A Guide to Your Plan of Benefits

Summary Plan Description

Effective July 1, 2015

I.B.E.W. LOCAL NO. 236

HEALTH AND BENEFIT FUND

I.B.E.W. 236 Health & Benefit Fund
3000 Troy-Schenectady Road, Schenectady, NY 12309 *Telephone: 518-782-5499*

July 1, 2015

Dear Participant:

This booklet is a description of the I.B.E.W. Local 236 Health Fund as it is in effect on July 1, 2015. There have been many changes in the Plan since the last booklet was written. We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

You will find that the benefits are described, as well as the eligibility requirements that you must satisfy with respect to each of them. These and other matters are discussed in ten sections of the booklet as follows:

I. Eligibility Requirements & Plan Participation
II. Insurance Benefits
III. HRA Plan Benefits
IV. Pooled Benefits
V. Claim Procedure
VI. COBRA Continuation Coverage Rights
VII. Special Allocations
VIII. Qualified Medical Child Support Order
IX. Rights Under ERISA
X. Technical Details

The Plan is governed by a Board of Trustees equally represented by Labor and Participating Employers. Our role, as Trustees of the Health and Benefit Fund, includes the responsibility for collecting contributions (which are required by an agreement between an employer and the I.B.E.W. Local Union No. 236 or between an employer and the Trustees). The Board of Trustees has the sole power to amend the Plan and the ultimate responsibility for the management of plan assets. The Board of Trustees is assisted in these and other tasks by professional advisors whom we hire from time to time. These include an actuary, an accountant, an attorney, an investment advisor and one or more investment managers.

The Fund Administrator maintains the daily operation of the Plan. The Fund Administrator and his staff are available to answer any questions or as a resource to obtain additional information about the Plan.

If, after going through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the fund office at 518-782-5499.

Sincerely,

Board of Trustees
I.B.E.W. Local No. 236 Health & Benefit Fund

Important Aspects

- **Familiarize yourself with the entire booklet.**
- **Application must be made for <u>all</u> benefits.**
- **The fund office should be aware of all your dependents and your current address.**
- **Keep your death benefit beneficiary designation up to date.**
- **All claim forms must be submitted in a timely manner and completely filled in; incomplete or late forms will be denied or returned.**

Directory

BOARD OF TRUSTEES

Employer

Joseph P. Gross
Gross Electric, Inc.
27 Silver Circle
Queensbury, NY 12804

Simeon Hunsdon
Hour Electric Company, Inc.
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Fort Edward, NY 12828

Christopher Spraragen
Schenectady Hardware & Electric
Erie Boulevard
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Schenectady, NY 12301

Union

Mark A. Lajeunesse
President, IBEW Local 236
3000 Troy-Schenectady Road
Schenectady, NY 12309

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Treasurer, IBEW Local 236
3000 Troy-Schenectady Road
Schenectady, NY 12309

Donald W. Rahm
Business Manager, IBEW Local 236
3000 Troy-Schenectady Road
Schenectady, NY 12309

PLAN PROFESSIONALS

Actuary

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

Attorney

William Pozefsky, Esq.
Pozefsky, Bramley & Murphy
90 State Street
Albany, NY 12207

Accountant

Teal, Becker & Chiaramonte, CPAs, PC
7 Washington Square
Albany, NY 12205

Fund Administrator

James Bennett
3000 Troy-Schenectady Road
Schenectady, NY 12309

HRA Administrator and Consultant

Jaeger & Flynn Associates
30 Corporate Dr.
Clifton Park, NY 12065

Fund Modification or Termination

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

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested at any time;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such right to modify or terminate is not contingent on financial necessity.

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

For All Participants, Including Employees, Retirees, And Dependents. This summary plan description includes information concerning the benefits provided by the Trustees to participants, including employees, retirees and dependents. It also outlines the circumstances that can result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits that an employee, retiree or dependent might otherwise reasonably expect plans to provide.

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

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

IMPORTANT NOTICE

The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. This booklet describes the Plan as it exists on July 1, 2015.

CAUTION

This booklet and the personnel at either the fund office or Jaeger & Flynn Associates are the only authorized sources of Plan information for you. The Trustees of the Fund have not empowered anyone else to speak for them regarding the Health and Benefit Plan. No employer, union representative, supervisor or shop steward is in a position to discuss your rights under the Plan with authority.

COMMUNICATIONS

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

NO GUARANTEE OF INCOME-TAX CONSEQUENCES

Neither the Board of Trustees nor the fund office makes any commitment that any amounts paid to you or for your benefit under this Plan will be excludable from your gross income for Federal or State income-tax purposes, or that any other Federal or State tax treatment will apply to or be available to you. You must consult your own tax advisor regarding all tax treatment.

