A Guide To Your Plan Of Benefits

Summary Plan Description **Effective January 1, 2014**

I.B.E.W. Local 910
Welfare Fund

PLAN FOR RETIREES ONLY

I.B.E.W. Local 910 Welfare Fund

25001 Water Street, Watertown, New York 13601

Telephone: 315-782-5941
Toll Free: 800-801-2201
Facsimile: 315- 782-7343

January 1, 2014

Dear Participant of the Retiree-Only Plan:

This booklet is a description of the Retiree-Only Plan maintained by the I.B.E.W. Local 910 Welfare Fund as it is in effect on January 1, 2014. We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

This booklet has eight sections:

Section I.	Eligibility Requirements
Section II.	Description Of Benefits
Section III.	Protected Rights For Continuing Coverage
Section IV.	Qualified Medical Child Support Order
Section V.	Your Rights Under ERISA
Section VI.	Claims Procedure
Section VII.	Protected Health Information
Section VIII.	Technical Details

The Plan is governed by a Board of Trustees of which half represents the former employees and half represents the participating employers. Our role, as Trustees of the Welfare Fund, includes the responsibility for administering the Retiree-Only Plan.

The Board of Trustees has the ultimate responsibility for the management of Plan assets. In addition, the Board of Trustees has the sole power to amend the Plan. The Board of Trustees is assisted in these and other tasks by professional advisors whom we hire from time to time. These include an actuary, an accountant, an attorney, and one or more investment managers.

The Plan Manager, John Love, maintains the daily operation of the Plan. Mr. Love and his staff are available to answer any questions or as a resource to obtain additional information about the Plan.

If, after going through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Fund Office. If your questions are not answered to your satisfaction by the staff, you may direct them to the Plan Manager or to the Trustees, in writing.

Sincerely,

Board of Trustees,
I.B.E.W. Local 910 Welfare Fund

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret or extend or change in any way the provisions of 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. This booklet describes the Plan as it exists on January 1, 2014.

CAUTION

This booklet and the personnel 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 Welfare Fund. No employer, union representative, supervisor, or shop steward is in a position to discuss your rights under the 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 Plan Manager or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

NO GUARANTEE OF INCOME TAX CONSEQUENCES

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Fund Office if the Participant has reason to believe that any such payment is not so excludable.

Directory

BOARD OF TRUSTEES

Employer

Leo J. Villeneuve
Route #1
Colton, NY 13625

James A. Williams
6184 State Hwy. 56
Potsdam, NY 13676

Curtis M. Hammond
PO Box 383
Ogdensburg, NY 13669

Employee

Andrew VanTassel
603 Main Street
Morristown, NY 13664

Elizabeth Cassada
15662 US Route 11
Watertown, NY 13601

John T. O'Driscoll
25001 Water St.
Watertown, NY 13601

CONSULTANTS

Actuary

Bolton Partners Northeast, Inc.
Golden Crest Corp. Center
2277 State Hwy #33, Suite 409
Trenton, NJ 08690

Attorney

Charles E. Blitman, Esq.
Blitman & King, LLP
Franklin Ctr, Suite 300
443 North Franklin Street
Syracuse, NY 13204

Accountant

Stackel & Navarra, CPA, PC
216 Washington Street
Watertown, NY 13601

Plan Manager

John Love
I.B.E.W. Local 910
25001 Water Street
Watertown, NY 13601

Table Of Contents

Important Aspects

- **Familiarize yourself with the <u>whole</u> booklet.**
- **You must apply for <u>all</u> benefits.**
- **Make sure that the Fund Office is aware of all your <u>dependents</u> and your <u>current</u> address.**
- **Make sure your Death Benefit beneficiary designation is <u>up to date</u>.**
- **All claim forms must be <u>completely</u> filled in; incomplete claims will be returned.**

Plan Change Or Termination

The Trustees reserve the rights to change or discontinue (1) the types and amounts of benefits under the Plan and (2) 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 at any time;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such right to modify or terminate 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.

Modification Of Benefits & Eligibility Rules

This Summary Plan Description includes information concerning the benefits provided by the Fund to pensioners and their dependents. It also includes the circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits that a pensioner or dependent might otherwise reasonably expect a plan to provide.

The benefits and eligibility rules applicable to pensioners 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 pensioners and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for pensioners 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 Agreement and Declaration of Trust, no pensioner or dependent has a vested right or contractual interest in the benefits provided. In addition to the right to terminate benefits of pensioners 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 pensioners and/or dependents and there shall not be any vested right by any pensioner, dependent, or beneficiary nor contractual rights after the disposition of plan assets in connection with the termination of this Plan. The provisions for pensioners' and dependents' coverage shall be reviewed periodically by the Trustees.

Section I. Eligibility Requirements

This Section describes how you and your dependents can qualify and continue to qualify for benefits under the I.B.E.W. Local 910 Welfare Fund Retiree-Only Plan.

A. IN GENERAL

The I.B.E.W. Local 910 Welfare Fund has been a personal account plan since January 1, 1995. Effective for your work after January 1,1995, employer welfare contributions were made to the personal account plan. A portion of such contributions were credited to a personal account based on your covered employment.* The Trustees determined the portion of these contributions that were credited to your personal account before you retired.

Your account grew before your retirement with all the contributions that were made to it. Your account decreased by any benefit distribution or Health Care Benefit premium made from it. No more will be paid out to you under this Plan than was deposited into your personal account by way of contributions made on behalf of your work and special allocations.

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.

If contributions were made to the Plan for you and the contributions could not be used and/or were insufficient to satisfy the eligibility requirements, such contributions were forfeited and used for Plan administrative costs. Likewise, if there was no activity (for example, payment of benefits) in your account for a consecutive two-year period, the balance in your account was forfeited and used for Plan administrative costs.

