SUMMARY PLAN DESCRIPTION
PENSION, HOSPITALIZATION AND
BENEFIT PLAN
OF THE ELECTRICAL INDUSTRY

NECA
NEW YORK
NATIONAL ELECTRICAL
CONTRACTORS ASSOCIATION
NEW YORK CITY CHAPTER

MAY 9, 2013

TABLE OF CONTENTS

SECTION I

SECTION II

This booklet is the Summary Plan Description of the Pension, Hospitalization and Benefit Plan of the Electrical Industry ("the Plan"). This Summary Plan Description is presented to Participants to explain the eligibility and coverage provisions, the benefits and options available, and your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA). This information applies to the Plan effective on or after May 9, 2013 unless specifically stated otherwise.

As part of a total benefits package negotiated on your behalf, the benefits described on the following pages are provided to eligible Participants and dependents covered by the Pension, Hospitalization and Benefit Plan. Included in this comprehensive welfare benefit Plan is coverage for in-patient and out-patient hospital services, anesthesia, surgery, physician visits, laboratory and radiological services, dialysis, prescription drugs and other services.

In an effort to control the continuing escalating costs of health care, high quality Networks that include hospitals, medical providers, laboratory and radiological facilities and pharmacies are offered to preserve the excellent coverage afforded to active and retired Participants.

Pension, Hospitalization and Benefit Plan Mission Statement

The primary objective of the Pension, Hospitalization and Benefit Plan of the Electrical Industry is to provide high quality care to both active and retired Participants and their families in the most cost-efficient manner. Recognizing that the financial health of the Plan and the health of its Participants are linked, the Trustees endorse a proactive approach to health care that focuses upon prevention and wellness. This integrated approach requires our Participants to be educated regarding their own health care and to take responsibility for maintaining a healthy lifestyle. The Trustees believe that the implementation of a comprehensive health management program will control costs and preserve the quality health coverage that is provided to all.

GENERAL INFORMATION

Name of Plan:	Pension, Hospitalization and Benefit Plan of the Electrical Industry 158-11 Harry Van Arsdale Jr. Ave. Flushing, N.Y. 11365 (718) 591-2000
Plan Sponsor Identification No:	13-0891045
Plan Number:	505
Plan Year:	October 1 through September 30
Plan Administrator and Agent for Legal Process:	Joint Industry Board of the Electrical Industry (Joint Industry Board) 158-11 Harry Van Arsdale Jr. Avenue Flushing, NY 11365 (718) 591-2000 Service may also be made upon any Trustee at 158-11 Harry Van Arsdale Jr. Avenue Flushing, NY 11365 (718) 591-2000
Type of Plan:	The Plan is a self-insured employee welfare benefit Plan under which Participants are covered for certain services relating to their health and are eligible for certain other benefits.

Type of Administration:

The Plan is maintained by a Joint Board of Trustees consisting of Trustees appointed by Local Union No. 3 of the International Brotherhood of Electrical Workers, AFL-CIO (the "Union") and employers under contract with the Union. The Trustees' names and office addresses are listed on the following page.

KRISTINE DENAPOLI
KND Electric
120 Brook Avenue, Unit B
Deer Park, NY 11729

STEPHEN GIANOTTI
Arcadia Electrical
1005 Wyckoff Avenue
Ridgewood, NY 11385

STEVEN LAZZARO
Hellman Electric Corp.
855 Brush Avenue
Bronx, NY 10465

JOHN G. MARCATO
PS Marcato Elevator Company, Inc.
44-11 Eleventh Street
Long Island City, NY 11101-5180

SANDRA MILAD-GIBSON
Milad Contracting Corp.
59-01 39th Avenue
Woodside, NY 11377

JOHN PINTO
Pinto & Teger Elec Corp.
14-14 123 Street
College Point, NY 11356-1740

EDWARD ROTHOWSKI
Fresh Meadow Electrical
65-01 Fresh Meadow Lane
Fresh Meadow, NY 11365

DAVID I. SAMUELS
Robert B. Samuels, Inc.
253 W. 35 Street, 5th Floor
New York, NY 10001

STEVEN SMITH
Five Star Electric Corp.
101-32 101st St.
Ozone Park, New York 11416

RUDY WEISSBERG
ASR Electrical Contracting, Inc.
39 Cain Drive
Plainview, NY 11803

THOMAS CAPURSO
Business Representative
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, NY 11365

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

ELLIOT HECHT
Business Representative
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, NY 11365

WILLIAM HOFVING
Business Representative
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, NY 11365

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

VINCENT McELROEN
Financial Secretary
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, NY 11365

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

LUIS G. RESTREPO
Assistant Business Manager
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

JAMES ROBSON
Business Representative
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, NY 11365

LANCE VAN ARSDALE
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, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, and the New York Electrical Contractors Association, Inc., 1430 Broadway, 8th Floor, New York, NY 10018, the 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.

ELIGIBILITY FOR BENEFITS

The following eligibility rules apply to Participants who are or were covered pursuant to 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 8 may also be covered by the Plan. In order to receive the hospitalization, surgical, medical or prescription drug 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 on a full-time basis for a Contributing Employer to this Plan, the Union, the Joint Industry Board, or any other employer that has signed a Participation Agreement, for at least 1,200 hours of service or for at least 26 consecutive weeks, 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 39 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 weeks in an 18-month period. The 18-month period will begin when the Participant is first re-employed.

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 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 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 or after June 1, 2007 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 30-31.

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 complete the applicable enrollment cards and submit 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 in accordance with the state where the marriage took place.

Your children from birth up to their 26th birthday. However, until October 1, 2014, adult children who are eligible for group health coverage through their own or their spouse's employer are not eligible for coverage under this Plan. This exclusion applies to adult children who are eligible for such other group health plan coverage, even if they have to pay for it, in whole or in part, whether or not they have actually elected the coverage, and even if the other coverage is not as good as this Plan's benefits. Other health coverage through an employer includes COBRA coverage.

2. The term "children" shall mean natural or legally adopted children. "Children" also includes step-children subject to the same terms and conditions as natural and 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 pursuing 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 Pension Committee. 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 for the balance of the 36 months under COBRA. (See pages 32-37 for more details on COBRA.)

4. 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 Pension Committee. 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 32-37 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 eligible children will be entitled to full benefits subject to the following:

    - Benefits to the spouse shall continue for his or her life unless he or she remarries; upon remarriage the benefits will cease, and

    - Benefits to the eligible children shall continue in accordance with the rules of the Plan as if the Participant were still alive, regardless of whether the surviving spouse remarries or dies.

An eligible Participant who needs to add a new spouse or child may enroll the individual 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, unless the spouse or child ceases to be an eligible dependent, as defined above, while the Participant is still eligible.

SECTION I

CONTRIBUTING EMPLOYERS

The benefits provided in Section I are applicable only to eligible active or eligible retired Participants, as previously defined, who are employed (or, in the case of a retiree, was last employed) by a Contributing Employer in one of the categories described below. Retired Participants who are covered under Medicare and are not covered under this Section should refer to page 21.

1. An Employer who is bound to the Collective Bargaining Agreement between New York Electrical Contractors Association, Inc. or the Association of Electrical Contractors, Inc., and the Union.

2. An Employer who is not a member of the above-referenced Employer Associations and who agrees in a Collective Bargaining Agreement to make contributions to the Pension, Hospitalization and Benefit Plan as prescribed by the Collective Bargaining Agreement with the Employer Associations mentioned in item 1.

3. An Employer who is not a member of the Employer Associations mentioned in Item 1 and whose contribution to the Pension, Hospitalization and Benefit Plan is greater than 8.5% of payroll.