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I. Eligibility Requirements & Plan Participation

This section describes the provisions of the Plan; such as general eligibility requirements and the requirements for continuing your eligibility. In addition to these general eligibility requirements, you may also need to satisfy specific eligibility requirements for each individual benefit.

A. GENERAL DESCRIPTION OF THE PLAN

The I.B.E.W. Local 236 Health & Benefit Fund is a Health Reimbursement Account (HRA) plan, IRS code 501 (c)(9). For each hour you work in Covered Employment, employer Health & Benefit Fund contributions will be made to the HRA plan. Covered Employment is work for an employer who is obligated to make contributions to the Fund pursuant to a Collective Bargaining Agreement or other written agreement with the Trustees. A portion of such contributions will be credited to an HRA for you.

The Trustees will determine the portion of the contributions which will be credited to your HRA. This determination may change from time to time contingent upon the financial requirements of the whole Plan.

Once you satisfy the general eligibility requirements, you will be a participant in the Plan.

Your account will grow with the contributions that are made to it in the future. Your account will be decreased by any benefit distribution or administration charges. Administration charges may be adjusted at the Trustees discretion on an equitable basis, if, for instance, the investment yield on the Plan reserves is not sufficient to offset the costs of administration of the Plan.

No more will be paid out to you (or your beneficiary) under this Plan than has come into your HRA by way of contributions made on your benefit and special allocations. Special allocations are explained later on in Section VII.

Once your account is reduced to zero or to an amount which is less than your monthly insurance benefit premium you will stop being a participant in this Plan unless your account is credited with a special allocation or you elect to self-pay. All dormant accounts will be accessed an administration charge until the account is depleted.

B. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

This notice has been drafted to comply with the "HIPAA Privacy Rules", under federal law. Any terms that are not defined in this notice have the meaning specified in the HIPAA Privacy Rules. The references to "we" and "us" throughout this notice mean the Plan(s).

1. How We Protect Your Privacy

   We are required by law to protect the privacy of your protected health information and to provide you with this notice of our privacy practices. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan(s), or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this notice to protect your confidentiality. We maintain confidential information and have procedures for accessing and storing confidential records. We restrict internal access to

your confidential information to employees who need that information to provide your benefits. We train those individuals on policies and procedures designed to protect your privacy. Our Fund Administrator monitors how we follow those policies and procedures and educates our organization on this important topic. We are required to notify you of any breach of your protected health information.

2. How We May Use and Disclose Your Protected Health Information

We will not use your confidential information or disclose it to others without your written authorization, except for the following purposes. When required by law, we will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

a. Treatment. We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

b. Payment. We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan(s). For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your protected health information to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment.

c. Health Care Operations. We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

d. Disclosures to the Plan Sponsor. We may disclose your protected health information to our Plan Sponsor. The Plan Sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan. The Plan Sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan, it will restrict access to your protected health information to those individuals whose job it is to administer the Plan and it will not use protected health information for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan Sponsor. The Plan may also disclose summary health information to the Plan Sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

e. Disclosures to Business Associates. We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

f. Disclosures to Family Members or Others. Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

g. Other Uses and Disclosures. The law allows us to disclose protected health information without your prior authorization in the following circumstances:

   i. Required by law. We may use and disclose your protected health information to comply with the law.

   ii. Public health activities. We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.

   iii. Reports about victims of abuse, neglect or domestic violence. We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

   iv. To health oversight agencies. We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.

   v. Lawsuits and disputes. If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.

vi. Law enforcement. We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).

vii. Coroners, medical examiners and funeral directors. We may disclose protected health information to facilitate the duties of these individuals.

viii. Organ procurement. We may disclose protected health information to facilitate organ donation and transplantation.

ix. Medical research. We may disclose protected health information for medical research projects, subject to strict legal restrictions.

x. Serious threat to health or safety. We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.

xi. Special government functions. We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

xii. Workers' compensation or similar programs. We may disclose your protected health information when necessary to comply with worker's compensation laws.

h. Uses and Disclosures with Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposes described in this notice, without your written authorization. Examples of disclosures of health information that would require authorization from you are:

i. Most uses and disclosures of psychotherapy notes (if recorded by a covered entity);

ii. Uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications (unless it is for certain limited Health Care Operations); and

iii. Disclosures that constitute a sale of protected health information.

You may revoke an authorization that you previously have given by sending a written request to our Fund Administrator, but not with respect to any actions we already have taken.

i. Your Individual Rights

You have the following rights:

i. Right to inspect and copy your protected health information. Except for limited circumstances, you may review and copy your protected health information. Your request must be addressed to the Fund Administrator. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

   If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

ii. Right to correct or update your protected health information. If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Fund Administrator. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

   We may deny your request if you ask us to amend information that:

   (1) Was not created by us, unless the person who created the information is no longer available to make the amendment;

   (2) Is not part of the protected health information we keep about you;

   (3) Is not part of the protected health information that you would be allowed to see or copy; or

   (4) Is determined by us to be accurate and complete.