Those individuals who engage in prohibited employment, as defined under the I.B.E.W. Local 910 Pension Plan, shall forfeit the Plan assets allocated into their then-existing Personal Account Plan to the general treasury of the Fund.

**Covered employment. Covered employment means work, prior to your retirement, for which your employer was required to contribute to the Welfare Fund because of a collective bargaining agreement or because your employer had a special agreement with the Fund Trustees. Reciprocal time with certain other plans, for which the Welfare Fund receives contributions, also counted as covered employment.*

B. GENERAL ELIGIBILITY REQUIREMENTS

1. I.B.E.W. Local 910 Pensioners. If you retire under the Local 910 Pension Plan, you will be eligible for coverage under this Retiree-Only Plan for as long as your account balance is sufficient to cover your Health Care Benefit premiums. At that time, you may be eligible to continue your retiree coverage by self-payment, if you meet each of the following requirements:

- you were covered under the Local 910 Welfare Fund on the effective date of your retirement under the Local 910 Pension Plan; and

- you were covered under the Local 910 Welfare Fund for at least half of the eight-year period ending on the day before your Local 910 retirement date; or

- you, your spouse, and dependent children are covered under your spouse's employer's health care plan, or some other employer sponsored health care plan, you may elect that you not be covered under this health insurance arrangement. However, if such other health care coverage stops you must apply immediately for pensioner health insurance coverage. If three months elapse from the day the other coverage stops, you will not be permitted to apply for pensioner coverage at a later date.

Your coverage will continue until the earlier of the following:

- the date you cease making timely self-payment;
- the date the Welfare Fund ceases;
- the date the Plan ceases coverage for the class of covered persons for which you belong; or
- the date of your death.

Your eligible dependents will also remain covered, provided:

- you remain eligible for pension benefits under the Local 910 Pension Plan; and
- they continue to remain an eligible dependent (as defined in Section C.).

If your monthly self-payment is not received by the 10th of the month for which you are to be covered, your coverage will stop. Once you stop making your payments, you will not be able to start again. Further, you can only make self-payments to continue coverage, not to start it.

Active employees over age 70½ who are receiving a pension benefit from the Local 910 Pension Plan but have not retired from covered employment must satisfy the eligibility requirements for active participants, as outlined in the separate Summary Plan Description for the active employees. They are not covered as pensioners as long as they are still working.

If you retire after July 1, 1993, you will be bound by the conditions listed above unless either of the following requirements are met:

- you must be covered by the I.B.E.W. Local 910 Welfare Fund on the effective date of your pension under the I.B.E.W. Local 910 Pension Plan and you must have been covered by the I.B.E.W. Local 910 Welfare Fund for at least half of the eight-year period ending on the day before your retirement date; or
- you must be covered by the I.B.E.W. Local 910 Welfare Fund on the effective date of your pension under the I.B.E.W. Local 910 Pension Plan and you must have worked an average of at least 1,800 hours per year for the number of years that you retire prior to age 65. For example: if you retire at age 62, you would need to have an average of 1,800 hours per year for the three years prior to your retirement date. If you retire at age 64, you would need to average 1,800 hours for the one year prior to your retirement date.

2. Loss of Eligibility and Benefits. The failure of an individual to cooperate and/or repay the Fund monies alleged by the Fund as being owed to it by the individual shall entitle the Trustees to

provide notice of loss of eligibility (effective in the future) for benefits for the individual until the claimed debt is paid. Such loss may include forfeiture of any amount in the individual's "personal account" maintained by the Fund. The above-referenced loss of eligibility may include the individual's spouse and dependents.

You, your spouse, and/or your dependents may be ineligible for benefits if the expenses relate to an injury, condition, or disease resulted 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.

C. ELIGIBLE CLASSES OF DEPENDENTS

For the purpose of the retiree benefits, eligible dependents are your lawful spouse and your unmarried children who are: (1) under age 19 (or under age 24 if a full-time student) as of the end of the calendar year; (2) live with you in the United States for more than one-half of the taxable year; and (3) do not provide over one-half of their own support in the taxable year. In addition, your unmarried child can be considered your dependent form January 1 of the calendar year in which the child attains age 19 until the child's 19th birthday even if the child is not a full-time student as long as the child receives over one-half of his or her support from the taxpayer during such year. Eligible dependents must be primarily dependent upon you for support and maintenance. At any time, you may be required to prove that a spouse or child qualifies or continues to qualify as a dependent as defined by this Plan.

1. Spouse. The term "spouse" shall mean the person recognized as your husband or wife under the laws of the state of New York. The Plan Manager may require documentation proving a legal marital relationship.

2. Child. The term "child" shall mean:

- your natural child;
- your legally adopted child;
- a child lawfully placed with you in anticipation of adoption by an authorized placement agency;
- a step-child who lives in your household;
- your foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- a child for which you have been appointed legal guardian who has the same principle place of abode as you;

- your child who is designated as an alternate payee under a Qualified Medical Child Support Order (QMCSO). You can obtain a copy of the Plan's QMCSO procedures upon request to the Plan Manager.

The Fund will not provide coverage for a dependent in any case where a court order has required a party other than you (the covered participant) to provide medical coverage on behalf of the dependent.

3. Full-Time Student. Coverage for a dependent child will normally cease at the end of the calendar year that immediately precedes the calendar year in which the dependent child attains the age of 19. However, your dependent child's coverage may continue up to the end of the calendar year in which he or she attains the age of 23, if the child is a full-time student at an accredited school and is enrolled for the number of hours or courses that the school considers to be full-time attendance during some part of each of any five calendar months during the year and otherwise remains your eligible dependent (as described above). Note that the time such a child spends away from home for full-time school attendance is a temporary absence due to a special circumstance and is counted as time having lived with you. In addition, your unmarried child may be considered your dependent from January 1 of the calendar year in which the child attains age 19 until the child's 19th birthday even if the child is not a full-time student as long as the child receives over one-half of his or her support from you during the year.

