SUMMARY PLAN DESCRIPTION

DENTAL BENEFIT FUND

OF THE ELECTRICAL INDUSTRY

NECA
NEW YORK
NATIONAL ELECTRICAL
CONTRACTORS ASSOCIATION
NEW YORK CITY CHAPTER

MAY 13, 2010

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This booklet is the Summary Plan Description ("SPD") of the Dental Benefit Fund of the Electrical Industry (Plan). This Summary Plan Description is presented to Participants and eligible dependents to explain, in plain language, who is eligible to receive benefits under the Plan, how to apply for benefits and what your rights are under the Employee Retirement Income Security Act of 1974, as amended (ERISA). This information applies to the Plan effective as of May 13, 2010, except as noted herein.

GENERAL INFORMATION

Name of Plan:	Dental Benefit Fund of the Electrical Industry
Plan Sponsor Identification No.	11-2585905
Plan Number:	507
Plan Year:	July 1 through June 30
Plan Administrator and Agent for Legal Process:	Joint Industry Board of the Electrical Industry 158-11 Harry Van Arsdale Jr. Avenue Flushing, N.Y. 11365 (718) 591-2000 Service may also be made on any Trustee at 158-11 Harry Van Arsdale Jr. Avenue Flushing, NY 11365
Type of Plan:	Multiemployer/employee welfare benefit Plan providing dental benefits to covered employees and their eligible dependents.

Type of Administration: The Plan is maintained by a Joint Board of Trustees whose names and office addresses are listed below:

GINA ADDEO
GMA Electrical Corp.
201 Edward Curry Avenue
Staten Island, NY 10314-7114

ROBERT AMABILE
S.J. Electric
228 Merrick Road
Lynbrook, NY 11563

KEITH D. CARNEY
Welsbach Electric Corp.
111-01 14 Avenue
College Point, NY 11356

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Gilston Electric
338 E. 95 Street
New York, NY 10028

JOHN MANNINO
Up Town Electric Inc.
128-20 14 Avenue
College Point, NY 11356

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Aurora Electric Inc.
JFK Airport, Bldg. 141
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Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
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Assistant Business Manager
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, NY 11365

SOURCES OF CONTRIBUTIONS

The Plan was established and is maintained under Collective Bargaining Agreements between Local Union No. 3, I.B.E.W., AFL-CIO ("The Union"), 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, and New York Electrical Contractors Association, Inc., 1430 Broadway, 8th Floor, New York, NY 10018, Association of Electrical Contractors, Inc., 36-36 33 Street #402, Long Island City, NY 11106, and other employers who are not members of the two Associations. Upon a written request from any Participant or beneficiary, the Plan Administrator will state in writing whether a particular employer is obligated to contribute to the Plan, the employer's principal business address and the level of benefits applicable to the particular employer. The Plan Administrator will also provide upon a written request from a Participant or beneficiary, a copy of the Collective Bargaining Agreement between the Union and the Participant's employer. Copies of Collective Bargaining Agreements are available for inspection at the office of the Plan Administrator during normal business hours.

SOURCE OF BENEFITS

The dental benefits available under the Plan are provided by Empire Blue Cross and Blue Shield and DDS, Inc. The Plan has a contract with both Administrators who will provide the benefits described herein as effective May 13, 2010. The Trustees may change these benefits or the Administrators at any time, but will give Participants written notice if a change is made.

DENTAL BENEFIT PROGRAMS

The Dental Benefit Fund of the Electrical Industry provides three optional programs under which a Participant may elect to be covered as follows:

1. EMPIRE BLUE CROSS AND BLUE SHIELD FEE-FOR-SERVICE PROGRAM

This fee-for-service program covers a complete range of dental services performed by a duly licensed dentist anywhere in the world. A partial schedule of covered services is listed in this booklet. Under this program, you may visit the dentist of your choice. You are responsible for the

payment of fees that exceed the Plan's maximum allowance per procedure, as well as for costs exceeding the calendar year limit applicable to covered prosthetic services and the lifetime limit covering orthodontic services.

2. EMPIRE DENTAL MANAGED NETWORK PROGRAM

This alternative dental delivery system uses a network of dental offices throughout New York and New Jersey and is administered by Empire Blue Cross and Blue Shield. Each year, you and your eligible dependents are able to choose from a list of network-affiliated dental offices. **Once enrolled, you and your family must remain with the office you have selected for one year.** Under this program, individuals are encouraged to obtain preventive dental care. There are no out-of-pocket expenses for covered services except for general anesthesia and the annual and lifetime limitations applicable to prosthetic and orthodontic services.

3. DDS INC. PROGRAM

This alternative dental delivery system has a panel of private practice dentists in the New York/New Jersey metropolitan area who have agreed to accept assignment as payment in full for covered services. Unlike the Empire network, there is no specified time period for your selection of a particular DDS dentist. Instead, you may choose a different dentist whenever you need to have dental work performed. Under this option, there are no out-of-pocket expenses, except for the annual and lifetime limitations applicable to prosthetic and orthodontic services. **If you elect to enroll in the Empire Dental Managed Network Program, you are not eligible to use the DDS Inc. panel.**

ELIGIBILITY FOR BENEFITS

The following eligibility rules apply to Participants who are or were covered under a Collective Bargaining Agreement that is recognized by the Plan, and to those employed by the Union and the Joint Industry Board. In addition, certain non-bargaining unit employees, as described on page 6 may also be covered by the Plan. In order to receive the benefits provided by the Plan, you must be an "eligible Participant," either active or retired.

Unless specifically provided elsewhere, initial eligibility is attained by having worked for a Contributing Employer to this Plan, the Union, the Joint Industry Board or other employer that has signed a Participation Agreement for at least 26 consecutive weeks on a full-time basis, during which time contributions were received on your behalf, unless the contribution requirement is waived by the Trustees. Thereafter, a Participant must have been employed on a full-time basis during which time contributions were made to this Plan for at least 26 consecutive weeks immediately prior to incurring a reimbursable expense, or, if unemployed during all or any portion of such period, the Participant must have been registered as available for employment with the Joint Industry Board Employment Department or with the Union's designated referral service.