   If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information.

iii. Right to obtain a list of the disclosures. You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. You must make a written request to the Fund Administrator to obtain this information.

   The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel. The list we provide will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period.

You may also request and receive an accounting of disclosures of electronic health records made for payment, treatment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009, or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

iv. Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

v. Right to request additional restrictions on health information. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.

j. Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to the Fund Administrator listed below. The Plan(s) will not retaliate against you for filing a complaint. You may also contact the Fund Administrator if you have questions or comments about our privacy practices.

k. Future Changes to Our Practices and This Notice

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this notice to reflect the change. We will send or provide a copy of the revised notice. You may also obtain a copy of any revised notice by contacting the Fund Administrator.

Contact Information

If you have any questions about this notice, please contact:

IBEW Local 236 Health & Benefit Fund
3000 Troy-Schenectady Road
Schenectady, NY 12309
Phone: (518) 782-5499

C. ELIGIBILITY REQUIREMENTS

Before you are eligible for any of the benefits under this Plan, you must satisfy the general eligibility requirements in your current period of Plan participation.

1. General Eligibility Requirements

   You must work 360 reported hours in Covered Employment within a period of no more than three calendar months. Once you satisfy this requirement, you will become a participant in the Health & Benefit Fund on the first day of the next month. You must also be available for Covered Employment at the time your coverage is to start.

   If you are not available for Covered Employment at the time your coverage is scheduled to begin, your hours of Covered Employment will be forfeited and, to be eligible for coverage again, you must accumulate 360 reported hours within three calendar months of Covered Employment again. An exception is made if it is your disability that makes you unavailable for Covered Employment. Once you satisfy the general eligibility requirements your account will not be forfeited.

   If contributions are made to the Plan for you before you satisfy the general eligibility requirements such contributions cannot be used for any benefit but will be used for Plan administrative expenses.

   If you have once satisfied the general eligibility requirements and become unavailable for Covered Employment, in order to qualify for coverage when you return to the plan you must have a positive balance in your HRA and have worked at least 360 hours over a three calendar month period immediately preceding your return to Covered Employment. If you do not have the required hours then you must either self-pay through COBRA or where possible, utilize the Premium Advance Allocation (see section VII. Special Allocations) to bring your balance to zero excluding the contributions received for requalifying.

   If you are a new participant, you will have sixty (60) days from the date of your eligibility to complete a health insurance enrollment form. Forms are available at the fund office. If you are eligible for coverage on or after 7/1/2015 and have not responded to the eligibility packet within the 60 day guideline, you will be automatically enrolled in individual coverage in the lowest cost health plan available. This automatic enrollment applies to all participants for whom the fund office has, or can reasonably obtain, the necessary demographic information (also known as “vitals”). If vitals are not available from any source, you will not be enrolled in a health plan and $500 will be deducted from your HRA for each month you fail to submit the required paperwork. Such deductions will not be returned to your account even if you later satisfy the enrollment requirements.

2. Active Participants

   You will be considered an Active Participant if you are eligible to participate in the Plan according to the rules of general eligibility established by the Trustees of the Fund and you fall into any of the following categories:

   a. You are employed by an employer who has a Collective Bargaining Agreement with IBEW Local 236 requiring the employer to contribute to the IBEW Local No. 236 Health and Benefit Fund on behalf of participants covered under the agreement. In order to

continue as an Active Participant you must be on Book 1 at least once during the previous six (6) months, otherwise, your participation stops at the end of the month.,

b. You are an employee of IBEW Local 236, IBEW Local 236 Health and Benefit Fund, or Tri-City Joint Apprentice Training Center, or

c. You are employed by an employer who has a reciprocal agreement or any other written agreement requiring the employer to contribute to the IBEW Local No. 236 Health and Benefit Fund and such contributions remain in the IBEW Local No. 236 Health and Benefit Fund.

If you have once satisfied the general eligibility requirements for this Plan and your participation stops, you must once again satisfy the general eligibility requirements to be entitled to any benefits.

In addition to having satisfied the general and continuing eligibility requirements, you may have to satisfy special eligibility requirements depending upon the specific benefit you wish to use.

3. Retired Participants

Former Active Participants in the Plan may continue coverage as a Retired Participant as follows:

a. If you were covered for retiree benefits on 6/30/01 you will continue such retiree coverage under the terms of the plan you retired under.

b. If your effective date of pension is on or after 1/1/02, in order to be eligible for retiree coverage under this Health & Benefit Fund, you must satisfy each of the following requirements:

   i. You must be at least age 60;

   ii. You must have at least 20 years of Pension Service or Vesting Service under the Local 236, 438 or 724 Pension Plan;

   iii. If you retire with a normal or early pension, you must have been covered under the Local 236, 438 or 724 Welfare Plan for at least 60 of the last 120 months immediately preceding the start of your pension. If you retire with a disability pension, you must have been covered under one of the Welfare Plans for each of the 120 months immediately preceding the start of your disability pension; and

   iv. You must be covered under this Plan (or one of the three merging plans) during the month immediately preceding the start of your pension.

