information about COBRA Coverage

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Fund Manager or the third-party administrator.

There may also be alternative health insurance coverage options for you and your family other than purchasing COBRA coverage from this Plan. When key parts of the health care law took effect in 2014, you became able to buy coverage through the Health Insurance Marketplace. The Marketplace is designed to help people without employer sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: HealthCare.gov. In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away. Information about the Marketplace can help you see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility coverage for a tax credit through the Marketplace. In addition to the options available from the Marketplace, you may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which you are eligible (such as a spouse's plan). Even if the other plan generally does not accept late enrollees, you may still qualify if you request enrollment within 30 days. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. For example, in New York State, the website for the Marketplace is: Healthbenefitexchange.ny.gov.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

Keep your Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Manager and the third-party administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Manager and/or the third-party administrator.

PART D.
CLAIM PROCEDURES

CLAIM PROCEDURE UNDER THE MEDICAL BENEFIT

All medical claims are processed by Excellus BlueCross BlueShield, a Third Party Payer. If you have questions regarding the status of a claim, how the claim was processed, or your explanation of benefits, call Excellus BlueCross BlueShield toll free at (800) 920-8889. You may also write to Excellus BlueCross BlueShield at:

Excellus BlueCross BlueShield
150 N. Main Street
Elmira, New York 14901

All medical claims must be submitted directly to this address:

Excellus BlueCross BlueShield
150 N. Main Street
Elmira, New York 14901

(The billing address is on the back of your identification card.)

PAYMENT OF BENEFITS

How Excellus BlueCross BlueShield pays medical expenses payable under your Plan is determined by whether you received treatment in or out of the Plan's Preferred Provider Network(s). To obtain a list of the Plan's Preferred Providers, you may contact the Fund Office or go to Excellus BlueCross BlueShield's website at www.excellusbcbs.com.

If you or your Dependent(s) receive treatment from a member of this Plan's Preferred Provider Network(s), Excellus BlueCross BlueShield, will make payment directly to the provider. Please do not pay your bill at the time of service. These providers have agreed to accept a lower fee. Therefore, the percentage that you may be required to pay will be the percentage of a lower fee-a savings to both you and the Plan. You **do not** have to submit claims.

If you or your Dependent(s) receive treatment from a Non-Preferred Provider, Excellus BlueCross BlueShield will pay expenses payable under this Plan for which you have proof of service. Proof of service must be furnished by you or your out-of-network provider via the claims procedure as follows.

HOW TO FILE A CLAIM

When completing a Claims form, be sure that you or your out-of-network provider includes:

1. Name of your union – IBEW Local 139.
2. Your name and identification number.
3. The full name of the person receiving treatment
4. The diagnosis for each date of service
5. An itemized bill (Note: A "balance forward" statement or canceled check is not acceptable since they provide no information about the medical treatment.)
6. If charges are due to an accident, note the date of the accident and a brief description of the circumstances.

Payments will be made to the provider unless the bills are marked "paid." When submitting claims, if you would like some payments to go directly to your health care provider and some to be paid directly to you, make separate submissions indicating where payment should be made.

If your union's name is not indicated on the claim, the claim will be returned to you or the provider for that information.

Send completed claim forms and bills to the appropriate address shown on the back of your identification card.

The trustees will have the right and opportunity to examine any claimant (while living) when and so often as it may reasonably require and, also, the right and opportunity to make an autopsy where it is not forbidden by law.

CLAIM PROCEDURE UNDER THE PRESCRIPTION DRUG BENEFIT

The prescription drug benefit is administered by Express Scripts, Inc.

If you need assistance, or wish a claim form, please call the Member Services phone number, 1-800-282-2881, found on the back of your identification card. Representatives are available to help you 24 hours a day, 7 days a week, except Thanksgiving and Christmas, with any questions on using this benefit. You may obtain claim forms by logging on to the Express Scripts, Inc., Inc. website, www.express-scripts.com. You may also obtain paper claim forms by writing to Express Scripts, Inc.