4. An Employer in any of the categories listed above who elects to contribute to the Plan for all eligible non-bargaining-unit employees who 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. Such an Employer must complete an application form for approval. The contribution rate will be established by the Pension Committee. An employer who elects coverage for such non-bargaining-unit employees will be responsible for remitting contributions as of the first of the month following approval of the application form and each first of the month thereafter. Notwithstanding anything herein to the contrary, non-bargaining unit employees described in this paragraph, initial Plan eligibility will be based upon the earlier of (1) a date no more than 90 days after the Participant achieves 1,200 hours of service or (2) after six (6) months of contributions have been remitted on their behalf, unless this provision is waived by the Trustees.

5. The Joint Industry Board, the Union and employers who sign a Participation Agreement. Employees of the Joint Industry Board, the

Union and employers who sign a Participation Agreement will be eligible for benefits based upon the earlier of (1) a date no more than 90 days after the Participant achieves 1,200 hours of service or (2) after six (6) months of contributions have been remitted on their behalf,.

BENEFITS

The Plan provides for the payment or reimbursement of hospital, medical, surgical and prescription drug expenses as indicated on the following pages, subject to the deductible and co-payments as described on the following pages and up to the maximum payment provision described on page 21.

HOSPITAL AND FACILITY BENEFITS:

Room and Board	Up to 100% at a semi-private rate. $100 per day co-payment (up to $500 maximum). Co-payment is waived if readmitted for same illness/injury within 90 days.
Ancillary Charges	Up to 100% of all medically necessary charges (in-hospital expenses such as lab tests, x-rays, etc.) when the Participant has no choice regarding the selection of a provider.
Anesthesia Allowance	Up to 100% of the Plan Fee Schedule.

In no event will the Plan be obligated to pay a provider in excess of what the Plan deems to be a reasonable and customary fee. For participating providers, a reasonable and customary fee shall be equivalent to the MagnaCare fee schedule (less applicable co-payments). For out-of-network providers, a reasonable and customary fee shall be determined in the Plan's discretion using comparative fee data, public cost to charge information by hospital department, including what Medicare would pay for the service or supply rendered or provided by such out-of-network provider, and is subject to the Plan's out-of-network cost-sharing requirements.

EMERGENCY ROOM BENEFITS:

Emergency care provided by a hospital, urgent care center or other licensed medical facility due to an injury or other sudden illness for which any delay in obtaining medical care would seriously jeopardize the life or health of the individual, will be paid in accordance with the Plan's established criteria. For services rendered in an Emergency Room when the Participant has no choice as to the selection of a provider, the Plan will negotiate the reimbursement amount so that there is no out-of-pocket expense to the Participant, other than the co-payment described on the next page. This may include services rendered by a

physician or for other ancillary charges within the facility. Examples of emergency conditions include but are not limited to: heart attacks, severe chest pain, strokes, and severe breathing difficulty such as asthma, shock, hemorrhaging or other acute conditions. This benefit is subject to a $100 co-payment. Surgical procedures associated with the emergency room visit with charges that are equal to or exceed $1,000 will be subject to the $250 surgical co-payment. Note that Emergency Room benefits are for emergencies only, as described above.

PRE-CERTIFICATION REQUIREMENTS

The Plan requires pre-certification of certain Network and non-Network services, as described below:

Pre-Certification Required Through MagnaCare: Physicians and/or hospitals are required to contact MagnaCare's Pre-Certification Department at 877-624-6210 for any of the following:

- Hospital admissions and acute in-patient rehabilitation (hospital must contact MagnaCare for pre-certification);
- Any surgical procedure to be performed at a hospital or surgi-center. This includes procedures done on both an inpatient and outpatient basis (provider must contact MagnaCare for pre-certification);
- Any MRI, MRA, SPECT, PET or CAT scan that needs to be performed in a hospital (provider must contact MagnaCare for pre-certification). If these diagnostic tests are performed at a free-standing facility or in a non-hospital setting, they do not require pre-certification. Further rules regarding these services may be found on page 11;
- Initiation of out-patient dialysis (facility must contact MagnaCare for pre-certification);
- Home health care or home hospice rendered directly following release, and durable medical equipment and supplies required following release, from a hospital. Generally, home health care and hospice planning and supplies and durable medical equipment will become part of discharge planning and will be done as part of the pre-certification (hospital/provider must contact MagnaCare for pre-certification);
- All therapies. (Provider must contact MagnaCare for pre-certification); and
- Office based vascular procedures (Provider must contact MagnaCare for pre-certification);

The hospital or provider's failure to pre-certify the foregoing services may result in no coverage for the service, if it is later determined that the services were not medically necessary, or otherwise not appropriate.

In addition, any radiological testing or surgical procedure (such as an MRI or colonoscopy) that is performed in a hospital and not pre-certified by MagnaCare will be paid at the MagnaCare non-hospital rate only, if it is determined to be medically necessary or otherwise appropriate. If a radiological test is done at a hospital instead of a free-standing (or non-hospital) facility, or if a surgical procedure is done at a hospital rather than the doctor's office or a surgi-center, the Participant will be responsible for any balance billing of the facility charge after the Plan's payment. Participants who require such services in a hospital setting due to medical necessity must have them pre-certified by MagnaCare prior to the date of service.

Pre-Certification Required Through the Hospitalization Department of the Joint Industry Board

The following services require pre-certification through the Hospitalization Department of the Joint Industry Board:

- Orthotics
- Home Health Care and Hospice (when not rendered directly after the release from a hospital)
- Supplies and durable medical equipment (when not provided directly after the release from a hospital)
- Office-based Extracorporeal Shock Wave Therapy (Orthotripsy)
- Certain office-based surgeries, procedures or treatments (other than vascular procedures, which must be pre-certified by MagnaCare)

Pre-certification for these items may be obtained by contacting the Managed Care Coordinator at the Joint Industry Board, 718-591-2000, ext. 1350, Monday through Friday between the hours of 8:30 A.M. and 4:30 P.M.

MEDICAL BENEFITS WHEN RELATED TO A HOSPITAL CONFINEMENT

The Plan will pay for medical, surgical (less the applicable co-payment) and anesthesia services based on the Network allowance for all medically necessary charges when incurred in conjunction with a hospital confinement that is covered by the Plan. For medically necessary services rendered by a non-Network provider during an in-patient hospital stay, when the Participant has no choice as to the selection of a provider, the Plan will negotiate the reimbursement amount so there is no out-of-pocket expense to the Participant. This may apply to services rendered by a physician or other providers. Examples of such services are anesthesiology, radiology and pathology services.

The Plan covers pre-admittance x-rays, tests, doctors' visits and follow-up care pertaining to the illness.

Home care and hospice care, and the purchase or rental of durable medical equipment and supplies following a hospital stay may be covered by the Plan, but must be approved in advance by the MagnaCare Pre-certification Department at 877-624-6210.

During the period immediately following hospitalization, the Plan may pay for medical care required for the recuperation process with limitations to be set by the Pension Committee upon review of each such case. **You must contact MagnaCare's Pre-certification Department at 877-624-6210 to obtain advance approval for these services.**

MEDICAL SERVICES PROVIDER NETWORK FOR IN-NETWORK PROVIDERS

The Plan has contracted with the MagnaCare Preferred Provider Organization ("Network") to provide a Network of medical providers. Since all providers in the Network agree to accept the Plan's assigned payment, there is no out-of-pocket expense to the Participant if a Network medical provider is used, other than any applicable co-payment or limitation as described herein. There is no requirement that you use a Network medical provider. However, the Plan's benefits are limited to the Network's Schedule of Fees, less the applicable co-payments. Thus, there will generally be a greater out-of-pocket cost to you if you use a non-Network provider. A listing of participating providers may be obtained by contacting MagnaCare at 877-624-6210 or visiting www.magnacare.com.