If you retire on or after 7/1/01 but before 1/1/02 you may elect the retiree coverage you would have been entitled to under the rules of your prior plan.

If you qualify under these terms, at the age of 60 the Fund will credit fifty percent (50%), up to a maximum credit of two hundred-fifty dollars ($250.00) per month towards the cost of your health, prescription drug, and dental insurance premiums obtained under the IBEW Local No. 236 Health and Benefit Fund. This credit is not applicable for coverage obtained outside those provided under the Plan nor is it applicable for working retirees receiving active coverage.

If you retire prior to your 60th birthday and you meet all of the eligibility conditions stated herein, you may elect coverage anytime after your 60th birthday. This election may be made during open enrollment or after a qualifying event.

After you become a Retired Participant and you subsequently elect to opt-out of coverage your participation in this plan will cease and you will not be allowed to participate in this Plan at a later date. However, your spouse may elect to remain covered if he/she was covered immediately before such election, once your spouse subsequently elects to opt-out of coverage your spouses' participation in this plan will cease and your spouse will not be allowed to participate in this Plan at a later date.

4. Eligible Dependents

The term Eligible Dependent means any of the following persons:

a. Your lawful spouse (if not legally separated per a judgment of separation or a duly executed and acknowledged separation agreement).

b. Your child, under 26 years of age who is:

i. Your natural child,

ii. Legally adopted,

iii. A proposed adopted child during the waiting period prior to the finalization of the child's adoption,

iv. Your step-child, or

v. A child that the Plan is required to cover under a Qualified Medical Child Support Order (QMCSO).

Your child will be an eligible dependent until the end of the calendar month in which the child attains age 26.

c. Your unmarried dependent child 26 years of age or over who would otherwise qualify as an Eligible Dependent per b. above except for the age restriction, and who is physically handicapped or incapable of self-sustaining employment because of mental retardation or physical handicap; became so incapable before attaining age 26; is chiefly dependent upon you for support and maintenance, and you provide proof of such incapacity at no expense to the Fund within 31 days of the date such child's coverage would ordinarily terminate due to attainment of age 26. Such dependent's coverage shall be continued as long as you remain eligible under the Fund.

D. DOCUMENTATION REQUIREMENTS

The following items are to be furnished to the fund office as proof and verification of eligibility for all dependents for either insurance coverage or reimbursement of uncovered medical expenses under the HRA.

The absence of the following documentation will suspend any coverage until provided:

1. For an eligible participant:
    a. driver's license,
    b. birth certificate,
    c. social security card,
    d. enrollment form, and
    e. attestation form as required
2. For a dependent spouse:
    a. spouse's social security number,
    b. certificate of marriage,
    c. spouse's birth certificate, and
    d. driver's license or other acceptable picture identification
3. For your dependent child under age 26:
    a. For a natural child born of a legally recognized marriage between you and your spouse:
        i. the child's birth certificate; and
        ii. the child's social security number.
    b. For a natural child not born of a legally recognized marriage between you and your spouse:
        i. the child's social security number, and
        ii. the child's birth certificate.
    c. For an adopted child:
        i. a copy of the court order of adoption,
        ii. a copy of the child's birth certificate, and
        iii. the child's social security number.

d. For a step child:

   i. a copy of the child's birth certificate, and

   ii. the child's social security number.

   Dependent claims submitted without the proper documentation will be delayed for payment until the fund office can determine whether dependent coverage is valid.

E. TERMINATION DATE OF BENEFIT COVERAGE

The benefit coverage for you or your dependent will terminate on the earlier of:

1. The date your eligibility terminates,

2. The date your spouse is no longer eligible as a dependent, or

3. The date your child is no longer eligible as a dependent.

F. REPORTING QUALIFYING EVENTS OR CHANGES

If you experience a qualifying event or a change occurs in your family status because of any of the below, you should immediately notify the fund office to revise your eligibility status to meet your new circumstances.

1. Qualifying Events

   a. A change in family status:

      i. marriage,

      ii. birth or adoption of a child or acquisition of a foster child,

      iii. legal separation,

      iv. divorce, or

      v. death of a spouse or dependent.

   b. You or a family member lose other coverage

      i. under another enrollment because the covering enrollment was terminated, canceled, or changed to self only,

      ii. under another federally-sponsored health benefits program,

      iii. under Medicaid or similar State-sponsored program for the needy, or

      iv. under CHAMPVA, TRICARE, or TRICARE-for-Life.