You may file a claim at the address shown below:

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121

You may file for secondary coverage for any eligible dependent who purchases a covered medication. You will need to complete the Medco Health claim form*, Coordination of Benefits/Direct Claim Form*, and attach any pharmacy receipts or explanation of benefits. The Coordination of Benefits section must be checked "yes" and "secondary." Be sure to provide all information that is requested, including the quantity and days' supply. (See the section "**Receipts must contain the following information"** on the back of the claim form.) You may write any requested information directly on the claim form if it is missing from the receipt. Your claim will be denied if requested information is not supplied.

CLAIM PROCEDURE UNDER OTHER BENEFITS

Application for all other Benefits (Health Expense Benefit, Life Insurance Benefit, and Disability Income Benefit) must be made in writing on forms that may be obtained from the Plan Office.

Time deadlines for filing, if any, are indicated under the particular Benefit description in Part A. of this booklet.

PLAN OFFICE CLAIM PAYMENT PROCEDURE

It is the policy of the I.B.E.W. Local 139 Welfare Plan to issue payments for all claims that are administered by the Plan Office within a period of 30 days from the date of receipt by the Plan Office.

For all claims, the following will be required:

1. Obtain an appropriate claim form(s) from the Plan Office.

2. Complete your portion of the form(s). Be sure that the participant's signature and the participant's social security number are in the proper spaces.

3. Upon completion of the claim form(s), attach all itemized bills and return it to the Plan Office.

An expense is considered to be incurred on the date the service or treatment is received or a purchase is made, rather than on the date the bill is received.

CLAIM REVIEW AND APPEAL PROCEDURES

Initial Decisions

Time Frames

Health Insurance Benefits (Administered by Excellus BlueCross BlueShield*), Health Expense Benefits, Prescription Drug Benefits (Administered by Express Scripts, Inc.) and Health-Related Employee Assistance Program (EAP) Benefits*

For these medical claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant.

Note that claims for Health Expense Benefits and Prescription Drug Benefits are Post-Service Claims. The only possible Pre-Service, Urgent Care, or Concurrent Care Claims are claims for the self-insured Health Insurance Benefits administered by Excellus BlueCross BlueShield.

Pre-Service Claims

For Pre-Service Claims, you will be notified of the benefit determination by Excellus BlueCross BlueShield, the third-party administrator (whether adverse or not), within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the third-party administrator expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, the third-party administrator will provide notice of the failure within 5 days.

Urgent Care Claims

The rules are slightly different for Pre-Service Claims that involve urgent care, i.e., Urgent Care Claims. For Urgent Care Claims, you will be notified by the third-party administrator regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. Notification of the decision on that claim will then be provided within 48 hours after the third-party administrator's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

Post-Service Claims

For Post-Service Claims, you will be notified of any adverse benefit determination by Excellus BlueCross BlueShield (the third-party administrator for Health Insurance Benefits), Express Scripts, Inc. (the third-party administrator for the Prescription Drug Benefit), or the Plan (for the Health Expense Benefit) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended up to 15 days for matters beyond the Plan's control if, before the end of the initial 30-day period, the third-party administrator or the Plan (if applicable), notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. A determination will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Concurrent Care Claims

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially-prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatments.

Prescription Drug Benefit

Claim forms are not needed to obtain prescription benefits. To request prescription benefits you simply present your card and prescription to the pharmacist. That request is not considered a "claim" under these procedures. However, if your request is denied in whole or in part, you may file a claim for benefits by submitting your paid receipts for the prescription drug, along with a completed claim form, to Express Scripts, Inc. at the following address:

One Express Way
St. Louis, MO 63121

If Express Scripts, Inc. denies your claim, the rules regarding post-service claims apply. If you need a claim form, or have any questions regarding these procedures, please call the Fund Office at (607) 732-5611.

Disability Income Benefit

If your claim for Disability Income benefits is denied in whole or in part for any reason, then within 45 days after this Plan receives your claim, this Plan will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the Plan. For any extensions, the Plan will provide advance written notice indicating the circumstances requiring the extension and the date by which the Plan expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable). A decision will then be made within 30 days after the earlier of the date you supply the requested information or the date by which you must supply the additional information.