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

Eligibility for benefits terminates as of the day when contributions cease to be made on behalf of the Participant. However, a Participant who is covered by a Local 3 Collective Bargaining Agreement and who is unemployed and has registered with the designated referral service as available for employment can remain eligible under this Plan for up to 52 weeks after the period for which the last contribution was made to the Plan.

A Participant on whose behalf contributions are no longer being made, who restricts availability for employment to a specific type of job, location or time will not be deemed to be available and will cease to be covered as of the date such restriction occurs. Participants will be responsible for expenses incurred and any benefit payments erroneously made by the Plan after eligibility for coverage terminates.

Benefits may be reinstated following a termination of eligibility once the Participant works again for a Contributing Employer to this Plan, the Union, the Joint Industry Board or other employer that has signed a Participation Agreement for at least 26 consecutive weeks (or as otherwise noted in a Participation Agreement).

However, if a Participant who was covered by the Plan loses coverage due to being unemployed, after 52-weeks such person shall be reinstated

to coverage if he/she was continually registered as available for employment with the Joint Industry Board Employment Department or applicable employment department and has 26 weeks of Employer contributions, which need not be consecutive, remitted to the Plans within a subsequent 18-month period. The 18-month period will begin when the participant is first re-employed. This provision will remain in effect through May 8, 2013.

You are an eligible retired Participant if you are receiving a Standard Pension, Early Retirement Standard Pension or Disability Pension under the Pension Trust Fund of the Electrical Industry and were covered under this Pension, Hospitalization and Benefit Plan immediately prior to the effective date of retirement. Except as provided in the next sentence, a Participant who is receiving an Early Retirement Standard Pension will cease to be entitled to any health benefits under this Pension, Hospitalization and Benefit Plan if employed in any capacity and will not be eligible for reinstatement, even after he or she terminates employment. Notwithstanding the previous sentence, those Participants who retire between ages 58 – 60 on June 1, 2007 or later on an Early Retirement Standard Pension shall be able to work outside the electrical industry and maintain their eligibility for health coverage under this Plan. If health coverage is provided by the new employer, please see the Coordination of Benefits section on pages 17-19.

An employer making contributions under a Collective Bargaining Agreement may elect to remit premium payments to the Plan for all eligible non-bargaining unit employees that are exempt, confidential or supervisory employees, as defined by the National Labor Relations Act and who perform job functions which are directly related to or in direct support of the work performed by bargaining unit employees upon whose behalf contributions are made by the participating employer. The premium rate will be established by the Plan. An employer who elects coverage for such non-bargaining unit employees will be responsible for remitting premium payments as of the first of the month following approval of the application form for all of its non-bargaining unit employees. The employee will be eligible for all benefits under this Plan only after six consecutive months of premium payments have been remitted. Employees of the Joint Industry Board of the Electrical Industry ("Joint Board") and the Union are also eligible for coverage under the Plan if their employers contribute to the Plan at the rates established by the Plan on behalf of such employees. Employees of the

Union and the Joint Board will be eligible for all benefits under the Plan only after six consecutive months of contributions have been paid on their behalf.

DEPENDENTS' ELIGIBILITY

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

Eligible dependents are:

1. Your lawful spouse. For purposes of this section, a spouse is the person to whom you are legally married. Please note that, effective October 1, 2011, while the Plan recognizes legally married same gender spouses, IRS tax requirements regarding health benefits will apply.

2. Your unmarried children from birth up to their 19th birthday. However, full-time unmarried dependent students attending approved institutions of higher learning shall be covered up to age 25.

   An original letter from the registrar's office of the applicable institution shall be required as proof of current college or school attendance after each spring and fall semester commences. Dental expenses incurred during the months of July and August will be processed after receiving the necessary documentation of a child's full-time student status for the next semester.

   The term "children" shall mean natural or legally adopted children. A child may be considered an eligible dependent on the conditional basis that proof of a pending adoption proceeding is submitted to the Plan Administrator and the Participant periodically furnishes the Plan Administrator with information as to the status of the proceeding and demonstrating that the Participant is actively pursing a final adoption decree.

3. Your spouse and eligible children for up to 36 months following your death, or until your spouse remarries, if sooner. If after 36

months your surviving spouse has not remarried, he or she may elect to purchase coverage for him or herself and/or eligible children for the rest of his or her life, or until remarriage, by paying the premium rates established by the Plan. Notwithstanding the foregoing, if your surviving spouse remarries during the first 36 months after your death, he or she will be entitled to purchase coverage for him or herself and/or eligible children for the balance of the 36 months (even though he or she is remarried) under COBRA. (See pages 21-27 for more details on COBRA.)

4. Effective June 1, 2010, coverage will be extended to your spouse and eligible children for up to 60 months following your death, **if your death occurs while you were actively employed or registered as available for employment,** or until your spouse remarries, if sooner. If after 60 months your surviving spouse has not remarried, he or she may elect to purchase coverage for him or herself and/or eligible children for the rest of his or her life, or until remarriage, by paying the premium rates established by the Plan. Notwithstanding the foregoing, if your surviving spouse remarries during the first 60 months after your death **while actively employed or registered as available for employment**, he or she will be entitled to purchase coverage for him or herself for the balance of the 60 months under COBRA. (See pages 21-27 for more details on COBRA.)

5. If a Participant dies while at work as a result of injuries suffered at work, the surviving spouse and dependent children will be entitled to full benefits subject to the following:

    a. Benefits to the spouse shall continue for his or her life unless he or she remarries; upon remarriage the benefits will cease, and
    b. Benefits to the dependent children shall continue in accordance with the rules of the Plan as if the Participant was still alive, regardless of whether the surviving spouse remarries or dies.