2. Changes

   It is important that you notify the fund office promptly if:

   a. Your retire from Covered Employment,

   b. You are receiving New York State or Social Security Disability benefits,

   c. You are receiving Workers' Compensation benefits,

   d. You change your address,

   e. You change your telephone number;

   f. You want to change your designated beneficiary, or

   g. You obtain employment outside the Collective Bargaining Agreement.

G. CHANGES IN THE PLAN

If this Plan is changed, all service you or your dependent receives after the effective date of the change will be subject to the change, even if you and your dependent were receiving care before the change became effective.

H. LEGAL ACTION

You must start any lawsuit against the Plan within 12 months from the date you or your dependent received the service and incurred the expense for which you want the Plan to pay for.

If you fail to file a claim within 12 months from the date the service is provided and the expense incurred, no legal action can be taken to recover benefits for such expense under the Plan. If you bring a suit against this Fund, you should be aware that the Trustees' decisions regarding your claim are binding on you, will be given deference in courts of law, and will not be overturned or set aside by any court of law unless they are found to be arbitrary and capricious or made in bad faith.

I. RIGHT OF EXAMINATION

The Fund will have the right and opportunity to examine any person who is the basis of a claim while that claim is pending. This will be done at the Fund s expense.

J. EFFECTIVE DATE OF BENEFIT COVERAGE

Initial benefit coverage for you will start at your effective date as determined by the rules of benefit eligibility. Initial benefit coverage for your dependents begins on your effective date.

K. BENEFIT COVERAGE

Benefits provided by the Health & Benefit Fund can be classified as one of three categories of benefits; the insurance benefits, HRA benefits, or pooled benefits. Each of these categories can then be subdivided into smaller benefits, as outlined below:

Insurance Benefits

- Comprehensive Medical
- Dental
- Prescription Drug

HRA Benefits

- Health Expenses
- Post-Tax Health Insurance Premiums

Pooled Benefits

- Short-Term Disability (STD)
- Long-Term Disability (LTD)
- Life Insurance

The insurance benefits are intended to cover most traditional medical expenses such as hospital charges, physician's fees, prescription drugs and dental expenses.

The HRA benefits are designed to reimburse IRS qualified medical, dental and vision expenses not covered by the insurance program. Refer to IRS Publication 502 for specific examples of qualified expenses. You may also visit their website at http://www.irs.gov/publications/p502/.

The pooled benefits cover life insurance and some wage replacement benefits should you become disabled while still an Active Participant.

II. Insurance Benefits

As long as you satisfy the Plan's eligibility requirements and remain available for Covered Employment, each month the charges for certain health care coverage will be subtracted from your account so long as your account balance is sufficient to cover the total monthly charges. These monthly charges are called premiums. The total amount of premium deducted from your account depends upon which plan of coverage you select.

Under certain conditions, if your account runs out, you may be permitted to self-pay your health care premium. Please refer to Section VI for information regarding self-payment under COBRA.

The health care insurance is available to you, as an eligible participant, your lawful spouse and your Eligible Dependent children. If your spouse and children are already covered under your spouse's employer's health care plan or government program (e.g. Child Health Plus, Family Health Plus), you may elect that you be covered for "single" health care insurance only. If you, yourself, are also covered under your spouse's employer's health care plan, government program or some other employer health care plan, you may elect that you also not be covered under the insurance benefit and your HRA will be charged the applicable opt-out fee. However, in order to forego coverage for your dependents or yourself, you have 60 days to show the fund office that the coverage of your dependents and/or you, under the spouse's employer's (or other employer's or government program) health care plan meets certain standards set down by the Trustees. The Fund Administrator will let you know what these standards are if you contact the fund office. Further, if such other health coverage stops (except for COBRA), the Plan's health care insurance benefit must be continued as of the date the loss from your spouse's employer's health care plan, government program, or some other employer health care plan.

Eligibility For Employment Assistance Under Medicaid Or Child Health Insurance Plan (CHIP)

You or your dependents who are eligible, but not enrolled, under the terms of the Plan are permitted to enroll for coverage under the terms of the Plan if you or your dependents are determined to be eligible for premium assistance through Medicaid or CHIP.

Termination of Medicaid or CHIP Coverage

If you or your dependents are covered under a Medicaid plan or under a State child health insurance plan (CHIP) and the coverage under such a plan is terminated as a result of loss of eligibility for such coverage then you may request coverage under this Plan not later than 60 days after the Medicaid or CHIP coverage ends.

Benefits

Each month premiums will be taken from your account (if you are eligible for the insurance benefit) to pay for your:

1. Medical coverage,
2. Dental coverage,
3. Prescription drug coverage, or
4. Medical Opt-out premium.

The following table is a brief outline of the benefits provided by the insurance benefit. A more detailed description of each benefit follows this table.