SCHEDULE OF FEES

A Schedule of Fees (also referred to herein as the "Network Allowance") has been established for all procedures and services rendered by ALL PROVIDERS. However, as described previously, **Network providers have agreed to accept this schedule as PAYMENT IN FULL for covered services, together with the applicable co-payment.** Therefore, there will be no out-of-pocket expense for the Participant who uses Network providers, other than the applicable co-payments, or limitations as described herein.

Services rendered by **non-Network providers** are paid in accordance with this Schedule of Fees (or their actual charges, if less). The Schedule of Fees will be reduced by applicable co-payments. The Participant is responsible for all charges in excess of the Network Allowance (in addition to the applicable co-payments).

MEDICAL BENEFITS WHEN THERE IS NO HOSPITAL CONFINEMENT

CO-PAYMENTS FOR MEDICAL SERVICES

There is a $30.00 co-payment for each office visit made by the Participant and/or eligible dependent, with the exception of approved physical, occupational, speech therapy visits and cardiac and pulmonary rehabilitation, which are each subject to a 4-co-payment maximum per injury or illness, as indicated on the following page. The co-payment applies to all office visits and radiological services for Network providers, and will be deducted from the Network Allowance payable for services rendered by providers who do not participate in the Network.

The following co-payments apply to medical and radiological services rendered by Network and non-Network providers:

SERVICE	***CO-PAYMENT*****
Office Visit An annual routine physical performed outside the JIB Medical Center or participating area group practices will be covered.	$30.00
Diagnostic Radiology Services (including, but not limited to: MRI, EKG, x-ray, EMG, PET scan, CAT scan, mammography, ultra sound)	$30.00 (Please note there is a $60.00 maximum co-payment for combined office visits and diagnostic services rendered in the same day by the same

	provider)
Physical and Occupational Therapy Visit *	$30 (maximum of 4 co-payments per injury or illness effective for all approved services)
Speech Therapy*	$30 (maximum of 4 co-payments per injury or illness effective for all approved services)
Cardiac and Pulmonary Rehabilitation*	$30 (maximum of 4 co-payments effective for all approved services)

* Each discipline is to be treated separately. Therefore, each therapy will be subject to a maximum 4-visit co-payment even if done at the same time for the same diagnosis within a 12-month period.

** As part of the Plan's Wellness Program, all Participants and spouses who have a physical in a two-year period immediately on or prior to the date of service shall receive a $5 reimbursement check for all $30 medical co-payments (such as MD visits, diagnostic radiology and physical, occupational and other therapies) for services rendered on or after October 1, 2013.

The co-payment does not apply to:

- Office visits made to the JIB Medical Center located at the Electrical Industry Center in Flushing, Queens.
- Visits to a laboratory
- Immunizations

Annual adult routine physicals are 100% covered by the Plan at conveniently located approved multi-specialty group practices. These practices are participating providers in the MagnaCare Network. Please note that co-payments for all other services at these practices, other than the annual adult well-care visits, will apply. You can find out more about each PHBP Area Group Practice by visiting the JIB website at www.jibei.org.

SURGICAL BENEFITS

Allowance MagnaCare surgeons and non-Network surgeons are reimbursed at the Plan's applicable Network Allowance, subject to the co-payment indicated below. There is a $1,000 out-of-pocket maximum expense for any surgical procedure performed by a non-Network provider.

The Plan covers assistant surgeons in hospitals other than teaching facilities where residents are not available at 25% of the allowable fee for the surgeon.

Co-payments Maternity $250

Major Surgery $250 (any surgical procedure for which the Plan's applicable network allowance equals or exceeds $1,000)

In order to determine if a surgical procedure is covered under the Plan, please contact MagnaCare at 877-624-6210.

Remember, your provider must contact MagnaCare's Pre-certification Department at 877-624-6210 to pre-certify any surgical procedure to be performed at a hospital or a surgi-center, whether on an in-patient or out-patient basis. Failure to pre-certify could result in coverage for a service being lost.

OUT-PATIENT
LABORATORY AND RADIOLOGICAL SERVICES

The Plan's payment will be based on the Network Allowance, and the Participant will be responsible for any balance billed.

Services rendered by Network providers are covered in full, subject to the applicable co-payments and pre-certification requirements described previously, and the maximum payment provision indicated on page 21.

ALCOHOLISM OR DRUG ADDICTION BENEFITS

If a Participant or eligible dependent is referred to an alcohol or drug treatment facility for the effective treatment of alcohol or drug addiction, the expenses of this treatment facility will be covered only if the following conditions are met:

1. The Participant has been employed or has been available for employment by employers who made contributions to the Plan for four (4) or more years immediately prior to the date that treatment begins.

2. For an elective admission, Participants may contact the Members' Assistance Program in order to be referred to an in-Network or preferred provider at 718-591-2000 ext 1396.

3. Pre-certification is required for both in-patient and out-patient facility care. Providers must contact MagnaCare's Pre-certification Department at 877-624-6210.

MENTAL HEALTH BENEFITS

Effective October 1, 2013 the following changes have been made to the Mental Health Benefits:

- There is no annual limit for mental health-related hospital admissions
- There is no four-visit calendar year deductible for out-patient visits (applicable co-payments still apply)
- There is no annual out-patient limit of 30 visits per family

In-patient Hospital

Hospitalization must be pre-certified by the MagnaCare Pre-certification Department at 877-624-6210, as described on page 10. During the period immediately following such an in-patient stay, the Plan may reimburse for out-patient care coordinated with an approved institution upon review of each such case. You must contact MagnaCare's Pre-certification Department to obtain advance approval for any such out-patient care.

Out-patient Physician or Provider:

Charges by a psychiatrist, psychologist ("PhD"), or a social worker (covered licensed behavioral health specialists include but are not limited to "MSW" or "LCSW") will be covered for active and retired eligible Participants and eligible dependents.

All covered office visits, both in- and out-of-network, are subject to the $30 co-payment for office visits described above. Reimbursement will be at the Network Allowance, less the co-payment.

MATERNITY BENEFITS

Medically necessary charges for pregnancy and pregnancy-related conditions will be covered for the Participant or the Participant's spouse only, at the Network Allowance, subject to the $250 co-payment.

Children are not eligible for this benefit.

CHIROPRACTIC CARE BENEFIT

A maximum of thirty (30) office visits to a chiropractor will be covered in a calendar year for each eligible family member. This benefit is available to active and retired Participants and all eligible dependents. All claims will be paid at the Network Allowance less the applicable co-payment.

HEARING AID BENEFIT

The hearing aid benefit shall be payable once in a four-year period to be paid at the Plan's allowance. The maximum shall apply to either a single hearing aid or where medically prescribed, binaural aids. The hearing aid benefit is available

to the Participant, the Participant's spouse and dependent children of active Participants. Retirees and their dependents are eligible for the same benefit one time in a five-year period, subject to the same maximum reimbursement.

There is no co-payment applicable to hearing aid benefits. The Participant is responsible for all amounts that exceed the Plan allowance.

PRESCRIBED BIRTH CONTROL METHODS AND DEVICES

The Plan will reimburse claims for medically prescribed birth control methods including surgical implants, IUDs, diaphragms and Depo-Provera.

DURABLE MEDICAL EQUIPMENT AND OTHER SUPPLIES

Supplies and durable medical equipment that are medically necessary to treat an illness or injury following an in-patient hospital stay may be covered under the Plan and require pre-approval by MagnaCare's Pre-certification Department at 877-624-6210.