6. Your stepchildren, if you elect to purchase coverage for them at the premium rates established by the Plan; provided, however, that you show proof to the Plan that no other group coverage is

available to such children. Stepchildren are covered for the same period as natural or adopted children, as described in paragraph 2.

If an eligible Participant needs to add a new dependent, the Participant may enroll the dependent by submitting to the Members' Records Department of the Joint Industry Board, at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, a copy of the marriage or birth certificate, as applicable. Coverage is effective as of the date of marriage or birth of a natural child only, provided the Participant was then eligible. During a pending adoption proceeding, eligibility will begin when the process commences and not as of the date of birth. Dependent eligibility terminates at the same time as the Participant's eligibility.

DENTAL FEE-FOR-SERVICE PROGRAM

A summary of Covered Dental Services, How To Obtain Benefits and a Partial Schedule Of Allowances, all pertaining to the Dental Fee-For-Service Program, follows:

COVERED DENTAL SERVICES

A) Diagnostic and Preventive Services
   1. Clinical Oral Examinations
      - not more than twice annually
   2. Cleaning, Scaling and Polishing
      - not more than twice annually
   3. Fluoride Treatment (up to age 19)
   4. X-rays

B) Palliative Services
   - Emergency treatment for relief of pain

C) Restorative Services
   - Fillings, amalgam or tooth coloring
   - Stainless steel crowns (up to age 19)

D) Oral Surgery
   - Extractions
   - Fractures
   - Other oral surgical procedures

E) Endodontic Services
- Root Canal treatment

F) Space Maintainers
- Simple (up to age 19)

G) Periodontic Services
- Curettage
- Gum Surgery

H) Repair of Dentures and Bridges
- Repair of broken full or partial dentures
- Repair of bridgework

I) Prosthetic Services
- Dentures, full or partial (once in 4 years)
- Crowns and inlays (once in 5 years)
- Bridges, fixed or removable (once in 5 years)
- Implants (once in 5 years)

J) Orthodontics
- Diagnosis
- Active treatment
- Retention treatment

HOW TO OBTAIN BENEFITS UNDER THE FEE-FOR-SERVICE PROGRAM

When you know that it will be necessary for you or an eligible dependent to be treated by a dentist, or in cases where emergency treatment was performed, you should get a Dental Claim Report form from the Joint Industry Board Members' Records Department at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, or visit the JIB website at www.jibei.org.

You fill out the patient's portion of the form and the dentist completes the rest. The dentist should keep one copy for his records. The form should then be sent to Empire Blue Cross and Blue Shield Dental Benefit Program located at P.O. Box 791, Minneapolis, MN 55440-0791.

Pre-Determination of Benefits is required for all Prosthetic and Orthodontic Procedures.

The pre-determination of benefits procedure requires that your dentist fill out a claim form (Treatment Plan), before treatment is begun. Be sure that the dentist includes the patient's X-rays. This will reduce the processing time. The Treatment Plan and X-rays should be sent directly to the Empire Blue Cross and Blue Shield Dental Benefit Program.

The Dental Fee-For-Service Program will process the Treatment Plan and the dentist will receive a pre-determination of benefits form showing which services are covered by the Program. Services not covered will also be indicated on the form. When treatment is completed, the dentist must insert the dates the authorized services were performed and return the pre-determination of benefits form for payment.

All claim forms received are processed for payment, screened for completeness, coded, numbered, microfilmed, checked for eligibility, reviewed for coverage and approved for payment or rejected. Both you and, in all instances, your dentist are advised of the approval or rejection of benefits and the payment is made to the appropriate party.

SUMMARY OF ALLOWANCES OF COVERED DENTAL SERVICES BASIC SERVICES

PROCEDURE	MAXIMUM ALLOWANCE
A. DIAGNOSTIC AND PREVENTIVE SERVICES	
Comprehensive oral examination (Not more than twice annually)	$44.00
Periodic Oral Exam	$33.00
(Limit 2 exams annually)	
Cleaning, scaling and polishing (Not more than twice annually)	
Adults	$64.00
Children	$45.00
X-Rays - periapical first film, individual films not to exceed the allowance for full mouth series (10 or more films)	$19.00
Full mouth complete series - not more than one in three years	$84.00
Fluoride treatment up to age 19	$31.00
Bitewing First film	$14.00
Two Films	$25.00
Periapical, single First film	$19.00
Each additional film	$15.00
Intraoral occlusal (edentulous jaw) each	$31.00
B. PALLIATIVE SERVICES	
Emergency treatment for relief of pain	$57.00
C. RESTORATIVE SERVICES	
Fillings	
Silver Fillings (Permanent Tooth) One surface	$65.00
Two surfaces	$92.00
Three or more surfaces	$118.00
Tooth color fillings (Resin)	
Per filling - 1 surface anterior	$87.00
Stainless steel crowns, each (up to age 19)	$165.00

PROCEDURE	MAXIMUM ALLOWANCE
D. ORAL SURGERY – INCLUDING X-RAYS, ANESTHESIA AND POST-OPERATIVE TREATMENT	
Extractions Routine or simple	$92.00
Soft tissue impaction	$226.00
Partial bony impaction	$321.00
Complete bony impaction	$420.00
Other oral surgical procedures:	
Alveoloplasty not in conjunction with extractions per quadrant	$321.00
Alveoloplasty in conjunction with extractions per quadrant	$190.00
Apicoectomy	$436.00
Biopsy, including report	
Hard tissue	$234.00
Soft tissue	$182.00
Frenulectomy	$283.00
E. ROOT CANAL TREATMENT – INCLUDING X-RAYS AND FOLLOW-UP CARE	
Anterior (excluding Final Restoration)	$449.00
Bicuspid (excluding Final Restoration)	$513.00
Molar (excluding Final Restoration)	$658.00
F. SPACE MAINTAINERS, SIMPLE (UP TO AGE 19)	
Fixed (unilateral)	$252.00
Fixed (bilateral)	$327.00
Removable (unilateral)	$209.00
Removable (bilateral)	$293.00
G. PERIODONTIC SERVICES (TREATMENT OF GUMS AND ASSOCIATED TISSUES)	
Periodontal root scaling and Planing, including medications One to three teeth Per Quadrant	$67.00
Periodontal root scaling and Planing, including medications Four or more teeth Per Quadrant	$111.00
Gum or bone surgery, including post-operative visits (per quadrant)	
Four or more teeth Per Quadrant Gingivectomy	$360.00
Four or more teeth Per Quadrant Osseous surgery	$708.00