Type of Benefit	Persons Covered	Benefit
Medical	Active Participants, Retirees and Dependents	Active Participants and Retirees may choose between an EPO Plan administered by Blue Shield of Northeastern New York (BSNENY), or two PPO plans administered by CDPHP. Retirees eligible for Medicare also have a Medicare Advantage Plan option insured by BSNENY.
Dental (optional)	Active Participants, Retirees and Dependents	Administered by BSNENY
Prescription Drugs	Active Participants, Retirees and Dependents not eligible for Medicare	SavRx Prescription Drug Card
	Retirees and Dependents eligible for Medicare	The Medicare Advantage Plan option includes Prescription Drug coverage. The other options do not include Prescription Drug coverage

Note: This Plan limits Participants' annual out-of-pocket medical costs for covered essential health benefits to no more than $6,600 (individual) and $13,200 (family). These limits are subject to change in accordance with the Affordable Care Act and to the extent that a higher limit is allowed under the law, that limit will apply.

A. MEDICAL BENEFIT

The medical benefit is administered by the insurance company you select. The products currently offered are an EPO Plan administered by BSNENY and two different PPO Plans administered by CDPHP. Medicare eligible retirees may choose a Medicare Advantage Plan insured by BSNENY. Please refer to the plan document or SPD provided by BSNEY or CDPHP for a complete description of this benefit.

Newborns' And Mothers' Health Protection Act Of 1996 (NMHPA)

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

The Women's Health And Cancer Rights Act Of 1998

Under a federal law called the Women's Health and Cancer Right's Act of 1998 the Fund is required to provide you with an annual notice of your rights under this Act.

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan's benefit for breast reconstruction and related services will be the same as the benefits that apply to other covered services. You should refer to the medical plan documents provided by your health insurance company or contact the fund office for a description of the benefits and any limitations that may apply.

B. DENTAL BENEFIT (OPTIONAL)

If you so choose, at open enrollment you may enroll in the dental benefit. Once you elect the dental benefit you must remained covered for a full year. The dental benefit is currently administered by BSNENY. If you use the services of a participating BSNENY dentist, basic preventive services will be covered at 100%. Basic restorative services and other benefits will be covered at 100%. Periodontal and prosthetics services are covered at 50%. Coverage on full or partial dentures is limited to once every five years.

There is a no annual maximum for the dental benefit.

Please refer to the plan document provided by BSNENY for a complete description of this benefit. If you have not received the BSNENY plan document, please contact the fund office.

C. PRESCRIPTION DRUG BENEFIT

Eligible Active and Retired Participants not eligible for Medicare and their Eligible Dependents will be covered for prescription drug benefit upon proper application. The prescription drug benefit is currently administered by SavRx, Inc. Please refer to the prescription drug summary plan description (SPD) for a complete description of this benefit.

III. HRA Plan Benefits

The HRA Plan benefits are designed to help you pay for certain medical costs not covered by this or any other health care or insurance plan. The following are the different benefits available to you under the HRA, if you are eligible (please review Section I. for general eligibility requirements):

- Health Expense Benefit
- Additional health insurance premiums the I.R.S. determined to be deductible

Please take note that although insurance premiums are considered an eligible expense under the IRS regulations, the following insurance premiums are not qualifying expenses: premiums for employer-sponsored group health coverage that are paid on a pre-tax basis under the employer's cafeteria plan, individual coverage you purchase through a public health insurance exchange or on the individual market, LTD insurance, fixed indemnity cancer insurance, and hospital indemnity insurance.

If your premiums for health coverage through your spouse's employer are paid on an after-tax (post-tax) basis then these premiums would qualify for reimbursement.

You are not allowed to reduce the balance in your account below the required minimum balance by using this benefit. The minimum balance is set annually by the Board of Trustees and may be changed from year to year. **However, once you leave covered employment, you may, after a twelve-month period without further contributions, continue to draw on your account by submitting any allowable reimbursement expenses.** No money may be withdrawn from your account for the Health Expense benefit if such withdrawal would result in an account balance less than the minimum.

A completed application for claims under this benefit must be *submitted within twelve (12) months from the date the expense was incurred*.

A. HEALTH EXPENSE BENEFIT

If you incur health care expenses (other than insurance premiums paid under the insurance benefit) for you, your lawful spouse, or your dependent child, and such expenses are not covered under the insurance benefit or any other insurance program, you may apply for a distribution from your account to pay for the uncovered expenses. Health care expenses include medical, prescription, dental and optical expenses that have been determined to be deductible by the Internal Revenue Service.

B. GUIDELINES – PART I

Before submitting your request or claim, be sure that items covered by the health plan are submitted to the medical benefit administrator first. You must also take note of reimbursement limits set by the Fund for specific items such as hot tubs and mattresses that have been certified as medically necessary. The limit for hot tub (maximum of 4 seats) and mattress reimbursement is set at $6,000 but is subject to change by the Board of Trustees.