Durable medical equipment and other supplies that are medically necessary to treat an illness or injury, but not as a result of an in-patient hospital stay, may be covered under the Plan and require pre-approval by the Plan's Managed Care Coordinator at 718-591-2000, extension 1350.

Diabetic supplies, which are not covered under the prescription drug program, and orthopedic equipment are examples of supplies and equipment that may be covered under the Plan. Coverage is available through the Network at no out-of-pocket expense to the Participant and with no co-payment. If supplies or equipment are provided outside of the Network, the reimbursement will be based on the Network Allowance. Claims for these services, whether rendered in or out of Network, must be approved in advance by calling the Managed Care Coordinator at the Joint Industry Board at 718-591-2000 ext. 1350, Monday through Friday between the hours of 8:30 A.M. and 4:30 P.M.

PRESCRIPTION DRUG BENEFITS

The Plan provides a Prescription Drug Plan that is managed by Express Scripts (formerly Medco) for Participants and eligible dependents. The Plan will issue a separate identification card which, when presented to pharmacists who participate in the Express Scripts Network, will cover the cost of the prescription, except for the applicable co-payment. You should call Express Scripts at 1-800-818-0883 for any questions on the Prescription Drug Plan.

Effective October 1, 2013, the following co-payments apply for active Participants:

	Retail Network Pharmacy Co-Payment	***Mail Order Pharmacy Co-Payment***
Generic Drugs	$15 (up to 34-day supply)	$36 *(90-day supply)
Preferred Brand (Formulary) Name Drugs	$25 (up to 34-day supply)	$73 *(90-day supply)
Non-Preferred (non-Formulary) Brand Name Drugs	$40 (up to 34-day supply)	$120*(90-day supply)

The following co-payments apply for retired Participants and their dependents:

	Retail Network Pharmacy Co-Payment	***Mail Order Pharmacy Co-Payment***
Generic Drugs	$10 (up to 34-day supply)	$30 *(90-day supply)
Preferred Brand (Formulary) Name Drugs	$20 (up to 34-day supply)	$60 *(90-day supply)
Non-Preferred (non-Formulary) Brand Name Drugs	$35 (up to 34-day supply)	$105 *(90-day supply)

*You will pay the same mail order co-payment regardless of whether the quantity is 90 days or a lesser amount.

The Prescription Drug Plan includes a mandatory generic substitution policy. If a prescription drug has a generic equivalent and the Participant or dependent elects the brand name drug or the physician indicates that only the brand name drug should be dispensed, the Participant must pay the pharmacist the difference between the maximum allowable cost of the generic drug and the cost of the brand name drug, plus the generic drug co-payment. There may be an exception to this mandatory generic substitution policy where the physician demonstrates that the brand name drug is medically necessary. Contact the Members' Records Department at 718-591-2000, ext. 2491 to obtain a form, which you may submit to seek approval of such an exception.

Generic drugs are the least expensive medications, while Preferred (Formulary) brand name drugs cost less than Non-preferred (non-Formulary) brand name

drugs. For more information on Preferred brand name drugs and Non-preferred brand name drugs, please refer to the Express Scripts "*Preferred Prescriptions Member Guide*," contact Express Scripts at 1-800-818-0883 or visit the Express Scripts website at www.expresscripts.com. Note that certain medications may be listed in the *Member Guide*, but are not covered by the Plan. See page 20 for the types of drugs that are not covered by the Plan. In addition, certain brand name drugs may be excluded based upon the action of the Trustees.

Participants may submit direct reimbursement claim forms to the Plan in those instances where the Participant does not use a participating pharmacy and pays the pharmacy for the prescription. In such cases, however, the Participant will incur out-of-pocket expenses because the Plan's reimbursement will be based on the Plan's allowable cost, less the applicable co-payment.

PREAUTHORIZATION OF CERTAIN MEDICATION

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

If you receive a new prescription for one of the medications that require prior authorization, the pharmacist will advise you of the need to obtain a coverage review and will provide the toll free number for Express Scripts' Coverage Review Unit to the prescribing physician's office. The pharmacist can also take the necessary information from you and the physician and provide it to Express Scripts, and Express Scripts will contact the physician directly. If the medication is approved, Express Scripts will send a letter to you and the physician and will also notify the pharmacist who will then fill the prescription. If you are using the mail order facility for one of these medications requiring advance review, the Express Scripts Coverage Review Unit will contact the prescribing physician directly and, if the drug is approved, will mail the medication to you. If the medication is not approved, a letter with the reason for the denial will be sent to you and the doctor. The letters will contain information and instructions on the appeal procedures, which are described later in this booklet on pages 47-49.

MAIL ORDER PHARMACY

The Prescription Drug Plan requires the use of Express Scripts' Mail Order Program for all maintenance medications. If you are using a maintenance medication to treat an ongoing illness, you can have your doctor prescribe the initial prescription for a month's supply that can be filled at a local retail pharmacy and a second prescription for a 90-day supply. After mailing your 90-

day prescription to Express Scripts, allow 14 days for delivery. The cost to you for a 90-day supply is only the applicable co-payment unless you request a brand name drug when a generic is available (and you have not demonstrated the medical necessity of the brand name drug). In that case, you are responsible for paying the difference in cost between the brand name drug and the generic drug, plus the co-payment.

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

- Epilepsy
- Arthritis
- Thyroid Disease
- Constipation
- High Blood Pressure
- Heart Disorder
- High Cholesterol
- Ulcers

The Plan will allow only the initial prescription and one refill of a maintenance medication to be filled at a local retail pharmacy. ***Any subsequent prescription or refill relating to the same maintenance medication must be filled through the Express Scripts Mail Order Program, or you will be responsible for the payment of the entire cost of the drug and will not receive any reimbursement from this Plan.*** For this reason, it is strongly recommended that you ask your physician for a 90-day supply, in cases where he or she would ordinarily prescribe a 30-34 day supply, with 2 or more refills.

After filling a maintenance medication at your local pharmacy two times, there may be circumstances when your physician needs to monitor the strength and/or dosage of the medication on a short-term basis. In such a case, you may call the Members' Records Department at 718-591-2000, ext 2491 to request an override that will allow you to continue to get a monthly supply from your local pharmacy until your physician is ready to prescribe a 90-day supply.

EXCLUDED PRESCRIPTIONS

The following prescriptions are excluded from coverage under the Plan, unless determined by the Plan to be medically necessary:

Non-sedating antihistamines
Fertility drugs
Anti-obesity drugs
Erectile dysfunction drugs
Vitamins (other than pre-natal vitamins, with applicable co-payments)

If you think one of the medications listed above is medically necessary, you may request a medical review of your prescription by contacting the Members' Records Department at 718-591-2000, ext 2491 to obtain a form which you and your doctor must submit.

The Plan does not coordinate payment of prescription drug benefits with other health plans.

Additional exclusions relating to medical and prescription drug coverage are set forth on pages 26-30.

MAXIMUM PAYMENT PROVISION

Effective October 1, 2014 there will no longer be any individual aggregate annual limit on benefits paid by this Plan to or on behalf of any eligible individual.

Before October 1, 2014 an individual aggregate annual limit of $2,000,000 per calendar year applies. Under this rule, a Participant and separately, each eligible dependent may incur a total of up to $2,000,000 in covered medical, hospital and prescription drug claims in the year. This individual aggregate annual maximum will remain in effect through September 30, 2014.