PROCEDURE	MAXIMUM ALLOWANCE

H. REPAIR OF DENTURES AND BRIDGES

Repairs to Partial Dentures

Repair acrylic saddle or base	$100.00
Repair cast framework	$119.00
Repair or replace broken clasp	$107.00
Replace broken teeth - per tooth	$67.00
Add tooth to existing partial denture	$94.00
Add clasp to existing partial denture	$117.00

Relining upper or lower full or partial denture

Full upper	$189.00
Partial upper	$177.00
Recement crowns	$55.00
Recement inlays	$61.00

PROSTHETIC SERVICES

The maximum amount payable for Covered Prosthetic Services is $4,000 per calendar year. Each covered member of the family is entitled to a separate maximum.

A. INLAYS, METALLIC

One Surface	$413.00
Two Surfaces	$550.00
Three or more surfaces metallic, Maximum per tooth	$641.00

B. DENTURES, FULL (Including supplying, inserting, fitting and adjustments)

1.	Upper, once in four years	$867.00
2.	Lower, once in four years	$867.00

PROCEDURE	MAXIMUM ALLOWANCE

C. DENTURES, PARTIAL

Bilateral acrylic or comparable base, either jaw, two or more full clasps, and rests, each $692.00

Upper bilateral, cast metal framework, two or more clasps and rests, acrylic attachment, each $910.00

Lower, bilateral, cast metal framework, two or more cast clasps and rests, acrylic attachment, each $884.00

D. CROWN AND BRIDGEWORK

1. REMOVABLE Unilateral
(one piece casting with clasps and rests)
One tooth replaced $543.00

2. FIXED Partial Denture retainers - crowns
(a) Three-quarter crown $726.00
(b) Full cast crown $787.00

3. PONTICS
(a) Pontic (porcelain facing with cast backing)..... $661.00
(b) Pontic (cast high noble metal) $770.00

4. CROWNS
Porcelain jacket $747.00

E. IMPLANT AND ASSOCIATED SERVICES

Implants $750.00
(Associated abutments are covered as per fee schedule.)
(Associated bone graft is covered as per fee schedule.)

ORTHODONTIC BENEFITS

Orthodontics provides for the correction of irregularities in the positioning of teeth. Orthodontic services will be provided subject to the following:

A. The need for Orthodontic Services must be diagnosed by a dentist and must indicate that the orthodontic condition consists of handicapping malocclusion, which is abnormal and is correctable.

B. A Detailed Treatment Plan must be submitted to Empire Blue Cross and Blue Shield and approved prior to the commencement of treatment.

The benefits provided will be:

For handicapping malocclusion

1. For diagnosis, including models and photographs, all necessary appliances and all adjustments (not to exceed 24 months) ..... $ 147.00 Per Month
2. For retention treatment following active treatment (not to exceed 24 months) ..... $ 20.00 Per month

3. Maximum Amount Payable..... $ 4,000.00

The maximum number of months for which benefits will be provided for active or retention treatment will be reduced by the number of months of such treatment received before commencement of coverage.

Exclusions and limitations:

If orthodontic services are terminated before completion of the approved orthodontic treatment for any reason, the responsibility of the program will cease with payment through the month of termination.

Any charges for the replacement and/or repair of any appliances furnished under the Treatment Plan will be excluded.

THE EMPIRE BLUE CROSS AND BLUE SHIELD DENTAL MANAGED NETWORK PROGRAM

HOW TO OBTAIN BENEFITS UNDER THE EMPIRE BLUE CROSS AND BLUE SHIELD DENTAL MANAGED NETWORK PROGRAM

Participants are permitted to elect coverage under this network and may do so by requesting an enrollment form from the Members' Records Department at the Joint Industry Board. Once you have elected to enroll in this program, you (and all of your eligible dependents) must continue to stay enrolled in the program for a minimum of one year. Instead of receiving a fixed reimbursement amount for a given dental service under this network, you receive necessary covered dental care on a prepaid basis through a network of private dental offices. For as long as you are enrolled, you will receive all necessary covered dental services at the office selected by you, except for specialty care arranged for you by your network dentist or for an out-of-area emergency. No pre-certification or claim form is required. All Plan limits as described in this booklet apply to this program.

THE DDS, INC. PROGRAM

If you are not enrolled in the Empire Blue Cross and Blue Shield Dental Managed Network Program, you may enroll in the DDS, Inc. program at any time during the year by calling the Members' Records Department at the Joint Industry Board of the Electrical Industry. You will be given a number to call that will enable you to select a dentist from the DDS Panel. Once eligibility has been verified with the Members' Records Department, simply contact the DDS provider you have selected and make an appointment. No pre-certification or claim form is required.

COORDINATION OF BENEFITS

Occasionally, a Participant or eligible dependent entitled to receive benefits under this Plan will also be eligible for health benefits under another group health Plan. If this happens, the two Plans will coordinate their benefit payments so that the combined payments of both Plans will not exceed the actual expenses incurred by the Participant or eligible dependent. One Plan (*the primary Plan*) will pay its full benefits. The other Plan (*the secondary Plan*) will pay any expenses in excess of the

primary Plan's benefits, up to a maximum amount that it would pay if the Coordination of Benefits ("COB") provision was not in effect. A Participant *must* report other group coverage on the claim form submitted for reimbursement of dental expenses.