Life Insurance and Non-Health Related Employee Assistance Program Benefits

If your claim for a Non-Health Related Employee Assistance Program Benefit is denied in whole or in part for any reason, then within 90 days after this Plan receives your claim, this Plan will send you written notice of its decision, unless special circumstances require an extension, in which case the Plan will send you written notice of the decision no later than 180 days after the Plan receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination. Life insurance benefits will be decided by the insurer (for the insured portion of the benefit) and by the Fund (for the self-insured portion of the benefit) within the same time frame.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;

2. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;

5. In the case of an adverse determination involving the claim for urgent care, a description of the expedited review process applicable to such claims;

6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request; and

7. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the Plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Appeals of Adverse Benefit Determinations

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in this Plan; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If you are not satisfied with the reason or reasons for your adverse benefit determination, you may appeal the determination. To appeal an adverse determination of a Health Insurance benefit, you must first appeal to Excellus BlueCross BlueShield within 180 days after you receive

the initial adverse benefit determination. For Health Insurance claims other than Urgent Care claims, the Plan employs a two-level appeal process. If you have your first level appeal of a Health Insurance claim denied, to appeal to the second level of appeal, you must appeal to the Board of Trustees (for Post-Service claims), and to Excellus BlueCross BlueShield. (for Pre-Service Claims), within 180 days of the first-level denial. To appeal an adverse determination of a Prescription Drug Benefit, a Non-Health Related EAP benefit or a Disability Income benefit, you must write to the Trustees within 180 days after you receive this Plan's initial adverse benefit determination. To appeal an adverse determination of the self-insured portion of a Life Insurance Benefit claim, you must write to the Trustees within 60 days after you receive this Plan's initial adverse benefit determination. To appeal an adverse benefit determination of the insured portion of a Life Insurance benefit claim, you must follow the procedures set forth in that underlying insurance policy and must be given at least 60 days to file an appeal. Notwithstanding anything in this paragraph to the contrary, for Concurrent Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will be afforded a reasonable period of time to appeal.

Special Rule Regarding Urgent Care Claims: If Urgent Care Claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan (or the third-party administrator, as applicable) by telephone, facsimile, or other similarly expeditious method. Further, if the appeal involves an Urgent Care Claim, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, all appeals other than those involving the Life Insurance Benefits or non-health related EAP benefits must adhere to the following criteria: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Determinations on Appeal

Time Frames

Pre-Service Claims for Health Insurance Benefits: These medical claims are subject to a two-level appeal process, as noted above. At the first level of appeal, Excellus BlueCross BlueShield the third-party administrator, will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review. If your first-level of appeal is denied and you appeal at the second level to the Board of Trustees, the Board will notify you of its decision on the second level appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Urgent Care Claims: Excellus BlueCross BlueShield will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

Post-Service Claims for Health Insurance Benefits: These medical claims are subject to a two-level appeal process, as noted above. At the first level of appeal, Excellus BlueCross BlueShield will notify you of its determination on appeal within 30 days of receipt of the appeal. If your first-level appeal is denied and you appeal to the second level to the Board of Trustees, the Board of Trustees will also notify you of its determination on appeal within 30 days of receipt of the appeal.

Insured Portion of Life Insurance Claims: Appeals of adverse Life Insurance determinations must be determined by the insurance company within 60 days (plus a possible 60-day extension, if necessary).

Life Insurance and Disability Income Benefit Claims: Appeals of adverse Disability Income Benefit claims must be decided by the Trustees within 45 days (plus a possible 45-day

extension, if necessary). Appeals of adverse self-funded Life Insurance claims must be decided by the Plan within 60 days (plus a possible 60-day extension, if necessary).

All Other Claims: The Trustees at their next regularly scheduled meeting will make a determination of appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

The Plan's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;

2. Reference to specific plan provisions on which the determination is based;

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The Trustees' Decision is Final and Binding

The Trustees' (or their designee's) final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address. Please note that filing a lawsuit without exhausting the Fund's appeals procedures could limit your right to appeal or cause you to lose benefits to which you would otherwise be entitled.

PART E.
COORDINATION OF BENEFITS

Coordination of benefits is a series of rules which apply if a person is eligible under another plan providing medical benefits as well as under this Plan. This frequently happens when both the member and the member's spouse work. The coordination of benefits rules determine the portion of your expenses which will be paid by each plan. They will not reduce your total benefit in any way.