BENEFITS FOR RETIREES COVERED UNDER MEDICARE

This Plan will act as Secondary Payor to Medicare once a Participant or dependent is **eligible** for Medicare, whether at age 65, or prior to 65 if such person is eligible for Medicare immediately due to a chronic illness or after receiving Social Security disability benefits for two years. Therefore, all retired Participants who are Medicare eligible must purchase Medicare Part B immediately upon Medicare eligibility in order for the Plan to properly coordinate benefits.

A covered dependent of a Medicare-eligible retiree will continue to be covered under the Plan's benefits for active Participants until the dependent becomes eligible for Medicare.

Retired Medicare-eligible Participants and their Medicare-eligible dependents are NOT covered for the basic hospital, surgical or medical benefits provided by this Plan, and they cannot access the MagnaCare Network.

Instead, this Plan will act as Secondary Payor to Medicare for services covered by the Plan (other than for HMOs and Managed Care Networks) and will provide benefits that include, but are not limited to the following:

1. The in-patient hospital deductible not paid or reimbursed by Medicare Part A.

2. The deductible not paid or reimbursed by Medicare Part B.

3. The 20% of customary and reasonable charges approved but not paid or reimbursed under Medicare Part B (**other than custodial care in a nursing home and all other excluded benefits as described on pages 26-30**). This is also known as the coinsurance amount. If a provider does not accept Medicare assignment with respect to a surgical procedure, the Plan's payment will be based on the Network Allowance.

4. Prescription Drug benefits.

5. The use of the JIB Medical Center and optical facilities located within the Joint Industry Board of the Electrical Industry.

Medicare-eligible active Participants and Medicare-eligible spouses of active Participants over age 65 will continue to be covered by the Plan to the same extent and in the same manner as active Participants and spouses under the age of 65. Active Participants and their dependents over age 65 should present their MagnaCare card, as applicable, when obtaining medical services. Even if a working Participant or his or her dependent has a Medicare card, this Plan is always primary as the Participant is working. Plan rules pertaining to Coordination of Benefits as described on pages 30-31 also apply to Medicare.

You are no longer required to submit your Medicare Summary Notice for reimbursement. Once Medicare has processed your claim, MagnaCare will *automatically* forward the eligible Part A and Part B deductibles or coinsurance payments approved but not reimbursed by Medicare **directly to the Medicare participating provider**.

Please note that paper claims will be required to be sent to MagnaCare for claims submissions of the following covered services:

✓ Covered services rendered by the Veterans Administration;
✓ The shingles (Zostavax) vaccination;
✓ Hearing aid devices;
✓ Diabetic needles and syringes;
✓ Foreign travel claims; and
✓ All Coordination of Benefit claims

The Pension Committee reserves the right at any time and for any reason to amend, modify or discontinue any benefits provided to retired Participants and their covered family members.

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:

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

2. The date which is 2 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.

Such 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 the continuation coverage provisions described on pages 32-37. 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 continued eligibility for Workers' Compensation payments is furnished to the Pension Committee periodically, as required.

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 Pension Committee that he or she was disabled.

Such a Participant who remains totally disabled after receiving 26 weeks of disability payments may continue to be covered under this Plan for up to a total of 24 months, as long as he submits proof of the total disability to the Pension Committee as required. After 24 months of disability, a Participant may purchase continuation coverage under the Plan for up to 18 months, as provided on pages 32-37. If such Participant is still totally disabled after this period of time, he may continue to purchase coverage on a monthly basis for as long as he is able to furnish proof of the disability to the Pension 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.

SECTION II

THE FOLLOWING INFORMATION APPLIES TO ALL PARTICIPANTS

THE MEDICAL CENTER

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

Annual Physicals	EKGs
Mammograms	Pap Smears
Lab Tests	P.S.A. Tests
X-Rays	Inoculations

OPTICAL BENEFITS

All eligible active and retired Participants and their eligible dependents are entitled to optical benefits provided through the Medical Center as described below. These benefits are provided once every 12 months.

The following benefits are provided within the Medical Center and are offered to Participants and their eligible dependents at no cost:

- Examinations performed by a licensed optometrist.
- Lenses for reading, distance or line-bifocals prescribed by a licensed optometrist.
- Frames selected in conjunction with lenses newly prescribed by a licensed optometrist. Frames may be chosen from an offered selection which includes both plastic and wire frames.

- A replacement pair of glasses for children 12 and under who break or lose their glasses within 12 months of their last visit. Prior to obtaining a replacement pair of glasses, the child must have an examination at the Medical Center.
- The following services require additional out-of-pocket expense:

  Lenses other than those described above (*i.e.*, progressive lenses, trifocals).

  Frames other than those described above.

  Contact lenses.

Retirees who live outside of the 5 boroughs of New York City may choose a provider outside of the Medical Center. The Plan will pay up to $56 for covered services provided outside of the Medical Center applicable to covered optical charges previously indicated. As an alternative, such retirees may choose a participating optical outlet within the **General Vision Services (GVS)** Network and may request a voucher from the Members' Records Department that will enable them to receive covered optical benefits.

To schedule a medical or optical appointment at the Medical Center, contact the Medical Center at (718) 591-2014 from Monday through Friday, 8:00 A.M. to 8:00 P.M. and Saturday from 8:00 A.M. to 3:00 P.M. Appointments should be made in advance.

HEALTH ADVOCATE

Health Advocate is a valuable benefit provided by the PHBP to help you and your entire family navigate the healthcare system and maximize your healthcare benefits.

Health Advocate can assist you with many clinical and administrative issues including, but not limited to:

- Finding an in-network physician
- Helping to understand complex provider bills and statements
- Help with eldercare issues
- Help to make arrangements for special needs services

Health Advocate's services are available to all eligible Participants, eligible dependents and even parents and parents-in-law. Health Advocate can be reached at 866-799-2723.

I.B.E.W. DEATH AND PENSION BENEFIT FUND PREMIUM

For Participants other than non-bargaining unit employees or those employed by the Joint Industry Board or the Union, your membership in Local 3, I.B.E.W. requires that you be designated either an "A" charter member or a "BA" charter member of the International Brotherhood of Electrical Workers. This membership provides you with death and/or pension benefits in amounts as defined under the rules and regulations for the I.B.E.W. Pension Plan. This Plan will reimburse the I.B.E.W. Death and Pension Benefit Fund premium of $80.40 to eligible "A" charter members and $34.80 to eligible "BA" charter members on a semiannual basis.

In March of each year, payments will be automatically made to Participants, as described below, who are employed by a Contributing Employer or available for employment during the six months immediately preceding December 31 of the prior year.

In September of each year, payments will be automatically made to Participants, as described below, who are employed by a Contributing Employer or available for employment during the six months immediately preceding June 30 of that year.

The payment is applicable to Participants who are "A" or "BA" charter members of the I.B.E.W. and who are required to make additional payments for death and pension coverage.

SERIOUS INJURY BENEFIT

The Plan provides a Serious Injury Benefit to Participants covered under Collective Bargaining Agreements between an employer and the Union who are injured on the job and taken directly to and admitted to the hospital. In such cases, the Participant shall receive a benefit payment at the rate of one (1) week's pay for each week, or proportionately for any part of a week that he or she is confined to the hospital, not to exceed fifteen (15) weeks. Such payments are in addition to any Workers' Compensation benefits the Participant receives from any source.