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

1. A Plan with no rules for coordination with other benefit Plans will be deemed to pay its benefits before a Plan that contains such rules.

2. A Plan that covers a person other than as a dependent will be deemed to pay its benefits before a Plan that covers the person as a dependent. For example: If Participant John's spouse Mary, is covered for health insurance through her job, her own insurance would be her primary Plan and this Plan (John's health coverage) would be her secondary Plan.

3. A Plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the Plan that covers the person as a dependent of a person whose birthday comes later in that calendar year. If a Plan does not have this provision regarding birthdays, then the rule set forth in that Plan will determine the order of benefits. For example: using the situation in item 2 above, John's birthday is January 1 and Mary's birthday is June 1. John's insurance would be primary for their children because it comes first in the calendar year. Mary's insurance would be secondary for their children.

If 1, 2 and 3 above do not establish an order of payment, the Plan under which the person has been covered for the longest will be deemed to pay its benefits first, except that the benefits of a Plan which covers the person as a retired employee or the dependent of such person shall be determined after the benefits of any other Plan which covers such person as an employee who is not retired or a dependent of such person. If either Plan does not have a provision regarding employees and as a result each Plan determines its benefits after the other, then the preceding sentence will not apply.

The benefits of a Plan which covers the person as a retired employee or the dependent of such person shall be determined after the benefits of any other Plan which covers such person as an employee who is not retired or a dependent of such person. If either Plan does not have a

provision regarding retired employees and as a result each Plan determines its benefits after the other, then the preceding sentence will not apply. For purposes of this section, another group Plan includes any Plan of dental or medical expense coverage for individuals in a group or "no-fault" automobile reparations insurance that is required under any law of a government. Individual policies are not subject to the Coordination of Benefits Provision.

LIMITATIONS OF BENEFITS

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

- Dental services received from a dental or medical department maintained by or on behalf of an employer, an actual benefit association, labor union, trustee or similar person or group;
- Dental services for which the subscriber incurs no charge;
- Dental services for which coverage is available to the subscriber, in whole or in part, under any Workers' Compensation Law or similar legislation whether or not the subscriber claims compensation or receives benefits hereunder;
- Dental services primarily for cosmetic surgery, except essential reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
- Dental services furnished or available to a subscriber in whole or in part under the laws of the United States, or any state, or political subdivision thereof (except Medicaid) or for which the subscriber would have no legal obligation to pay in the absence of this or any similar coverage;
- Dental services rendered by a dentist beyond the scope of his license;
- Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage existed hereunder;
- Gold foil restorations;
- Dental services not considered within the scope of normal good dental practice or which are inconsistent with the highest ethical standards of the dental profession;

- Dental services other than those specifically listed as Covered Dental Services;
- Any loss, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable;
- General anesthesia;
- Re-treatment of root canals.

The above-mentioned list of exclusions is provided for illustrative purposes and is not all inclusive. You should always contact Empire Blue Cross/Blue Shield or DDS, Inc. for verification as to a covered service or provider.

PARTICIPANTS RECEIVING WORKERS' COMPENSATION BENEFITS

An eligible Participant who is unable to work due to a work-related injury and is receiving workers' compensation benefits, shall remain eligible for coverage under this Plan until the earlier of:

- The date on which the Participant ceases to be eligible for workers' compensation benefits; or
- The date which is two years following the date on which the Participant first became unable to work because of the injury, including all periods during which workers' compensation benefits were received.

A Participant who ceases being eligible for workers' compensation benefits prior to receiving 24 months of benefits shall then be entitled to purchase coverage for up to 18 months, pursuant to continuation coverage provisions referred to on pages 21-27.

A Participant who receives more than 24 months of workers' compensation benefits shall be entitled to purchase coverage for up to 18 months. If the Participant is still receiving workers' compensation benefits after the 18 month period, he or she will be entitled to continue purchasing such coverage as long as proof of the workers' compensation payment is furnished to the Dental Committee.

PARTICIPANTS WHO ARE DISABLED

An eligible Participant who is unable to work and is receiving disability benefits or is disabled shall remain eligible for coverage under this Plan until the earlier of:

1. The date on which the Participant ceases to be eligible for disability benefits; or

2. The date which is two years following the date on which the Participant first became unable to work, including all periods during which the Participant received disability benefits and furnished evidence to the Dental Committee that he was disabled.

If such Participant remains disabled after receiving 26 weeks of disability payments, he or she may continue to be covered under this Plan for up to a total of 24 months, as long as the Participant submits proof of the disability on a monthly basis to the Dental Committee. After 24 months of being disabled, a Participant may purchase continuation coverage under the Plan for up to 18 months, pursuant to continuation coverage provisions referred to in the next section. If such Participant is still totally disabled after this period of time, the Participant may continue to purchase coverage on a monthly basis for as long as he is able to furnish proof of the disability to the Dental Committee.

IMPORTANT NOTE:
Any extension of health coverage immediately prior or during the period when the Participant is collecting Workers' Compensation payments or is disabled, as a result of the Participants' being unemployed and available for employment will be credited as part of the extension of health coverage for 24 months.

COBRA CONTINUATION COVERAGE

INTRODUCTION

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The following generally explains COBRA continuation

coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this entire booklet or contact the Plan Administrator.

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

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

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

Your spouse's hours of employment are reduced;

Your spouse's employment ends for any reason other than his or her gross misconduct;

Your spouse dies; or

You become divorced from your spouse.

Note that if you are the spouse of a Participant who dies, you will receive 36 or 60 months of coverage (depending on the event) at no expense (or until the date of your remarriage if sooner). See pages 7 and 8 for a description of the Plan's coverage of surviving spouses and children following the death of a Participant.