You must provide proof of your eligible dependent child's full-time enrollment in an accredited school if you wish to continue his or her coverage. A letter from the school will provide proof of enrollment. The proof of enrollment must show the number of credits taken and the date of your dependent's enrollment.

If your unmarried child, who is a full-time student at an accredited school, is required to take a Medically Necessary leave of absence, coverage will be continued by the Plan, upon receipt of a written certification of that Medical Necessity by a treating physician, until the earlier of either one year after the first day of the Medically Necessary leave of absence or the date when the coverage would otherwise terminate under the Plan. The physician's written certification must state that the student is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary. A "Medically Necessary leave of absence" means a leave of absence from college or any other change in enrollment of such student at such an institution that commences while the student is suffering from a serious illness or injury, is Medically Necessary and causes the student to lose full-time student status for purposes of Plan coverage.

The participant or student must provide written notice to the Fund Office as soon as practicable of the facts and circumstances establishing the entitlement to a Medically Necessary leave of absence no later than the date coverage would otherwise terminate under the Plan. Further, the treating physician's written certification shall be in a form that is satisfactory to the Trustees.

4. Disabled Dependent Child. If your covered dependent child is totally disabled, coverage may be continued beyond age 19. To be considered totally disabled, your dependent child must be:

- incapable of self-sustaining employment by reason of mental retardation or physical handicap;
- primarily dependent upon you for support and maintenance;
- unmarried, and

- covered under the Plan when reaching age 19.

The Plan Manager may require, at reasonable intervals during the two years following the dependent's 19th birthday, subsequent proof of the child's total disability and dependency. After the initial two-year period, the Plan Manager may require subsequent proof not more than once each year. The Plan Manager reserves the right to have a disabled dependent examined by a physician of the Plan Manager's choice, at the Fund's expense, to determine the existence of a total disability.

5. Health Expense Benefit - Dependents. For the purpose of the Health Expense Benefit, your dependents may include other people, such as your brother, sister or parent. However, you must pay for over one-half of the person's support. You should contact the Fund Office to see if a particular person can be included as your dependent for the Health Expense Benefit.

6. Status. Under this Plan, you may only be covered as either a pensioner or a dependent at any one time. If conditions so warrant, you may change your status from pensioner to dependent or dependent to pensioner.

If both husband and wife are pensioners, their eligible dependent children will be covered as dependents of either the husband or the wife but not as dependents of both.

7. Duration Of Dependent Coverage. Your eligible dependents will participate in the Health Care Benefit (and be covered) during the same period of time that you are covered as a participant.

D. SPECIAL ALLOCATIONS

In addition to employer contributions on your covered work, there are other ways in which your account can grow. These are called "special allocations". The only Special Allocation that applies to the Retiree-Only Plan is the "**Financial Activity Allocation**." When the Plan's financial activity permits, the Trustees may declare a bonus to be credited to eligible accounts. This will happen no more than once a year. In determining whether or not to declare this bonus and the amount of the bonus, the Trustees will take into consideration the investment results on the Plan's assets, the expenses of administration of the Plan, the amount of any other allocations and reserve requirements for the future.

E. REINSTATEMENT AFTER TERMINATION OF ELIGIBILITY

If you are a retired participant and your coverage is terminated because you did not self-pay in a timely manner, you may not reinstate your coverage.

F. SPECIAL ENROLLMENT RIGHTS

Effective April 1, 2009, this group health plan will permit a dependent of a retiree if the dependent is eligible, but not enrolled for coverage, to enroll for coverage under the terms of the Retiree-Only plan if either of the following conditions are met:

Termination of Medicaid or CHIP Coverage. The dependent is covered under a Medicaid plan or under a State child health insurance plan (CHIP) and the coverage of the 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 dependent becomes eligible for premium assistance through Medicaid or CHIP and the retiree requests coverage under this plan not later than 60 days after the dependent is determined to be eligible for such assistance.

Section II. Description Of Benefits

This Section contains descriptions of each individual benefit available under the Plan. Any special eligibility requirements or any limitations specific to a particular benefit is also covered in this Section. General eligibility requirements are discussed in Section I. and the procedure for making claims with related limitations and/or exclusions are covered in Section VI. For purposes of this Section, the Personal Account Plan Health Expense Benefit is reimbursement coverage. Each of the benefits described in this Section may have different conditions and maximum benefit amounts. Also, not all classes of covered persons are entitled to all of the available benefits.

The following table is intended to give you a quick summary of the benefits available under the Local 910 Welfare Fund Retiree-Only Plan. A detailed description of each benefit follows the table.

Type of Benefit	Covered Persons	Benefit
(Self-Insured) Health Care Benefit	– Pensioners – Dependents	Self-Insured - Third-Party Administrator – EBS-RMSCO, Inc. See separate booklet regarding the schedule of health care benefits administered by EBS-RMSCO, Inc., or the EBS-RMSCO, Inc. website: www.rsolutionz.com
Prescription Drug Benefit	– Pensioners (Age 55 Through Age 61) & Their Dependents – Pensioners (Age 62 Through Age 64) & Their Dependents – Medicare-Eligible Pensioners & Their Dependents	80% Administered by Sav-Rx.* 100% Administered by Sav-Rx.* The Fund will reimburse Medicare Part D premiums quarterly up to $750.00 per calendar year per family unit.* *Medicare-eligible dependents will not be covered by this Plan.

Health Expense Benefit	– Pensioners – Dependents	Reimbursement from your account for health care expenses.