LIMITATIONS OF BENEFITS

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

1. Charges resulting from injuries caused by acts of war or insurrections;

2. Charges incurred as the result of any illegal acts;

3. Charges for the effective treatment of alcohol or drug addiction that is not rendered through a facility approved by the Members' Assistance Program for dates of service prior to 10/1/2013;

4. Charges for routine eye refractions, eyeglasses or hearing aids except as provided herein;

5. Charges the covered individual is not required to pay;

6. Accidental bodily injury arising out of or in the course of employment, or sickness entitling the Participant or eligible dependent to benefits under a Workers' Compensation Act or similar legislation;

7. Charges for services or supplies that are provided or required by reason of past or present service of any person in the armed forces of a government;

8. Charges for services or supplies which any school system is required to provide under any law;

9. Charges for services and supplies that are provided or required under any law of government;

10. Charges for services and supplies not necessary or reasonable, as determined by the Plan, for the diagnosis, care or treatment of the physical or mental condition involved, even if prescribed, recommended or approved by a covered health care provider;

11. Charges for services and supplies not prescribed, recommended and approved by the covered person's attending physician;

12. Charges for services of a resident physician or intern rendered in that capacity;

13. Charges for medical care provided by a hospital which is not equipped for diagnosis, major surgery and 24-hour nursing service, except those specific facilities approved by the Pension Committee;

14. Elective cosmetic procedures and complications of elective cosmetic surgery regardless of the place of service;

15. Cosmetic surgery, except treatment of accidental injuries if the treatment begins within 90 days of the accident and reconstructive surgery necessitated by major surgery;

16. Charges for dentistry, except for the following dental treatment performed within 90 days after an accident:

a) Dental treatment of accidental injuries to natural teeth

b) Setting of a jaw fractured or dislocated in an accident

17. Charges for dentistry or hospital costs incurred as a result of dentistry, except for hospital charges incurred where a valid medical reason exists which precludes the dental treatment from being performed outside of a hospital;

18. Charges for the treatment of Temporomandibular Joint Disorder/Disease ("TMJ");

19. Charges, as determined by the Plan, for maintenance, long term or custodial care;

20. Charges for the treatment of obesity when related to diet or weight control;

21. Charges related to liposuction;

22. Charges related to the treatment of sexual dysfunctions or inadequacies, including but not limited to surgery, therapy, supplies or counseling;

23. Charges related to sex change surgery or medical treatment as to gender identity;

24. Charges related to artificial insemination, in-vitro-fertilization or embryo transfer procedures; Charges in connection with cryopreservation or storage of stem cell or sperm;

25. Charges in connection with umbilical cord blood collection;

26. Elective abortions;

27. Charges for the reversal of a sterilization procedure;

28. Charges relating to the following therapies: aqua, primal, rolfing, psycho-drama, megavitamin, bioenergetic, vision and perception training or carbon dioxide, as well as charges for transcendental meditation, cognitive therapy, behavioral therapy or biofeedback;

29. Charges relating to counseling services including but not limited to group, marriage, family, child, career, social adjustment, pastoral and financial, except as provided herein;

30. Charges in connection with speech therapy unless such therapy is expected to restore speech to a person who has lost an existing speech

function as the result of a disease or injury, and the therapy is pre-certified;

31. Charges in connection with occupational or physical therapy unless such therapy is expected to restore a maximum level of function to a person who has lost an existing function as a result of a disease or injury and the therapy is pre-certified;

32. Charges in connection with Early Intervention Programs, developmental delay or learning disabilities and related speech therapy services;

33. Charges for services, procedures, drugs and other supplies relating to treatment that are determined by the Plan to be experimental. For purposes of this section, experimental means any medical procedure, device, technology, treatment, course of treatment, drug or biological product that is: used for investigational or research purposes; restricted to use at centers which are primarily intended for the purpose of carrying out clinical and scientific studies; not proven to have therapeutic value or benefit for diagnosis or treatment of the covered person's condition; or whose effectiveness is medically questionable or not generally recognized by the medical literature as effective or appropriate for diagnosis or treatment of the covered person's particular condition. Government approval of a procedure, device, technology, treatment, drug or biological product is relevant but not conclusive in determining whether such procedure, device, technology, treatment, drug or biological product is experimental;

34. Charges for services rendered in a skilled nursing facility except if approved (for up to a maximum of 30 days per incident) through the MagnaCare pre-certification program;

35. Charges incurred for the acquisition of donor organs in the case of an organ transplant unless pre-approved by the Plan;

36. Charges for infant formula, regardless of the medical condition of the infant;

37. Charges for acupuncture unless provided through the JIB Medical Center located at the Electrical Industry Center;

38. Charges for genetic testing;

39. Charges for Lasik eye surgery, laser hair removal and other non-approved laser surgery;

40. Charges for the treatment of Autism, Attention Deficit Disorder or Adult Attention Deficit and Hyperactivity Disorder, unless the treatment is by a psychiatrist or an approved provider as described herein;

41. Charges for services by assistant surgeons in teaching hospitals where residents are available;

42. Charges for full-body screening CT scans and virtual colonoscopies;

43. Services in connection with alternative, holistic or homeopathic medicines;

44. Charges for durable medical supplies or appliances prescribed by a chiropractor or dentist;

45. Charges for diabetic and nutritional counseling unless as allowed under approved programs and within the JIB Medical Center;

46. Charges for non-urgent ambulance or ambulette transport and non-certified air ambulance transfer;

47. Charges related to lactation services such as consultation, breast pump and other supplies;

48. Charges for residential facility and habilitation care; and

49. Charges for private duty nursing services.

Any exclusion under this section will not apply to the extent that coverage is otherwise specifically provided in this document. Excluded charges will not be used when determining reimbursement.

The above list of exclusions is provided for illustrative purposes and is not all inclusive. You should always call MagnaCare at 1-877-624-6210 for verification as to a covered service or procedure.

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 were not in

effect. A Participant ***must*** report other group coverage on the claim form submitted for reimbursement of medical expenses.

The order in which this group health plan will coordinate with other group health plans is as follows:

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

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

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

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

For purposes of this section, another group plan includes any plan of medical or hospital expense coverage for individuals in a group or "no-fault" automobile reparations insurance that is required under any law of a government. Individual policies are not subject to the Coordination of Benefits Provision. In addition, the Plan will not act as the primary payer for eligible working dependent children who receive medical benefits from their employer or if a Participant's automobile policy has a Personal Injury Protection ("PIP") provision available. The Plan does not coordinate payment of prescription drug benefits with other health plans.

COBRA CONTINUATION COVERAGE
INTRODUCTION

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this entire booklet or contact the Plan Administrator.

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

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you elect continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under this Plan to similarly situated Participants or family members.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse dies; or
- You become divorced from your spouse.

Note that if you are the spouse of a Participant who dies, you will receive 36 or 60 months of coverage (depending on the event) at no expense (or until the date of your remarriage if sooner). See page 6 for a description of the Plan's coverage of surviving spouses and children following the death of a Participant.

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

- 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 (or 60 months of continued coverage or until the surviving spouse remarries, if sooner for dependents of Participants who die while employed or are registered as available for employment) at no expense to dependent children of a Participant who dies. See page 6 for a description of these provisions.

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries who would lose coverage as a result of the end of the Participant's employment (for other than the Participant's gross misconduct), reduction of hours or the death of the Participant. The Plan will notify the Participant and other qualified beneficiaries of their COBRA election rights.

You Must Give Notice of Some Qualifying Events

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

How Is COBRA Coverage Provided?

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

How Do I Elect COBRA?

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

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

How Long Does Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. If the qualifying event is the end of employment or due to the reduction of the employee's hours of employment, COBRA continuation coverage can last for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as explained on the following page. When the qualifying event is the death of the employee, your divorce or a dependent child is losing eligibility as a dependent child, COBRA continuation coverage can last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability extension of 18 month period of continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have

caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Early Termination of Continuation Coverage

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

1. The Plan no longer provides coverage to any Participant.

2. The premium for your continuation coverage is not paid on a timely basis.

3. You become covered for medical benefits under another group health plan that does not have a pre-existing condition exclusion. If the new plan includes a pre-existing conditions limitation or exclusion, coverage will cease under this Plan once the pre-existing conditions limitation or exclusion has been satisfied or once eligibility for continuation coverage otherwise terminates.