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

The parent-employee dies;

The parent-employee's hours of employment are reduced;

The parent-employee's employment ends for any reason other than his or her gross misconduct;

The parents become divorced; or

The child stops being eligible for coverage under the Plan as a "dependent child."

Again, as with the surviving spouse coverage, the Plan provides up to 36 months of continued coverage (or until the surviving spouse remarries, if

sooner) at no expense to dependent children of a Participant who dies. See pages 7 and 8 for a description of these provisions.

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

You Must Give Notice of Some Qualifying Events

If the event pertains to the divorce of the employee and spouse or a dependent child's loss of coverage, the Participant or a family member must notify the Joint Industry Board in writing within 60 days after the date of the divorce or loss of eligibility as a dependent child. You must provide this notice to: Members' Records Department of the Joint Industry Board of the Electrical Industry, 158-11 Harry Van Arsdale Jr. Ave., Flushing, NY 11365. The notice must identify the qualifying event, the date on which it occurred and the names of the covered individual(s) whose coverage under the Plan will be lost due to the qualifying event. If the qualifying event is a divorce, you must include with your notice a copy of the divorce decree. If the qualifying event is a dependent child's losing eligibility for coverage as a dependent child, you must identify the child's date of birth and the last date that the child was a full-time student.

How Is COBRA Coverage Provided?

Once the Joint Industry Board determines that there has been a death, reduction in hours or termination of employment, or it is notified that a divorce or loss of eligibility status has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Do I Elect COBRA?

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

election. Monthly premiums are then required. You will be billed for the coverage on a monthly basis.

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

How Long Does Continuation Coverage Last?
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA

continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you do not choose continuation coverage, your dental coverage will end, unless you elect to enroll in an individual conversion Plan with Empire Blue Cross and Blue Shield.

Early Termination of Continuation Coverage

The law also provides that your COBRA continuation coverage may be cut short for any of the following reasons:

- The Plan no longer provides coverage to any Participant.
- The premium for your continuation coverage is not paid on a timely basis.
- You become covered for dental benefits under another group health Plan that does not have a pre-existing condition exclusion. If the new Plan includes a pre-existing conditions limitation or exclusion, coverage will cease under this Plan once the pre-existing conditions limitation or exclusion has been satisfied or once eligibility for continuation coverage otherwise terminates.
- Any other reason for termination provided under the Plan, such as your fraud.
- The employer with respect to whom you obtained your coverage in the first place withdraws from the Plan and covers a classification of its employees under another group health Plan. In that case the employer's new Plan is required to continue your COBRA coverage.

Addition of New Dependents While on COBRA

If a child is born to you or placed with you for adoption while you are on COBRA continuation coverage, the child will be treated as a qualified beneficiary under COBRA and will be eligible for coverage for the balance of the COBRA coverage period available to other qualified beneficiaries with respect to the same qualifying event. You may also add a new spouse to your coverage if you get married while you are on COBRA continuation coverage, but the new spouse is not a qualified

beneficiary under COBRA even though he or she will receive coverage under the Plan for the balance of the period. In order to add a new dependent, you must notify the Members' Records Department at the Joint Industry Board, 158-11 Harry Van Arsdale, Jr., Flushing, N.Y. 11365, within 30 days after the birth, placement or marriage and provide the birth certificate, adoption papers or marriage certificate, as applicable.

Military Duty In The United States Armed Forces

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

Instead of TRICARE coverage, and in accordance with Federal law, referred to as the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the employee may elect to purchase COBRA coverage for up to two years under this Plan from the date of the employee's absence due to military service begins or the day after the date on which the employee fails to apply for or return to a position of employment. If the period of military service is less than 31 days, coverage under this Plan for the employee will continue during the period of military service. If the period of military service exceeds 31 days, the employee can elect to pay the applicable COBRA premium to continue his/her coverage. If the employee does not elect COBRA coverage during the period of military service, the employee will be entitled to have coverage reinstated on the date he/she returns to covered employment with a Contributing Employer. No exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted under USERRA are dependent upon uniformed service that ends honorably.

CERTIFICATE OF CREDITABLE COVERAGE

When your coverage ends you and/or your covered dependents, as required by law, will be provided with a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time

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

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

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

Please address all requests for certificates of creditable coverage to:

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

CONVERSION

Whether or not you elect to purchase continuation coverage, you may choose to convert to an individual policy with Empire Blue Cross and Blue Shield. This can be done upon your rejection of continuation coverage, or you may convert to an individual policy upon the expiration of your continuation coverage. You will be furnished with the appropriate applications and full instructions concerning this conversion policy when you request such information from the Plan Administrator.

The benefits provided upon your conversion to an individual policy with Empire Blue Cross and Blue Shield will not be the same as the coverage under this group Plan. Before you decide to convert to an individual policy, you have the right to contact Empire Blue Cross and Blue Shield to review the benefits provided under their Plan. Applications for conversion of coverage must be received by Empire Blue Cross and Blue Shield within 30 days after your benefits under this Plan terminate.

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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

In addition, the FMLA now permits a spouse, son, daughter, parent, or next of kin to take up to 26 work weeks of leave (including any other FMLA leave in the same 12-month period) to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

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

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

CLAIMS AND APPEALS PROCEDURES OF THE DENTAL BENEFIT FUND OF THE ELECTRICAL INDUSTRY

The Dental Benefit Fund of the Electrical Industry (the "Dental Plan") will apply the following procedures to all claims and appeals filed under the Dental Plan. If you have any questions about these procedures, please contact the Dental Plan at:

158-11 Harry Van Arsdale Jr. Avenue
Flushing, New York 11365
(718) 591-2000

The procedures for filing claims with respect to your benefits under the Dental Plan will vary depending upon which of the three benefit programs offered by the Dental Plan you elect to participate in: the Empire Blue Cross and Blue Shield Fee-For-Service Program, the Empire Dental Managed Network Program, or the DDS Inc. Program as described in this Summary Plan Description.