For items that could be covered by your medical benefit carrier:

1. A benefit claim for the item/service must be submitted first to your medical benefit administrator (i.e. insurance carrier) before submitting for Health and benefit (HRA) reimbursement.

2. An explanation of benefits *(EOB) from the carrier must be submitted with your HRA reimbursement request,* or

3. Original prescription from your *medical doctor* stating that the specific medical need for this item/service is for long term treatment of disease or illness.

4. A denial letter from insurance carrier stating item is not allowed and reason(s) denied.

5. If the denial is based upon missing information, a properly documented appeal containing the requested information must be submitted to the insurance carrier.

6. Denial of appeal from insurance carrier stating reason(s) for denial.

7. Signed Statement:

   I certify that I have submitted all the required documents necessary to submit a claim to my health insurance carrier and I have no other carrier(s). Attached are all pertinent copies from my insurance provider (e.g. – my submission, appeal, denial(s), and EOB).

C. GUIDELINES – PART II

For all other reimbursement requests your submission for a HRA reimbursement must include the following:

1. Medical and IRS Requirements:

   a. Original prescription from your *medical doctor* stating that the specific medical need for this item/service is for long term treatment of disease or illness.

   b. Primary purpose is for medical care for the benefit of you or your dependents for whom prescription is written.

   c. Item/Service is not for convenience only.

2. Fraudulent Claim Warning:

If you knowingly and with intent to defraud file a statement of claim or assist anyone else in filing such a statement of claim which contains any material with false information, or conceals, for the purpose of misleading, information concerning any fact material hereto, you commit a fraudulent act which is a crime.

In the event that such a claim is submitted by you or anyone else, the claim would be denied, the full sanctions under the law would be followed, and the eligibility of such person submitting or being a party to such fraudulent claim would be suspended for a minimum period of one year with reinstatement subject to review and approval by the Board of Trustees.

In the event any claim is paid as the result of such a fraudulent statement or submission, which is determined as fraudulent, the full penalty of the law will be applied, the amount of the claim paid will be recovered with interest and your eligibility for all benefits under the Fund would be indefinitely suspended.

3. Item Descriptions:

    a. Specifications from manufacturer (i.e. hot tub, air conditioner, etc).

    b. Capacity/Size of item should be limited to that which is sufficient to accommodate you or your dependents for whom the prescription is written.

    c. Invoice stating item type, model, size and price from purchaser.

    d. Price of item does not include plumbing, electrical or landscaping costs.

    e. Item must have capability of year-round use for its primary medical care purpose.

4. Additional documentation:

    a. Signed statement from Part I of these guidelines.

    b. All pertinent copies from your insurance provider (e.g. – your submission, appeal, denial(s), and EOB).

D. ADDITIONAL HEALTH INSURANCE PREMIUMS

Premiums paid by you, on your behalf, your spouse, and your qualified dependents, are also reimbursable under the HRA Account. Please note that only post tax premium payments required for enrollment in another health plan are eligible for reimbursement.

They include, but are not limited to the following:

1. Long-term healthcare premiums reimbursements (subject to an indexed annual limit set by the IRS.)

2. Health insurance coverage for you that is paid through payroll by your spouse on an after-tax (post-tax) basis. The reimbursable amounts are limited to that amount actually paid by your spouse and not your spouse's employer's portion.

3. The following insurance premiums are **not qualifying expenses**: premiums for employer-sponsored group health coverage that could be paid on a pre-tax basis under the employer's cafeteria plan, individual coverage you purchase through a public health insurance exchange or on the individual market, LTD insurance, fixed indemnity cancer insurance, and hospital indemnity insurance.

E. LIMITED PURPOSE HRA

The limited purpose HRA allows funds to be used for qualified dental and vision expenses. You may elect to convert your general purpose HRA to a limited purpose HRA under certain circumstances. Please contact Jaeger & Flynn for more details.

IV. Pooled Benefits

There may come a time in your working career that you are incapacitated because of illness or injury. The short-term and long-term disability benefits are designed to help you through such time. A life insurance benefit is also provided to eligible Active Participants and retirees. These benefits are as follows:

Type of Benefit	Persons Covered	Benefit
Short-Term Disability	Active Participant only	According to schedule, maximum 26 weeks per disability
Long-Term Disability	Active Participant only	According to age and monthly earnings
Life Insurance	Active Participant Retiree	$10,000 $ 3,000
Accidental Death and Dismemberment (AD&D)	Active Participant Only	$10,000

For a detailed description of the short-term disability benefit, long-term disability benefit, life insurance benefit, or AD&D benefit please refer to the summary plan description from the underwriter, Mutual of Omaha.

V. Claim Procedure

A. CLAIM PROCEDURE FOR MEDICAL, PRESCRIPTION, AND DENTAL BENEFITS

Please read the applicable medical, prescription or dental summary plan description (or plan document) for the procedures on how to file a claim for the benefits provided under the Health & Benefit Fund.