MEDICAL BENEFITS

Coverage Options

When you are eligible for the Medical Benefits, you will automatically receive coverage for yourself and (if you are married) your eligible dependents. Medical Benefits consist of the Health Care Benefit and the Prescription Drug Benefit. If you would like to waive automatic coverage, you must complete and return an enrollment form, which will be sent to you by the Fund Office. On this form, you may select one of the following optional coverage choices:

1. Single Coverage (for married participants): Coverage for yourself only, or

2. Limited Coverage: No Medical Benefits, Welfare Plan coverage is limited to the Health Expense Benefit.

In order to waive automatic coverage, you must submit proof that you and/or your family are covered under your spouse's employer's health care plan or some other employer group health care plan. Further, you must demonstrate that such other coverage meets certain minimum standards.

You may change your Medical Benefits coverage option during open enrollment. Open enrollment is twice a year, during the months of September and March, for coverage effective the following October 1 and April 1, respectively.

You may also change your enrollment at any time if you do so within 90 days of a change in family status and the change is commensurate with the change in family status. Otherwise you may only change enrollment during open enrollment. A change in family status means a change in your martial status, the death, birth, or adoption of a child, your spouse's termination of employment or change from full time employment to part-time, or a significant change in benefit under any other plan of health care benefits in which you or your spouse are enrolled.

A. HEALTH CARE BENEFIT

Pensioners and dependents are eligible for the self-insured Health Care Benefit. This benefit is administrated by a third-party administrator, EBS-RMSCO, Inc. You should refer to the applicable booklet provided by EBS-RMSCO, Inc. for a schedule of health care benefits for retired participants. You may also visit the EBS-RMSCO, Inc. website: www.rsolutionz.com. If for some reason, you do not have a copy of the EBS-RMSCO, Inc. booklet, please contact the Fund Office.

B. PRESCRIPTION DRUG BENEFIT

(a) **Retirees (who are age 55 through age 61) and their Non-Medicare-eligible Dependents:** Prescription Drug costs are paid at 80% by the Fund, and the participant is responsible for the remaining 20%. Diabetic maintenance supplies are paid at 100%.* (This benefit is administered by Sav-Rx).

(b) **Retirees (who are age 62 through age 64) and their Non-Medicare-eligible Dependents:** Prescription Drug costs are paid by the Fund at 100%.* (This benefit is administered by Sav-Rx.)

(c) **Medicare-Eligible Retirees and Their Dependents:** You will have no coverage through the I.B.E.W. Local 910 Welfare Fund. The Fund will reimburse your Medicare Part D premiums quarterly, up to $750.00 per calendar year per family unit.* (This benefit is administered by the Fund.)

***Medicare-eligible dependents are not covered by this Plan.**

1. Covered Charges. Prescription drug charges will be covered, if:

- the prescription drug is purchased at a participating pharmacy;
- the prescription drug is prescribed by a physician who is licensed to do so;
- the prescription is not more than a 34-day supply (100-day supply for mail order program); and
- the prescription is for a drug or device approved by the Food and Drug Administration.
- diabetic supplies (insulin syringes and needles, Lancets and Lancet devices, blood, ketone and urine testing strips);

The following items may be covered after receiving prior authorization;

- Desoxyn and Dexedrine are covered when medically necessary;
- Retin-A after age 26, when medically necessary; and

2. Exclusions. Your Plan excludes coverage for the following:

- contraceptive devices;
- durable or disposable medical supplies;
- immunizations;
- legend vitamins;
- medications for cosmetic purposes;
- self-administered injectables;
- replacement scripts, except insulin;
- over the counter (OTC) drugs which are lawfully obtainable without a prescription;
- any charge for the administration of prescription Legend Drugs, except for those charges required by law to be covered;

- medications used for experimental indications and/or dosage regimens determined to be experimental; and

- prescriptions refilled after one year from the order of a physician.

PERSONAL ACCOUNT PLAN BENEFITS

The Personal Account Plan Health Expense Benefit is designed to help you pay for certain medical costs not covered by this or any other health care or insurance plan. Upon your death, your spouse and/or eligible dependents will be entitled to keep your Personal Account Plan 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 dependants. Upon the death of your spouse/eligible dependents, any balance remaining in the Personal Account Plan will be forfeited.

Those individuals who engage in prohibited employment, as defined under the I.B.E.W. Local 910 Pension Plan, shall forfeit the Plan assets allocated into their then-existing Personal Account Plan to the general treasury of the Fund.

C. HEALTH EXPENSE BENEFIT

The Health Expense Benefit is available to eligible pensioners. If you incur health care expenses while you are a participant in the Plan, for yourself, your spouse, or your eligible dependents and these expenses are not covered under the Health Care Benefit or any other insurance, you may apply for a distribution from your account to pay for the uncovered bills.

These expenses may include, but are not limited to expenses incurred for dental care, eye care, and hearing aids. They may also include expenses for (1) over-the-counter medicines and drugs, but only if they are purchased with a prescription, and (2) over-the-counter medical devices and supplies, such as crutches and bandages. Please note that you must provide itemized receipts evidencing the purchase of drugs, medicine, or medical care items. For drugs or medicine other than insulin, you must also provide a copy of the prescription, unless the receipt identifies the name of the purchaser (or the name of the person for whom the prescription applies) and an Rx number.

Claims under this benefit may be submitted only if they total at least $100. You may add several bills together in order to reach the $100. However, in the month of December you may submit bills for reimbursement regardless of the amount. Retirees are not required to maintain a minimum balance in order to use this benefit.

Section III. Protected Rights For Continuing Coverage

In some circumstances, it may be possible for your dependents to continue coverage under the Retiree-Only Plan even when your coverage would have otherwise terminated. This section contains important information about your family's right to COBRA Continuation Coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances where coverage would otherwise end. The section generally explains COBRA Continuation Coverage, when it may become available to your family, and what you need to do to protect the right to receive it. Please read this information carefully.

When is COBRA Continuation Coverage Available?