CLAIMS PROCEDURES FOR THE EMPIRE BLUE CROSS AND BLUE SHIELD FEE-FOR-SERVICE PROGRAM

If you choose to participate in the Empire Blue Cross and Blue Shield Fee-For-Service Program (the "Fee-For-Service Program"), you and your dentist will need to complete a Dental Claim Report Form for all services received. You may obtain a Dental Claim Report Form by contacting the Members' Records Department at the address above, or visiting the JIB website at www.jibei.org. You must complete the patient's portion of the Dental Claim Report Form and have your dentist complete the remainder of the form, and return the completed form to Empire Blue Cross and Blue Shield Dental Benefits Program located at P.O. Box 791, Minneapolis, MN 55440-0791.

You are required to submit a Dental Claim Report Form to Empire Blue Cross and Blue Shield Dental Benefits Program located at P.O. Box 791, Minneapolis, MN 55440-0791 within one year of receiving dental

services. Although not required, you are encouraged to contact the Dental Plan in advance of receiving dental services to verify that coverage is available, especially in the case of prosthetic and orthodontic services.

Ordinarily, you will be notified of the decision on your claim within 30 days from the Dental Plan's receipt of your Dental Claim Report Form. The Dental Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Dental Plan provided that, prior to the expiration of the initial 30-day period, the Dental Plan notifies you of the circumstances requiring the extension of time and the date by which the Dental Plan expects to render a decision. If an extension is needed because the Dental Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from your receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period you are given to supply additional information, the 30-day period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of (i) 45 days or (ii) until the date you respond to the request (whichever is earlier). The Dental Plan then has 15 days from receiving the additional information from you to decide your claim and notify you of the determination.

CLAIMS PROCEDURES FOR THE EMPIRE BLUE CROSS AND/BLUE SHIELD DENTAL MANAGED NETWORK PROGRAM

If you choose to participate in the Empire Blue Cross and Blue Shield Dental Managed Network Program (the "Managed Network Program"), once you enroll and select a dental office, you will not need to submit any forms or obtain pre-certification for any services. Your dentist office will take care of any required paperwork.

Emergency Treatment

In the event that you receive emergency care when you are outside of a 50 mile radius of your designated dental office, you must contact the Empire Managed Dental Care Program at 1-800-722-8879 and request a claim form. The claim form and the dentist's original bill must then be submitted to the Empire Managed Dental Care Program, Dept. 316,

Empire Blue Cross and Blue Shield, P.O. Box 791, Minneapolis, MN 55440-0791. You will be reimbursed up to a maximum of $25 per emergency visit. The time frames for deciding emergency treatment claims under the Managed Network Program are the same as those stated above for the Fee-For-Service Program.

CLAIMS PROCEDURES FOR THE DDS, INC. PROGRAM

If you choose to participate in the DDS, Inc. Program, once you enroll by contacting the Members' Records Department, you will not need to submit any forms or obtain pre-certification for any services. You need only call the DDS network provider to schedule an appointment. The dental office is responsible for any required paperwork.

NOTICE OF DECISION

You will be provided with written notice of a denial of a claim. This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific Dental Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures and applicable time limits.
- A statement of your right to bring a lawsuit under ERISA following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of dental necessity, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Dental Plan to your claim, or a statement that it is available upon request at no charge.

APPEALS PROCEDURE

First-Level Appeal to the Fee-For-Service Program, the Managed Network Program, or DDS, Inc.
If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may appeal the determination.

If you participate in the Fee-For-Service Plan, your appeal should be sent to: Empire Blue Cross and Blue Shield Program, Dental Benefits Claims Review, P.O. Box 791, Minneapolis, MN 55440-0791.

If you participate in the Managed Network Program, your appeal should be sent to: Empire Managed Dental Care Program Dept. 316, Empire Blue Cross and Blue Shield, P.O. Box 791, Minneapolis, MN 55440-0791.

If you participate in the DDS Inc. Program, your appeal should be sent to: DDS Services, Inc., 1640 Hempstead Turnpike, East Meadow, New York 11554.

Your appeal must be made in writing within 180 days after you receive notice of denial of your claim and must include your current identification number, the claim number, any pertinent information or comments you wish to make, and shall set forth the reasons why you believe the decision is incorrect. You will be sent a notice of the decision on appeal within 30 days of receipt of the appeal by the Fee-For-Service Program, the Managed Network Program, or DDS, Inc.

Second-Level Appeal to the Joint Industry Board of the Electrical Industry
If the Fee-For-Service Program, the Managed Network Program, or DDS, Inc., denies your appeal in whole or in part, you may file a second appeal to the Joint Industry Board of the Electrical Industry (the "Joint Board"). Your appeal to the Joint Board must be in writing and must be made within 60 days after you receive notice of denial of your appeal by the Fee-For-Service Program, the Managed Network Program, or DDS, Inc., and shall set forth the reasons why you believe the decision is incorrect. The Joint Board will notify you of the determination of your appeal within 30 days of the Joint Board's receipt of the appeal.

Optional Third-Level Appeal to the Board of Trustees

If the Joint Board denies your second-level appeal in whole or in part, you have the option of filing a third-level appeal with the Board of Trustees (the "Trustees"). If you elect to file an appeal with the Trustees, your appeal must be in writing and must be made within 30 days after you receive notice of denial of your appeal by the Joint Board, and shall set forth the reasons why you believe the decision is incorrect. The Trustees will notify you of the determination of your appeal within 90 days of the Trustees' receipt of the appeal. This third-level appeal with the Trustees is voluntary. The Dental Plan will not assert your decision not to file a third-level appeal with the Trustees as a defense if you bring a lawsuit against the Dental Plan instead of appealing a decision to the Trustees. If you do file a third-level appeal, the Dental Plan agrees that any statute of limitations or other defense based on timeliness will be tolled during the time that the appeal to the Trustees is pending. The decision of whether to appeal to the Trustees will have no effect on your rights to any other benefits under the Dental Plan.