A set of rules is established to determine whether this Plan or the other plan will be the "primary plan" and pay benefits first. If this Plan is the primary plan, it determines the benefit payable regardless of the provisions of any other plan. If this Plan is the secondary plan, it will pay benefits only after the primary plan has determined what it will pay.

If you or your dependent is covered under another health care plan, the total amount received from all plans will never be more than 100% of "Allowable Expenses". Benefits are reduced only to the extent necessary to prevent any person from making a profit on his coverage.

"Allowable Expenses" are any necessary and reasonable expenses for medical services, treatment, or supplies, covered by one of the plans under which you or your dependents are covered.

A "health care plan" is any group providing health care coverage on an insured or uninsured basis. This includes group BlueCross, group BlueShield, labor-management trusteed plans, union welfare plans, employer plans, and any coverage under governmental programs, student insurance plans, and no-fault auto insurance.

If the other plan which may be liable for benefits does not contain a Coordination of Benefits provision, this Plan will be the secondary plan. If the other plan does contain such a provision, this Plan will be the primary plan if the person incurring the expense is covered by this Plan as an employee. If the person incurring the expense is covered by this Plan as a dependent, this Plan will be the secondary plan if the other plan covers such dependent as an employee regardless of the coordination of benefits provisions or other terms of the dependent’s other plan.

In the case of dependent children, benefits are determined by reference to the parents' birthdays. If your children are eligible for coverage under both this Plan, and a plan provided by your spouse’s employer (and you and your spouse are not separated or divorced), this Plan will be the primary plan if your birthday falls earlier in the year than your spouse’s birthday. If you happen to have the same birthday, this Plan will be the primary plan if it has covered you longer than your spouse’s plan has covered your spouse. If your spouse’s plan determines liability based on the gender of you and your spouse or based on a rule other than the birthday rule, the birthday rule set forth in this Plan will, nonetheless, govern.

If the parents are divorced or separated, the plan covering the parent with custody is primary. If the parent with custody remarries, the order of payment is as follows:

1. Natural parent with whom child resides;

2. Step-parent with whom child resides; and

3. Natural parent not having custody of the child.

If the divorce decree makes one parent liable for the expenses of the child's medical care, the plan covering that parent would be the primary plan regardless of these rules. In any event, payment of benefits will be made pursuant to a Qualified Medical Child Support Order. ("QMCSO"). For a copy of the Fund's QMSCO procedures, contact the Fund Office.

If, for some reason, the proper Coordination of Benefits cannot be determined under the rules described above, the provisions of the regulations issued by the New York State Department of Insurance Section 52.23 govern.

It is your obligation to notify the Plan if you, your spouse, or any of your dependents are covered by another health care plan.

If you fail to do so, any amount by which the Plan overpays benefits will be recovered from you, either directly, or through a reduction in future benefits.

In accordance with applicable law, the Fund shall not take into consideration medical assistance provided through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by participant.

Please Note: Information necessary for the administration of the COB provision will be required at the time the claim is submitted. You should file your claims with the primary plan and then to the secondary plan with a copy of the primary plan's explanation of benefits.

Coordination With Medicare

When you become eligible for Medicare, you will be considered to be insured under Parts A. and B. of Medicare. This is regardless of whether or not you have registered for Part A. or enrolled in Part B.

We suggest, therefore that at least three months before you reach age 65, or three months before you receive your 24th Social Security Disability Pension Payment, you contact your local Social Security Office. This is necessary in order to insure that as soon as you are eligible, you are adequately covered by Medicare, which includes both Part A. for hospital coverage and Part B. for medical expenses.

Plan benefits are affected by Medicare benefits if Medicare is the primary plan for you or your eligible dependent's health expenses. Medicare primary plan status is determined according to Medicare Secondary Payer (MSP) rules as established by government regulations. Revisions or changes in these legislated rules will automatically apply to the Plan whenever such legislation is directed at this type of health plan program.

Medicare Secondary Payer Rules

Currently, Medicare primary status will be based on the following Medicare Secondary Payer (MSP) rules:

1. Persons Eligible for Medicare due to age (65 and over) or Due to Disability: Medicare is secondary to the plan that covers this person as an active employee or the dependent of an active employee.