COBRA Continuation Coverage is a continuation of Retiree-Only Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event is properly provided to the Plan Manager, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." Your spouse and your dependent children (including any child covered pursuant to a Qualified Medical Child Support Order ("QMCSO")) could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for such coverage.

Who is Entitled to Elect COBRA Continuation Coverage?

COBRA Continuation Coverage is available to your eligible spouse and dependents <u>if coverage would otherwise end</u> because:

- You die;
- You divorce or become legally separated by Court Order from your spouse;
- You become entitled to Medicare; or
- Your dependent child ceases to be eligible for Plan coverage (for example, if he or she reaches the maximum age limit for coverage under the Plan).

You Must Give Notice of a Qualifying Event.

You or your qualified beneficiaries must inform the Plan Manager of your death, divorce, judicial order of legal separation, or entitlement to Medicare, or your child's loss of status as an eligible dependent. To do this, you or your qualified beneficiaries must use the Fund's "Participant's Notice to Plan Manager" form, which can be obtained from the Fund Office. 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 Plan Manager within the time limits may result in your ineligibility for COBRA continuation coverage. The notice should be sent to:

IBEW Local 910 Welfare Fund
Attention: John Love
25001 Water Street
Watertown, NY 13601

After the Plan Manager receives notice of the occurrence of one of the above qualifying events, the Fund 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 Fund 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. You can also request this information at any time by contacting the Plan Manager at the above address.

How is COBRA Continuation Coverage Elected?

Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage.

Spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the COBRA Election Notice will lose his or her right to elect COBRA Continuation Coverage.**

If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. However, the qualified beneficiary may change his or her election within the 60-day period described above as long as the completed COBRA Election Form is received by the Plan Manager on or before the due date. If the qualified beneficiary changes his or her mind after first rejecting COBRA continuation coverage, the qualified beneficiary's COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the election is hand-delivered, the qualified beneficiary's COBRA continuation coverage will begin on the date of delivery.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to, and is actually enrolled in, Medicare benefits or becomes covered under another group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Please note that if the qualified beneficiary is enrolled in Medicare and elects COBRA Continuation Coverage at a time when he or she is not actively employed, COBRA Continuation Coverage will be secondary to Medicare.

If the qualified beneficiary elects COBRA Continuation Coverage, the qualified beneficiary will be entitled to the same health coverage that he or she had when the event occurred that caused his or her health coverage under the Plan to end. The qualified beneficiary will be required to pay for the full cost of such coverage. In addition, if there is a change in the health coverage provided by the Plan to similarly-situated active participants and their families, the same change will be made to the qualified beneficiary's COBRA Continuation Coverage.

How is COBRA Continuation Coverage Paid for?

The amount that your covered spouse and/or dependent children will be required to pay for COBRA Continuation Coverage will be payable monthly. The Plan charges the full cost of coverage for similarly situated participants and beneficiaries who have not lost coverage under the Plan, plus an additional 2% (for a total charge of 102%).
The Fund Office will notify the qualified beneficiary of the cost of the coverage and of any monthly COBRA premium charges at the time the qualified beneficiary receives his or her notice of entitlement to COBRA Continuation Coverage. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Your first payment for COBRA Continuation Coverage does not have to be sent with the COBRA election form. However, the first payment must be made no later than 45 days after the date of the COBRA election. (This is the date that the Election Notice is post-marked, if mailed). Coverage will not be effective until payment is received. **Failure to make the first payment for COBRA Continuation Coverage in full within 45 days after the date of the COBRA election will result in the loss of all COBRA Continuation Coverage rights under the Plan. Once COBRA Continuation rights are terminated, they cannot be reinstated.**

After the first payment is received, payments are due on the first day of each month. There will then be a grace period of 30 days in which to make the payment. Please note that the qualified beneficiary's coverage will be suspended and claims will not be paid until a payment is made to the Fund Office. However, once payment is received, your coverage will be reinstated retroactive to the first day of the month.

If payment of the applicable COBRA Continuation Coverage premium is not made by the end of the applicable grace period, COBRA Continuation Coverage will terminate. Once COBRA Continuation rights are terminated, they cannot be reinstated.

What is the Duration of COBRA Continuation Coverage?

COBRA Continuation Coverage is available for your eligible spouse and dependent children as follows:

COBRA Continuation Coverage is available if coverage would otherwise be lost because:	For up to:
Your dependent child ceases to be eligible for coverage under the Plan.	36 months from the date the child becomes ineligible under the terms of the Plan.
You divorce or legally separate by Court Order from your spouse.	36 months for your spouse and eligible dependent children from the date of divorce or legal separation.
You die.	36 months for your spouse and eligible dependent children from the date of your death.
You become eligible for Medicare.	36 months for your spouse and eligible dependent children from the date of your death.

What Happens When COBRA Continuation Coverage Ends?

Once COBRA Continuation Coverage has been elected, it may be terminated prior to the exhaustion of the 36-month COBRA Continuation Coverage period as a result of the occurrence of any of the following events:

- The premium for coverage is not paid in a timely manner;
- The Plan ceases to provide group health coverage for any retirees;
- After electing COBRA Continuation Coverage, the qualified beneficiary becomes covered by another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have; and/or
- After electing COBRA Continuation Coverage, the qualified beneficiary enrolls in Medicare.

Keep the Plan Informed of Address Changes.

To protect your and your family's rights, the qualified beneficiary should keep the Plan Manager informed of any changes to his or her address and the addresses of family members. The qualified beneficiary should keep a copy, for his or her records, of any notices sent to the Plan Manager. The qualified beneficiary should send all notices to the Plan Manager at the address listed in the ***You Must Give Notice of a Qualifying Event*** paragraph above.

Section IV. Qualified Medical Child Support Order

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled "alternate recipients." Both you and your beneficiaries can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Manager.