4. You become entitled to Medicare.

5. Any other reason for termination provided under the Plan, such as fraud.

6. The employer with respect to whom you obtained your coverage in the first place withdraws from the Plan and covers a classification of its employees under another group health Plan. In that case the employer's new Plan is required to continue your COBRA coverage.

Addition of New Dependents While on COBRA

If a child is born to you or placed with you for adoption while you are on COBRA continuation coverage, the child will be treated as a qualified beneficiary under COBRA and will be eligible for coverage for the balance of the COBRA coverage period available to other qualified beneficiaries with respect to the same qualifying event. You may also add a new spouse to your coverage if you get married while you are on COBRA continuation coverage, but the new spouse is not a qualified beneficiary under COBRA even though he or she will receive coverage under the Plan for the balance of the period. In order to add a new dependent, you must notify the Members' Records Department at the Joint Industry Board, 158-11 Harry Van Arsdale, Jr. Avenue, Flushing, N.Y. 11365, within 30 days after the birth, placement or marriage and provide the birth certificate, adoption papers or marriage certificate, as applicable.

Other Coverage Options

If you become entitled to COBRA continuation coverage, please note that there may be other coverage options for you and your family. You'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

CERTIFICATE OF CREDITABLE COVERAGE

On or before December 31, 2014, 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 preexisting 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

After December 31, 2014, you will no longer need a Certificate of Creditable Coverage because exclusions based on preexisting conditions will be prohibited.

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.

If You Have Questions

Questions concerning the Plan, your COBRA continuation coverage rights, or your coverage while on Military Duty should be addressed to the Joint Industry Board. For more information about your rights under ERISA, including COBRA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Joint Industry Board informed of any changes in the addresses of family members and of any change in your marital status. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

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

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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 exclusions.

If the Participant does not return to work after the FMLA leave or upon the Participant's determination that he or she will not return to employment, if earlier, the Participant will be considered to have terminated employment, and the Participant will be eligible for COBRA continuation coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. Coverage under this Plan includes reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Coverage for these services will be subject to the Plan's co-payments if rendered by a Network provider. If such services are provided by non-Network

providers, reimbursement will be based on the Plan's schedule of surgical fees, after applying the applicable co-payments.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

In accordance with the Newborns' and Mothers' Health Protection Act of 1996, the Plan provides that coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a Cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child.

CLAIMS AND APPEALS PROCEDURES

WHAT IS A CLAIM?

A Claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures. Simple inquiries about benefits or eligibility that are unrelated to any specific benefit claim or requests for prior approval of a benefit that does not require prior approval by the Plan will not be considered as claims for benefits.

TYPES OF CLAIMS

The claims and appeals procedures for benefits will vary depending on whether your Claim is Pre-Service, Urgent Care, Concurrent Care, or Post-Service. Read each section carefully to determine which procedures govern your Claim.

PRE-SERVICE CLAIMS

A Pre-Service Claim is a Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. The types of claims that require prior approval have been previously described.

Important: If you fail to pre-certify a service that requires prior approval, you will receive a REDUCED BENEFIT or NO BENEFIT for that service.

For properly filed Pre-Service Claims, you and/or your doctor will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than 5 days after receipt of the Claim of the procedures to be followed in filing a claim. You will receive notice of an improperly filed

Pre-Service Claim only if the Claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the Claim is re-filed properly, it will not constitute a Claim.

If an extension is needed because additional information is needed from you or your doctor, the extension notice will specify the information needed. In that case, you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your Claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the Claim will be suspended until the earlier of either 45 days or the date you respond to the request. The Plan then has 15 days to decide your Pre-Service Claim and notify you of the determination.

URGENT CARE CLAIMS

An Urgent Care Claim is any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

- could seriously jeopardize your life or health or your ability to regain maximum function, or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your Claim is an Urgent Care Claim is determined by the applicable claims payer by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, any Claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than 24 hours after receipt of the Claim of the procedures to be followed in filing a Claim. Unless the Claim is re-filed properly, it will not constitute a Claim.

If you are requesting pre-certification of an Urgent Care Claim, the Plan will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical emergencies, but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you and/or your

doctor will be notified as soon as possible, but not later than 24 hours after receipt of the Claim of the specific information necessary to complete the Claim. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your Claim will be denied.

Notice of the decision will be provided no later than 48 hours after the specified information is received or the end of the period given for you to provide this information, whichever is earlier.

CONCURRENT CLAIMS

A Concurrent Claim is a Claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a previously approved benefit. (An example of this type of Claim would be an in-patient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days are still appropriate). In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve Urgent Care will be decided according to the applicable Pre-Service or Post-Service time frames.

POST-SERVICE CLAIMS

A Post-Service Claim is a Claim that does not require that you obtain approval prior to obtaining the service. Any Claim that is not identified as a Pre-Service or Concurrent Claim is a Post-Service Claim.

Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days of receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which a decision will be made.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have

45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your Claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The deadline is suspended from the earlier of either 45 days or until the date you respond to the request. The entity responsible for paying the claim then has 15 days to decide the claim and notify you of the determination.

WHEN CLAIMS MUST BE FILED

All Claims should be filed within one year following the date the charges were incurred. Any Claim that is not submitted within a 12-month period will be denied as untimely.

HOW CLAIMS MUST BE FILED

Medical and Hospitalization Claims

Pre-Service, Urgent and Concurrent Medical and Hospitalization Claims

Pre-CertificationThrough MagnaCare

For Pre-Service Claims that require pre-certification through MagnaCare as described above, you must contact MagnaCare's Pre-certification Department at 877-624-6210.

Pre-Certification Through JIB Hospitalization Department

For Pre-Service Claims that require pre-certification through the Hospitalization Department of the Joint Industry Board as described above, you must contact the Hospitalization Department at the Joint Industry Board, 718-591-2000, Monday through Friday between the hours of 8:30 A.M. and 4:30 P.M.

Pre-Certification of Substance Abuse Claims

For Pre-Service Claims for alcoholism or drug addiction you must contact MagnaCare's Pre-certification Department at 877 624-6210 .

Post-Service Medical and Hospitalization Claims

In-Network Claims

Except as described below, you are generally not required to file a Claim in order for the Plan to pay for services received from an in-Network provider. You need only present your MagnaCare identification card at the time services are rendered and pay the applicable co-payment; the MagnaCare participating provider or hospital will then submit a bill for services and any other required

information directly to MagnaCare, Inc., P. O. Box 1001, Garden City, NY 11530.

Out-of-Network Claims

All out-of-Network Claims must be submitted to:

MagnaCare
P.O. Box 1001
Garden City, NY 11530

Medicare Claims

You are not required to submit your Medicare Summary Notice for reimbursement. Once Medicare has processed your claim, MagnaCare will ***automatically*** forward the eligible Part A and Part B deductibles or coinsurance payments approved but not reimbursed by Medicare **directly to the Medicare participating provider**. Please note that certain claims, as described on page 22 will require a paper submission.

Prescription Drug Claims

Pre-service Prescription Drug Claims

For those prescription drugs that require pre-approval as described above, you or your pharmacist must contact Express Scripts' Coverage Review Unit at 800-818-0883.

For drugs that require proof of medical necessity as described above, you must submit proof of medical necessity to the Joint Industry Board, Members' Records Department, at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365.

Post-service Prescription Drug Claims

In-Network

If you fill a prescription at a participating Express Script pharmacy, you need only submit your identification card to the pharmacist and pay the applicable co-payment.