2. Persons Eligible for Medicare Due to End-Stage Renal Disease (ESRD):

    a. Medicare is secondary for the first thirty months with regard to Medicare eligibility due to end stage renal disease following the month of the first eligibility ESRD treatment for this person.

    b. Medicare is primary after the first thirty months with regard to Medicare eligibility due to end stage renal disease following the month of the first eligible ESRD treatment for this person.

PLEASE NOTE: Once Medicare eligibility is established due to ESRD, the eligible person is entitled to full Medicare coverage. Medicare benefits are not limited to ESRD expenses.

Effects of Medicare on Plan Benefits

If Medicare is found to be primary payer for you or your dependent, the benefits of the Plan will be integrated as follows:

1. If Medicare is primary, the usual Plan benefit for a covered service will be reduced by the Medicare payment for that service. The Plan will pay the balance of the usual Plan benefit, if any, which results from this reduction. The combination of the Plan payment and the Medicare payment shall not exceed the usual Plan benefit for a covered expense.

2. This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare. If a Medicare eligible person is not enrolled in Medicare Part A or Part B and Medicare is found primary, the Medicare benefit will be estimated and used to reduce allowable fees. This could result in significant reduction or denial of the Plan benefits.

Allowable Fees

Allowable fees for Medicare integration purposes only will be determined based on the following:

1. If the provider accepts Medicare assignment of benefits, the allowable fee will be the same fee allowed by Medicare.

2. If the provider does not accept Medicare assignment, the allowable fee will be based on the usual, customary and reasonable charge or the charge as determined by Medicare limiting charge regulations whichever is the lower charge.

According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amount and the provider's charge when that provider accepts Medicare assignment. If a provider does not accept assignment, a beneficiary cannot be billed for charges more than the limiting charge established by Medicare for that service by that provider.

PART F.
MISCELLANEOUS PROVISIONS

RECOVERY OF CERTAIN PAYMENTS

The Trustees have the right to recover any overpayment or payment made in error to you or to a third party on your behalf, or any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted. Such a recovery may be made by reducing other benefit payments made to you or on your behalf, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate.

Note: This provision applies to all participants and their covered spouses and dependents, with respect to all of the Benefits provided under this Fund. For the purposes of this provision, the terms "you" and "your" refer to all participants, covered spouses and covered dependents.

Claims Involving Third Party Liability

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 or receiving other benefits from the Fund. The Trustees, in their discretion, may determine not to provide benefits under the Plan for you if a third party may be responsible for the Payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party's responsibility to you. The rules in this section govern how this Plan pays benefits in such situations. The rules in this section govern how this Fund pays all benefits in such situations.

These rules have two purposes. First, the rules ensure 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. These rules permit this Fund to pay your covered expenses and provide any other Benefits to which you are entitled until your dispute with the third party is resolved.

Second, the rules protect this Fund from bearing the full expense in situations where a third party is liable. Under these rules, 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 in any way 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, or if you become entitled to other benefits as a result of the same events which caused you to incur the covered expenses, you are required to advise the Fund of that fact. By law, the Fund automatically acquires any and all rights which you may have against the third party.

In addition to its subrogation rights, the Fund has the right to be reimbursed for payments made to you or on your behalf under these circumstances. The Fund must be reimbursed in full from any settlement, judgment, or other payment that you obtain from the liable third party, and other expenses, including attorneys' fees, cannot be taken out of the payment. *The Fund's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine.*

The Trustees may, in their sole discretion, require the execution of this Fund's lien 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. If the Trustees have required execution of the Fund's lien forms, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Fund if you retain another attorney or an additional attorney since that attorney may be required to execute the form.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE FUND'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

At the Plan's request, you must complete a form(s) which includes, but is not limited to the following information:

1. The details of your accident or injury;

2. The name and the address of the person you claim caused the accident or injury as well as the name and address of that person's insurance company and attorney; and

3. The name and address of your attorney.

You must also:

1. Sign the Fund's Subrogation Agreement;

2. Have your attorney sign the Subrogation Agreement and return it to the Fund Office before any benefits are paid;

3. Provide the Fund Office with quarterly reports regarding status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and

4. Promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Plan is a continuing one.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole." The Plan has no responsibility to contribute to the Payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees have the right to disregard any findings, determinations, conclusions, or judgments regarding a third party action relating to your obligation to reimburse the Fund. The Trustees have the right to independently determine whether reimbursement is required and/or how the Fund receives the appropriate reimbursement or credit, including reduction of future benefits for you, your Spouse or dependents.