Upon receipt of a medical child support order, the Plan Manager will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a Participant under the Welfare Fund and will receive copies of summary plan descriptions, summary annual reports, and summaries of any amendments made to the Plan according to current ERISA requirements.

Section V. Your Rights Under ERISA

As a participant in the I.B.E.W. Local 910 Welfare Fund Retiree-Only 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 plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

- **Continue 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 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits 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 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 575
  Boston, MA 02203
  (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.

Section VI. Claim Procedure

CLAIM PROCEDURE FOR THE HEALTH CARE BENEFIT

All medical claims are processed by EBS-RMSCO, Inc., 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 EBS-RMSCO, Inc. toll free at (866) 616-7225. You may also write to EBS-RMSCO, Inc. at:

EBS-RMSCO, Inc.
115 Continuum Drive
Liverpool, New York 13088

All Health Care claims must be submitted directly to:

EBS-RMSCO, Inc.
115 Continuum Drive
Liverpool, New York 13088

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

PAYMENT OF BENEFITS

How EBS-RMSCO, Inc. 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 EBS-RMSCO, Inc.'s website at www.rsolutionz.com.

If you or your Dependent(s) receive treatment from a member of this Plan's Preferred Provider Network(s), EBS-RMSCO, 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, EBS-RMSCO, Inc. 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 Claim form, be sure that you or your out-of-network provider include:

1. Name of your union – IBEW Local 910.
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 FOR THE PRESCRIPTION DRUG BENEFIT

The prescription drug benefit is administered by Sav-Rx. If you need assistance, or wish a claim form, please call the Member Services phone number (866) 233-4239, found on the back of your identification card. You may obtain claim forms by logging on to the Sav-Rx website, **www.savrx.com**. You may also obtain paper claim forms by writing to:

Sav-Rx
P.O. Box 8
Freemont, NE 68026

You may file for secondary coverage for any eligible dependent who purchases a covered medication. You will need to complete the Sav-Rx claim form, and attach any pharmacy receipts or explanation of benefits. Be sure to provide all information that is requested, including the quantity and days' supply. 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 FOR THE HEALTH EXPENSE BENEFIT

Application for Health Expense Benefits must be made in writing on forms that may be obtained from the Fund Office. Time deadlines for filing, if any, are indicated under the particular Benefit description within this booklet.

Fund Office Claim Payment Procedure

It is the policy of the I.B.E.W. Local 910 Welfare Plan to issue payments for all claims that are

administered by the Fund Office within a period of 30 days from the date of receipt by the Fund Office.

For all claims, the following will be required:

1. Obtain an appropriate claim form(s) from the Fund 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 Fund 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 Care Benefits (Administered by EBS-RMSCO), Health Expense Benefits and Prescription Drug Benefits (Administered by Sav-Rx).

For these medical claims, the rules that apply to denied claims depend on the type of claim. There are generally 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 Pre-Service Claim involving an ongoing course of treatment and care made concurrently with the treatment itself. 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. Pre-Service, Urgent, and Concurrent claims are not Post-Service claims.

Post-Service Claims: For claims not requiring pre-approval, i.e., Post-Service Claims, you will be notified of any adverse benefit determination (by the plan or by the third-party administrator) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the plan's (or the third-party administrator's) control if, before the end of the initial 30-day period, the plan (or the third party administrator) 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. (Note: The Personal Account Plan Health Expense Benefit under this plan does not require pre-approval as a condition of receipt of benefits. Thus, all claims for this

benefit are Post-Service Claims.)

Pre-Service Claims: The receipt of some medical benefits (Health Care and Prescription Drug Benefits) may be conditioned on advance approval from the third-party administrator or prescription benefits manager (PBM). Claims for such benefits are considered Pre-Service Claims, as defined above. For Pre-Service Claims, the following rules apply. Generally, you will be notified of the third party administrator's or prescription benefits manager's determination (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 third-party administrator's or prescription benefits manager'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's or prescription benefits manager 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. If the claim is improperly filed, the third-party administrator or prescription benefits manager will provide notice of the failure within 5 days.

Urgent Care Claims: The rules are slightly different for Pre-Service Claims involving urgent care, i.e., Urgent Care Claims. For such 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.

Concurrent Care Claims: With regard to Concurrent Care claims, if the third-party administrator 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 third-party administrator 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 Sav-Rx at the following address:

P.O. Box 8
Freemont, NE 68026

Telephone: (866) 233-4239
www.savrx.com

If Sav-Rx 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 (315) 782-5941.

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. 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;

6. 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; and

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

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 Care benefit, you must first appeal to EBS-RMSCO, Inc. within 180 days after you receive the initial adverse benefit determination. For Health Care claims other than Urgent Care claims, the Plan employs a two-level appeal process. If you have your first level appeal of a Health Care claim denied, to appeal to the second level of appeal, you must appeal to the Board of Trustees (for Post-Service claims), and to

EBS-RMSCO, Inc.(for Pre-Service claims), within 180 days of the first-level denial. To appeal an adverse determination of a Prescription Drug Benefit, you must write to the Trustees within 180 days after you receive this Plan's initial adverse benefit determination. 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 other appeals 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 Care Benefits: These medical claims are subject to a two-level appeal process, as noted above. At the first level of appeal, EBS-RMSCO, Inc., 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 EBS-RMSCO, Inc., EBS-RMSCO, Inc. will also 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.

Urgent Care Claims: EBS-RMSCO, Inc. 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 Care Benefits: These medical claims are subject to a two-level appeal process, as noted above. At the first level of appeal, EBS-RMSCO, Inc. 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.

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 other 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.

The Trustees are responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees have exclusive authority and discretion: to determine whether an individual 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 this booklets provisions; to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting this Plan; to interpret all the provisions of any other document of instrument involving or impacting the Plan; and, to interpret all of the terms used in this booklet and in all of the other previously-mentioned agreements, documents, and instruments.