Right to Review Documents and to Obtain Other Information

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

Right to Independent Review

A different person will consider your appeal other than the one who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that you submit. The Joint Board will not afford deference to the decision by the Fee-for-Service Program, the Managed Network Program, or DDS, Inc., and the reviewing parties at the Joint Board will not be the same parties who made the decision at the first level of review with the Fee-for-Service Program, the Managed Network Program, or DDS, Inc., nor will they be the subordinates of those parties. Similarly, the Trustees will not afford

deference to the decision by the Fee-for-Service Program, the Managed Network Program, DDS, Inc., or the Joint Board and the reviewing parties will not be the same parties who made the decision at the first level of review with the Fee-for-Service Program, the Managed Network Program, or DDS, Inc., or the second level of review at the Joint Board nor will they be the subordinates of those parties.

Cases Involving a Professional Judgment

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

NOTICE OF THE DETERMINATION OF YOUR APPEAL

The Fee-For-Service Program's, the Managed Network Program's, or DDS, Inc.'s and/or the Joint Board's and or Trustees' decision on your appeal will be in writing and will include the following information:

- The specific reason(s) for the determination.
- Reference to the specific Dental Plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement of your right to bring a lawsuit under ERISA following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Dental Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on a professional judgment, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Dental Plan to your claim, or a statement that it is available upon request at no charge.

DESIGNATED AUTHORIZED REPRESENTATIVES

You may submit a claim and appeal a denial of a claim on your own behalf. Alternatively, you may designate another individual to act as your representative. If you choose to designate someone else to act on your behalf, you must do so in writing on a form provided by the Dental Plan.

The designation will not be effective until it is received by the Dental Plan. You may revoke your designation of an Authorized Representative but such revocation will not be effective until received by the Plan and such revocation must be in writing in order to be effective. You may obtain a Designated Authorized Representative form by contacting the Plan. Once you have designated an Authorized Representative, all communications and notices from the Dental Plan that would otherwise be sent to you will only be sent to your Authorized Representative.

FRAUD AND PLAN'S RIGHT TO RECOVERY

The Dental Committee reserves the right to suspend, discontinue or deny the claim of any Participant who makes or whose service provider makes a willfully false statement material to an application, furnishes fraudulent information or proof or otherwise finds or refuses to provide information deemed reasonably necessary to determine whether to pay a claim. The Dental Committee shall have the right to recover benefits or to offset against future benefits, any payments made as a result of willfully false or fraudulent statements, information or proof submitted by a Participant or by a service provider. The Dental Committee shall have the right to recover benefits paid or to offset against future benefits to a Participant on behalf of a spouse for services rendered to a spouse subsequent to divorce.

DENTAL BENEFIT PLAN OF THE ELECTRICAL INDUSTRY SUBROGATION AND RESTITUTION RIGHTS FOR PERSONAL INJURY

If you or your eligible dependent suffers an injury or illness, or requires medical treatment through the act or omission of someone else or for which a third party may be legally responsible, the Plan shall pay benefits related to such injury or illness to the extent benefits are payable under the terms of the Plan, provided that the costs have not already been paid by the third party, only after you or your dependent (and your attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Plan. By accepting benefits from this Plan related to such an injury or illness, you agree to hold any reimbursement or other recovery received by you or your eligible dependent, legal representative or agent in trust on behalf of the Plan to cover all benefits paid by the Plan with respect to such injury or illness. You also agree to reimburse the Plan promptly for the benefits paid out

of any recovery from any source including the third-party or his or its insurer.

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

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

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

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

coverage. The Plan will not pay medical expenses for you or your eligible dependents up to the maximum amount available through your carrier or $25,000.00, whichever is greater.

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

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

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

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

You must forward any recovery to the Plan within 10 days of receipt or notify the Plan why you are unable to do so. The Plan shall have an equitable lien on any recovery until you reimburse the Plan for the amount of its claim. The Plan may offset its subrogation claim against any other Plan benefits otherwise due or payable to you or your eligible dependents.

Note that other provisions of this Plan may exclude or limit coverage under certain circumstances where the injury or illness may have been the result of the act or omission of a third party (e.g., Workers'

Compensation cases, certain automobile accidents, etc.). Please refer to the Summary Plan Description for information on specific limitations and exclusions.

AMENDMENT AND TERMINATION

The Dental Committee, acting pursuant to the Trust Agreement, may at any time and from time to time modify this Plan in any of its terms, with respect to all Participants, including active Participants and retirees and their eligible dependents, or terminate the same in its entirety, and neither the promulgation of this Plan nor the creation of the Trust Fund by the Trust Agreement shall be construed as giving any Participant or any person whatsoever any legal or equitable right against the Union, any Employer, Employer Association, the Dental Committee, the Plan Administrator and/or the Trust Fund, except such right as is specifically provided for herein, or given by action of the Dental Committee duly taken in accordance with the provisions hereof, provided, however, that no such modification or termination shall:

(A) Cause or permit any property held subject to the terms of the Trust Agreement to be diverted to purposes other than the exclusive benefit of Participants, retired Participants and their dependents and/or for the administration expenses of the Trust Fund; or,

(B) Increase the duties or liabilities of the Dental Committee without their written consent.

The Plan may be terminated when there is no longer in force any Collective Bargaining Agreement requiring contributions to the Plan. The Plan and Trust may likewise be terminated by the unanimous vote of the Dental Committee with the consent of the Employers and the Union.

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

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

ALIENATION OF BENEFITS

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

The Plan will, however, allow an eligible Participant to assign the payment of benefits directly to a provider who accepts the reimbursement from the Plan as payment in full.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

STATEMENT OF ERISA RIGHTS

As a Participant in the Dental Benefit Plan of the Electrical Industry you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

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

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation

coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Vito V. Mundo
Counsel