Right of Future Subrogation and Reimbursement

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

"Net proceeds" shall be defined as the amount of your total recovery and/or judgment less payment in full of the amount of the Fund's lien, less payment of your attorneys' fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses arising out of or related to the injuries which were the subject of the third party action and which would have otherwise been Covered by the Plan until the amount of said proceeds is exhausted.

It is only that point that your further related Plan Benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Administrative Manager will determine the net proceeds available for a future credit.

Assignment of Claim

You may not assign any rights or causes of action that you may have against any third-party tortfeasor without the express consent of the Fund.

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 making the recovery, then the excess will be paid to you.

Failure to Disclose and/or Cooperate

You will be personally liable to the Plan for reimbursement owed to the Plan, as well as for the Plan's attorneys' fees and costs incurred in recovering that amount from you, and we will discontinue your benefits, if any of the following occurs:

1. You fail to tell the Plan that you have a claim against a third party;

2. You fail to assign your claim against the third party to this Plan when required to do so:

3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;

4. You fail to require any attorney you subsequently retain to sign the Plan's Subrogation Agreement;

5. You and/or your attorney fail to reimburse the Plan;

6. You fail to provide the Plan with medical or other authorization to obtain the necessary information; or

7. You or your attorneys fail to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount you owe from any future claims submitted by you as well as by your dependents and Beneficiaries and/or will discontinue benefits to you, your dependents and Beneficiaries, or, if necessary, take legal action against you. The Plan may also recover the amount you owe from your Health Reimbursement Account. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien.

RIGHT TO CEASE PAYMENT ON BEHALF IN OTHER INSTANCES

In the event that you or a third party are paid benefits from the Fund in an improper amount or otherwise receive Plan assets not in compliance with the Plan (hereinafter "overpayment" or "mistaken payments"), the Fund has the right to start paying the correct benefit amount and take other appropriate action, including the right to recover any overpayment or mistaken payment made to you or a third party. You, the third party, or the other individual or entity receiving the overpayment or mistaken payment must return the overpayment or mistaken

payment to the Fund with interest at a rate set by the Trustees. Such a recovery may be made by reducing other benefit payments made to you or on your behalf. The recovery might also be made by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. You, the third party, or the other individual or entity, shall reimburse the Fund for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Fund in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

PLAN INTERPRETATION AND DETERMINATIONS

Notwithstanding any other provisions of this Plan, the Board of Trustees are responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees shall have exclusive authority and discretion:

- to determine whether an Employee is eligible for any benefits under the Plan;
- to determine the amount of benefits, if any, an individual is entitled to from the Plan;
- to determine or find facts that are relevant to any claim for benefits from the Plan;
- to interpret all of the Plan's provisions;
- to interpret all of the provisions of the Summary Plan Description;
- to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement, involving or impacting the Plan;
- to interpret the provisions of the Trust Agreement governing the operation of the Plan;
- to interpret all of the provisions of any other document or instrument involving or impacting the Plan; and,
- to interpret all of the terms used in this Plan, and all of the other previously mentioned Agreements, documents, and instruments.

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 and upon all Employees, all Employers, the Union, and any party who has executed any agreement with the Trustees or the Union;

- shall be given deference in all courts of law, to the greatest extent allowed by applicable law; and,

- shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

Benefits under this Plan will be paid only if the Trustees decide in their discretion that you are entitled to them.

INCOMPETENCE PROVISION

If the Trustees (or their designee) determine that a person entitled to benefits from the Plan is unable to care for his affairs because of illness, accident, or incapacity (either physical or mental), payment which would otherwise be made to that person shall be made to that person's duly appointed legal representative. In the event no legal representative shall have been appointed, such payment shall, in the discretion of the Trustees (or their designee), be made to that person's spouse, child, or such person who shall have care and custody of that person.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, the Trustees, or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

TEMPORARY BENEFITS

The Trustees reserve the right to provide temporary benefits under this Plan if conditions warrant. If the Trustees authorize any temporary benefit you will be notified at your last known address.