All such interpretations and determinations 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; will be given deference in all courts of law, to the greatest extent allowed by applicable law; and will 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

In the event it is determined that a claimant is unable to care for his or her affairs because of illness, accident, or incapacity, either mental or physical, payments due may, unless the claim has been made therefore by a duly appointed guardian, committee, or other legal representatives, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant, as the Trustees will determine in their sole discretion.

COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably

requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulas, methods and procedures as they consider advisable.

CLAIM REPRESENTATIONS

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information, or proof submitted, as well as any benefit payments made in error.

COORDINATION OF BENEFITS WITH OTHER HEALTH INSURANCE

Many times, both husband and wife are covered by more than one health care plan. As a result, two or more plans are paying for the same expense. To avoid this costly problem, your Retiree-Only Plan provides a coordination of benefits provision. The provision affects all your health care benefits.

If you or your dependent is also covered under another plan or policy, 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 "plan" is considered to be any group plan providing health care coverages on an insured or uninsured basis. This includes group Blue Cross, Blue Shield, labor-management trusteed governmental programs, No-fault auto insurance, or any other policy. In the event the covered person has coverage under another employer-sponsored plan that provides health care benefits, there will be coordination of benefits regarding the health care reimbursement of this Plan.

This coordination will apply in the event a covered expense is incurred under this Plan which also is covered under other programs. A determination will be made as to which plan is the "first" plan. The method of determining which plan is "first" is:

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

2. The plan that covers the patient as a current employee is the first plan, regardless of the coordination of benefits provisions or other terms of another plan.

3. If the patient is a dependent child of parents not separated or divorced, then the plan covering the parent whose birth date falls earlier in the calendar year is the first plan. If the parents have the same birthday, the plan that covered the parent longer shall be the first plan. If the other plan does not use the birthday rule, then the birthday rule stated in this plan shall govern unless the first plan is already determined by 1 or 2 above.

When the parents of such dependent are separated or divorced, then the following rules apply:

a) The plan which covers the parent, who has not remarried, with custody of the dependent, is the

first plan.

b) If the parent of the dependent has remarried, the plan which covers the dependent as a dependent of the parent (or step parent) with custody is the first plan.

c) If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the dependent, the plan which covers the dependent as a dependent of the parent with such financial responsibility is the first plan.

4. If the other plan has a provision that it is always secondary, then this Plan will be secondary in coordination with such plan, except as stated above.

5. If none of the above criteria establishes which plan is the first plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the first plan.

If this Plan is the second plan, it will pay its benefits as if there were no other such plan, except that this Plan will pay not more than 100% of the charge when the amount covered by this Plan and another plan(s) are added to the part(s) together.

COORDINATION OF BENEFITS WITH MEDICARE

If Medicare is your primary plan and there are covered charges remaining unpaid (that is, after Medicare has paid or would have paid), you will be reimbursed by the Retiree-Only Plan up to the amount payable under the Retiree-Only Plan provisions. However, the total amount received from Medicare and the plan will never be more than 100% of your "allowable expenses". "Allowable Expenses" means any necessary, reasonable and customary item of expense for medical care and treatment of the type and kind covered under this plan.

This Plan will be primary and Medicare will be secondary for 30 months for eligible individuals under age 65 with Medicare solely because of permanent kidney failure. Thereafter, Medicare will be primary. If you are age 65 and older with end stage renal disease, Medicare will be primary in accordance with applicable law. If you suffer from end stage renal disease before age 65, Medicare will be primary after the coordination period described in the regulations of the Department of Health and Human Services.

It must be stressed that if you are a covered person nearing age 65 you may suffer a loss of benefits if you fail to enroll in Medicare, because, even if you don't enroll in Medicare, claims will be paid as if you had.

When you become eligible for Medicare, you will be considered to be insured under Part A. and B. Medicare. This is regardless of whether or not you have registered for Part A. or enrolled for Part B. We suggest, therefore, that at least 3 months before you reach age 65 or 3 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.

RECOVERY OF OVERPAYMENTS AND MISTAKEN PAYMENTS

In the event that you or a third party are paid benefits from the Fund in an improper amount or

otherwise receive Fund assets not in compliance with the Plan (hereinafter "overpayments" or "mistaken payments"), the Fund has the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to you or to a third party. You, the third party, or the individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Fund with interest at 18% per year. This recovery may be made by reducing other benefit payments made to or on behalf of you or your dependents by commencing a legal action or by any other method the Trustees determine to be appropriate. You, the third party, or other individual or entity shall reimburse the Fund for attorney's fees, 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.

CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all pensioners and their covered dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all pensioners and covered dependents.

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

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 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, 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 on your behalf under these circumstances. The Fund must be reimbursed from any settlement, judgment or other payment that you obtain from the liable third party before any other expenses, including attorneys' fees, are taken out of the payment. The 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. The Plan's Subrogation Agreement must be signed by you and your attorneys and received at the Fund

Office on the earlier of either (1) one year from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Subrogation Agreement to be signed or no Benefits will be paid by the Plan for the expenses related to that accident. You must also notify the Fund before you retain another attorney or an additional attorney since that attorney must also 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. The Plan'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. In enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not limited by any determination of the trier of fact as to the causal relationship between the injuries giving rise to these expenses and the liability of the third party if evidence exists which, in the opinion of the Trustees, supports causation.

RIGHTS OF FUTURE SUBROGATION AND REIMBURSEMENT

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

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 written consent of the Plan.

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

If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Fund for the reimbursement owed to this Fund by the third party as well as for the Plan's attorney's fees and costs incurred in recovering that amount. This Fund may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you. The reimbursement owed to the Plan may also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with overpayments and mistaken payments.

VII. Protected Health Information

This Section describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your protected health information.

A. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR.