Out-of-Network

If you get your prescription filled at a non-participating pharmacy, you must submit a Direct Reimbursement Claim Form along with the original pharmacy receipt directly to the Plan. You may obtain a Direct Reimbursement Claim Form by contacting the Plan.

Optical Benefits

In-Network

The Plan provides optical benefits through the JIB Medical Center. However, if you are retired and live outside of the five boroughs of New York City contact the Members' Records Department to obtain an optical voucher for a participating optical outlet within the General Vision Services ("GVS") Network. If you obtain an optical voucher form, you are not required to submit a claim form.

Out-of-Network

If you do not obtain services from a participating optical provider, you must submit an Application for Benefits along with the original optical bill for services to the Plan.

Notice of Decision

You will be provided with written notice of a denial of a Claim, whether denied in whole or in part. This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

If an internal rule, guideline or protocol was relied upon in deciding your Claim, you will receive a statement that a copy of the rule is available upon request at no charge.

If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or if some other, similar exclusion applies, you will receive a statement that a copy of the exclusion is available upon request at no charge.

For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

APPEALS PROCEDURE

First Level Appeal to the Joint Industry Board of the Electrical Industry

If your Claim is denied in whole or in part and you wish to contest the denial, you must appeal the Plan's determination to the Joint Industry Board of the Electrical Industry (the "Joint Board"). Your appeal must be made in writing within 180 days after you receive notice of denial of your Claim and shall set forth the reasons why you believe the Plan's decision is incorrect. In the case of Urgent Care Claims, your appeal need not be in writing and may be made by calling the Hospitalization Department at the Joint Board at 718-591-2000.

For Urgent Care Claims, you will be sent a notice of the Plan's decision on appeal within 72 hours of the Joint Board's receipt of the appeal. The appeal to the Joint Board is the only level of appeal for Urgent Care Claims. If you wish to challenge any denial of an Urgent Care Claim, you may bring a civil action under ERISA Section 502(a).

For Pre-Service Claims, you will be sent a notice of the Joint Board's decision on appeal within 15 days of the Joint Board's receipt of the appeal.

For Post-Service appeals, you will be sent a notice of the Joint Board's decision on appeal within 30 days of the Joint Board's receipt of the appeal.

Second Level Appeal to the Board of Trustees

For all Claims other than Urgent Care Claims, if the Joint Board denies your first level appeal and you wish to contest the denial, you must file a second appeal to the Board of Trustees (the "Trustees"). Your appeal to the Trustees must be in writing and must be made within 60 days after you receive notice of denial of your appeal by the Joint Board and must set forth the reasons why you believe the decision is incorrect.

For appeals of denials of Pre-Service Claims, the Trustees will notify you of the determination of your appeal within 15 days of the Trustees' receipt of the appeal. For appeals of denials of Post-Service Claims, the Trustees will notify you of the determination of your appeal within 30 days of the Trustees' receipt of the appeal.

Review Process

You have the right to review documents relevant to your Claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of the Plan's policy regarding the denied treatment or

service. Upon request, you will be provided with the identities of medical experts, if any, who advised the Plan concerning your Claim, without regard to whether the advice was relied upon in deciding your Claim.

A different person will consider your first level appeal at the Joint Board from the one who originally denied your Claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that you submit. Similarly, on the second level appeal, the Trustees will not afford deference to the decision by the Joint Board.

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

NOTICE OF THE DETERMINATION OF YOUR APPEAL

The Joint Industry Board's and/or the 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 Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your Claim, upon request and free of charge;
- A statement of your right to file a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or if some other, similar exclusion applies, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your Claim, or a statement that it is available upon request at no charge.

DESIGNATED AUTHORIZED REPRESENTATIVES

You may submit a Claim and appeal a denial of a Claim on your own behalf. Alternatively, you may designate another individual to act as your representative. If you choose to designate someone else to act on your behalf, you must do so in writing on a form provided by the Plan; the designation will not be effective until it is received by the Plan. You may revoke your designation of an Authorized Representative but such revocation will not be effective until received by the Plan and such revocation must be in writing in order to be effective. You may obtain a Designated Authorized Representative form by contacting the Plan. Once you have designated an Authorized Representative, all communications and notices from the Plan that would otherwise be sent to you will be sent only to your Authorized Representative.

FRAUD AND PLAN'S RIGHT TO RECOVERY

The Pension Committee reserves the right to suspend or discontinue benefits, or to deny the Claim of any Participant or eligible dependent who makes or whose service provider makes a 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 Pension Committee shall have the right to recover, or to offset against future benefits, any payments made as a result of false or fraudulent statements, information or proof submitted by a Participant, eligible dependent or by a service provider. The Pension Committee shall have the right to recover, or to offset against future benefits, benefits paid on behalf of a former spouse for services rendered to a spouse subsequent to divorce, other than under the COBRA continuation coverage provisions described above .

PENSION, HOSPITALIZATION AND 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 (and have, if applicable) 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 and your eligible dependent also agree to reimburse the Plan promptly for the

benefits paid out on behalf of any recovery from any source including the thirdparty or the third party's insurer.

The Plan's right to subrogation and reimbursement applies to all rights of recovery of you, your eligible 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, 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 Pension 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 Pension 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 by agreement 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 review carefully the specific limitations and exclusions set forth above.

The Plan has contracted with *NexClaim Recoveries* to administer all subrogation cases.

"Grandfathered" Plan Status

The Pension, Hospitalization and Benefit Plan of the Electrical Industry, believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with

certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the Joint Industry Board of the Electrical Industry at 718-591-2000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

AMENDMENT AND TERMINATION

The Pension Committee, acting pursuant to the Trust Agreement, may at any time and from time to time modify this Plan and all benefits provided hereunder in any of its terms, with respect to all Participants, including active Participants and retirees, and with respect to their eligible dependents, including benefits for which individuals have already established eligibility. 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 Pension Committee, the Plan Administrator and/or the Trust Fund, except such right as is specifically provided for herein, or given by action of the Pension 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 Pension 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 Pension Committee with the consent of the Employers and the Union.

In the event of a termination of the Plan, the Pension 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 the Trust 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 Pension 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 eligible 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 or eligible dependent to assign the payment of benefits directly to a hospital as a result of a hospital stay. In addition, an eligible Participant or eligible dependent may assign the payment of benefits directly to a provider who accepts the reimbursement from the Plan as payment in full.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Benefits may become payable directly or indirectly to an eligible 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 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 Pension, Hospitalization and 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.

- Until January 1, 2015, reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. After December 31, 2014, you will no longer need a Certificate of Creditable Coverage because exclusions based on preexisting conditions will be prohibited.

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.

NOTES

NOTES

NOTES

PENSION COMMITTEE
JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365
718-591-2000
www.jibei.org

OFFICERS AND TRUSTEES

Steven Smith
Chairman

John Pinto
Treasurer

Christopher Erikson
Secretary

John E. Marchell
Trustee

EMPLOYER TRUSTEES

Kristine DeNapoli
Stephen Gianotti
Steven Lazzaro
John G. Marcato
Sandra Milad-Gibson
John Pinto
Edward Rothowski
David I. Samuels
Steven Smith
Rudy Weissberg

EMPLOYEE TRUSTEES

Thomas Capurso
Christopher Erikson
Elliot Hecht
William Hofving
John E. Marchell
Vincent McElroen
Raymond Melville
Luis G. Restrepo
James Robson
Lance Van Arsdale

Dr. Gerald Finkel
Chairman,
Joint Industry Board of the Electrical Industry

Vito V. Mundo
Counsel