STATEMENT OF ERISA RIGHTS

As a participant of the I.B.E.W. Local 139 Welfare Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Office, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue 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 on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in Federal Court. In such a case, the Court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits 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 Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay the 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 plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor at:

Boston Regional Office
JFK Federal Building, Room 3575
Boston, MA 02203
Telephone: (617) 565-9600

Or

The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor at:

200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART G.
TECHNICAL DETAILS

(As required by the Employee Retirement Income Security Act of 1974)

1. PLAN NAME: I.B.E.W. Local 139 Welfare Plan, Plan A.

2. EDITION DATE: This Summary Plan Description is produced as of July 1, 2016.

3. PLAN SPONSOR: Board of Trustees of the I.B.E.W. Local 139 Welfare Plan.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 16-0839767.

5. PLAN NUMBER: 501.

6. TYPE OF PLAN: Welfare Plan.

7. PLAN YEAR ENDS: June 30th.

8. PLAN ADMINISTRATOR: Board of Trustees of I.B.E.W. Local 139 Welfare Plan, 415 West Second Street, Elmira, NY 14901.
Phone: (607) 732-5611.

9. AGENT FOR SERVICE OF LEGAL PROCESS: Kristine VanFleet, Fund Manager
I.B.E.W. Local 139 Welfare Plan, 415 West Second Street, Elmira, NY 14901.
Phone: (607) 732-5611.

   In addition to the person designated as agent for legal process, service of legal process may also be made upon any Plan Trustee.

10. TYPE OF PLAN ADMINISTRATION: The Plan is administered by the Board of Trustees. Health related benefits are administered by Excellus BlueCross BlueShield. and Express Scripts, Inc., third-party administrators:

Excellus BlueCross BlueShield
150 N. Main Street
Elmira, NY 14901
(607) 734-1551

Express Scripts, Inc.
One Express Way
St. Louis, Missouri 63121
(800) 818-6602

11. TYPE OF FUNDING: Partly self-funded and partly insured.

12. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the I.B.E.W. Local 139 Welfare Plan, certain welfare plans with whom this Plan has reciprocal agreements from time to time, and, in certain circumstances, participants.

13. COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with collective bargaining agreements. A copy of an agreement may be obtained by you upon written request to the plan manager and is available for examination by you at the Plan Office.

14. PARTICIPATING EMPLOYERS: You may receive from the Plan Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

15. PLAN BENEFITS PROVIDED BY: The I.B.E.W. Local 139 Welfare Fund, Union Labor Life Insurance Company, and Union Assistance Program.

    The address and telephone number of the insurance or benefit providers are:

    Union Labor Life Insurance Company
    111 Massachusetts Avenue, N.W.
    Washington, D.C. 20001
    Telephone: (202) 682-0900

    Union Assistance Program
    55 Chamberlain Street
    Wellsville, New York 14895
    Telephone: (800) 252-4555

16. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: See Parts A, B, C, D, E and F of this booklet.

17. HOW TO FILE A CLAIM: See Part D of this booklet.

18. REVIEW OF CLAIM DENIAL: If you submit a benefit application to the Plan Office and it is denied, in whole or in part, you will be so notified.

    If a denial takes place, you are entitled to appeal the decision. See Part D of this booklet.

19. NO INSURANCE UNDER THE PBGC: Since this Plan is not a defined benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

20. TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the I.B.E.W. Local 139 Welfare Plan. The following are the individual Trustees that make up the Board as of July 1, 2016:

Ernest A. Hartman
I.B.E.W. Local 139
415 West Second Street
Elmira, NY 14901

Lindsay T. Mills
P.O. Box 2068
1832 Grand Central Avenue
Elmira Heights, NY 14903

Josh Fitzwater
415 West Second Street
Elmira, NY 14901

Michael J. Sincock
154 East Fifth Street
P.O. Box 34
Elmira, NY 14902

Steven Spaziani
I.B.E.W. Local 139
415 West Second Street
Elmira, NY 14901

Bruce Condie
c/o Southern Tier Chapter NECA
P.O. Box 1326
Binghamton, NY 13902

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