The Plan shall disclose protected health information to the Plan Sponsor only to the extent necessary for the Plan Sponsor to perform the following Plan administrative functions:

1. Review Benefit claims in regards to a claim denial, complaint, or an Appeal; and

2. To proceed under the Appeal Process under the Plan which is described in Section VI.

B. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PLAN SPONSOR.

The Plan Sponsor shall use and/or disclose protected health information only to the extent necessary to perform the following Plan Administration functions, which it performs on behalf of the Plan:

1. Address changes;

2. Eligibility/benefit;

3. Student status;

4. Provider lookup;

5. Billing;

6. New enrollment;

7. Reinstatements;

8. Order I.D. cards;

9. Add dependent;

10. Terminations eligibility;

11. Benefit claims;

12. Monitor personal account balances for the purpose of paying health premiums; and

13. Contact service providers for the purpose of verifying service dates co-pays.

C. PLAN SPONSOR CERTIFICATION.

The Plan agrees that it will only disclose protected health information to the Plan Sponsor (which is the Board of Trustees), subject to the following:

1. Prohibition on Unauthorized Use or Disclosure of Protected Health Information.

The Plan Sponsor will not use or disclose any protected health information received from the Plan, except as permitted in these provisions or required by law. When used in this Section, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

2. Subcontractors and Agents.

The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide protected health information to agree to written contractual provisions that impose at least the same obligations to protect protected health information as are imposed on the Plan Sponsor.

3. Permitted Purposes.

The Plan Sponsor will not use or disclose protected health information for employment-related actions and decisions or in connection with any other of Plan Sponsor's benefits or employee benefit plans.

4. Reporting.

The Plan Sponsor will report to the Plan any impermissible or improper use or disclosure of protected health information not authorized by the plan documents.

5. Access to Protected Health Information.

The Plan Sponsor will make protected health information available to the Plan to permit Participants to inspect and copy their protected health information contained in the designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits.

6. Correction of Protected Health Information.

The Plan Sponsor will make a Participant's protected health information available to the Plan to permit Participants to amend or correct protected health information contained in the designated record set that is inaccurate or incomplete and the Plan Sponsor will incorporate amendments provided by the Plan.

7. Accounting of Protected Health Information.

The Plan Sponsor will make a Participant's protected health information available to permit the Plan to provide an accounting of disclosures.

8. Disclosure to Government Agencies.

The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of protected health information available to the Plan and to the U.S. Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA.

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Fund will be required to operate. For example, where such laws have been enacted, the Fund will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

9. Return or Destruction of Health Information.

When the protected health information is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all protected health information that the Plan Sponsor received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the protected health information. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

10. Minimum Necessary Requests.

The Plan Sponsor will use best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested.

D. ADEQUATE SEPARATION.

The Plan Sponsor represents that adequate separation exists between the Plan and Plan Sponsor so that protected health information will be used only for plan administration. The following employees or persons under the control of the Plan Sponsor have access to Participants' protected health information for the purposes set forth above:

John Love, Plan Manager

E. ADEQUATE SEPARATION CERTIFICATION.

The Plan requires the Plan Sponsor to certify that the employee identified above is the only employee that will access and use Participants' protected health information. The Plan Sponsor must further certify that the above employee will only access and use protected health information for the purposes set forth above.

F. REPORTS OF NON-COMPLIANCE.

Anyone who suspects an improper use or disclosure of protected health information may report the occurrence to the Plan's Privacy Official at the I.B.E.W. Local 910 Welfare Fund Office at (315) 782-5941. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Section VIII. Technical Details

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

1. PLAN NAME: I.B.E.W. Local 910 Welfare Fund Retiree-Only Plan.

2. EDITION DATE: This summary plan description is produced as of January 1, 2014.

3. PLAN SPONSOR: Board of Trustees of I.B.E.W. Local 910 Welfare Fund.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 16-6053626.

5. PLAN NUMBER: 501 (assigned by federal government)

6. TYPE OF PLAN: Welfare Plan

7. PLAN YEAR ENDS: June 30.

8. PLAN ADMINISTRATOR: Board of Trustees of the I.B.E.W. Local 910 Welfare Fund, 25001 Water Street, Watertown, New York 13601.

9. AGENT FOR THE SERVICE OF LEGAL PROCESS: Mr. John Love, Plan Manager, 25001 Water Street, Watertown, New York 13601.

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

10. TYPE OF PLAN ADMINISTRATION: Direct employees of the Board of Trustees.

11. TYPE OF FUNDING: Self-insured.

12. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the I.B.E.W. Local 910 Welfare Fund while participants were previously active employees, certain benefit funds with whom this Fund has reciprocal agreements, and participants.

13. COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with

collective bargaining agreements. A copy of these agreements may be obtained by you upon written request to the Plan Manager and is available for examination by you at the Fund 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 910 Welfare Fund.

16. THIRD-PARTY ADMINISTRATOR: EBS-RMSCO, Inc., Attn: Group Claims, P.O. Box 6309, Syracuse New York 13217-6309, telephone number: (315) 448-9070, toll free number: (800) 889-4520, website: www.rsolutionz.com.

17. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: See Sections I. & II. of this booklet.

18. HOW TO FILE A CLAIM: See Section VI. of this booklet.

18. REVIEW OF CLAIM DENIAL: See Section VI. of this booklet.

19. NO INSURANCE UNDER THE PGBC: 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. The following are the individual Trustees that make up the Board as of January 1, 2014.

Employer	***Employee***
Leo J. Villeneuve Route #1 Colton, NY 13625	Andrew VanTassel 603 Main Street Morristown, NY 13664
James A. Williams 6184 State Hwy. 56 Potsdam, NY 13676	Elizabeth Cassada 15662 US Route 11 Watertown, NY 13601
Curtis M. Hammond PO Box 383 Ogdensburg, NY 13669	John T. O'Driscoll 25001 Water St. Watertown, NY 13601