B. CLAIM PROCEDURE FOR HRA BENEFITS

How To File An HRA Claim:

1. You must request reimbursement in writing using an approved form or online at the website provided by Jaeger & Flynn Associates, Inc.. All forms, online or paper, must be completed and signed.

2. All reimbursement requests must include itemized receipts. Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

    a. Date service was received or purchase was made,

    b. Description of service or item purchased,

    c. Indication of person for whom treatment was provided, and

    d. Dollar amount (after insurance, if applicable).

3. Unacceptable forms of documentation include:

    a. Provider statements that only indicate the amount paid, balance forward, or previous balance;

    b. Credit card receipts that only reflect a payment;

    c. Bills for prepaid dependent medical expenses where services have not yet been rendered.

4. When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If “co-payment” is not clearly identified, please have the provider write “co-payment” on the receipt and sign it.

5. Each reimbursement request (online or paper) must acknowledge the following terms and conditions:

    a. I certify that the expenses listed above have been incurred by me or eligible members of my family.

b. I understand that I am responsible for the validity of claims submitted to my pre-tax accounts, and that these expenses occurred during my coverage period, within the plan year.

c. I certify that these expenses were not for cosmetic or general health purposes, and any products claimed do not constitute toiletries/cosmetics.

d. I certify that these expenses have not been reimbursed under the above mentioned accounts or by any other source, and will not be claimed as deductible expenses when I file my personal tax returns.

e. I understand that I am responsible for retaining copies of valid receipts for a period of 3 tax years per IRS guidelines.

f. I will provide valid receipts of service where required and authorize the appropriate pre-tax account to be reduced by the amounts shown above.

6. You must submit HRA reimbursement requests no later than 12 months from the date of service (the date that the expense was incurred, not the date it was paid).

7. Send your Reimbursement Request & Documentation to:

Jaeger & Flynn Associates, Inc. Flex Plan Services
Mail: 42 South Street, Glens Falls NY 12801
Fax: 518.792.0226 email: https://jfaflex.lh1ondemand.com

8. Debit Cards will be issued to you if you have an active HRA benefits account. The debit card can be used to pay for qualified expenses at the time of service and these expenses will be automatically deducted from your available HRA balance.

a. If you are enrolled to use your Visa prepaid card ("Card"), you certify that you will only access your HRA account for payment of qualifying expenses under that Plan.

b. You also agree and affirm that any expense you pay with the Card will not be submitted (and has not been submitted previously) for reimbursement to any other plan or program of benefit coverage. Further, you agree to save all invoices and receipts for any expense you pay with the card and, upon request, to submit these documents to your Plan administrator.

Cash access: You may not use your card to obtain cash from an Automated Teller Machine ("ATM"), Point-of-Sale ("POS") device, or by any other means.

C. CLAIM DENIAL

In order to carry out their responsibility for interpreting the Plan and making determinations under it, the Trustees have exclusive authority and discretion:

1. to determine whether an individual is eligible for any benefits under the Plan,

2. to determine the amount of benefits, if any, an individual is entitled to from the Plan,

3. to determine or find facts that are relevant to any claim for benefits from the Plan,

4. to interpret all of the Plan's provisions,

5. to interpret all of the provisions of the Summary Plan Description "the Plan",

6. to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting the Plan,

7. to interpret the provisions of the Trust Agreement governing the operation of the Plan,

8. to interpret all of the provisions of any other document or instrument involving or impacting the Plan, and

9. to interpret all the terms used in the Summary Plan Description, and all of the other previously mentioned Agreements, document, and instruments.

All such determinations and interpretations made by the Trustees, or their designee:

1. shall be final and binding upon individuals claiming benefits under the Plan and upon all employee, all employers, the Union, and any other party who has executed any agreement with the Trustees or the Union,

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

3. shall not be overturned or set aside by any court of law unless the court finds that the Trustees or their designee abused their discretion.

In the event a claim is denied, wholly or in part, the Trustees will furnish to a claimant whose claim has been denied, a written notice stating:

1. the specific reason or reasons for the denial,

2. the specific reference or references to the plan provisions on which the denial is based, and

3. a statement of Plan's appeal procedure.

D. CLAIM DENIAL APPEAL PROCEDURE

If your claim for benefits is denied, in whole or in part, you will be notified by the fund office, in writing:

1. regarding the specific reason for the denial;

2. the particular plan provision upon which the denial is based; and

3. an explanation of the plan's claim denial appeal procedure.

If additional information or documentation is required to perfect a claim, you will be notified and an explanation will be given as to why such additional material is necessary.

You, or your duly authorized representative, may appeal the denial of a claim by a written application to the fund office made not later than 60 days after receipt of the denial, and submission of such additional information and comments, in writing, as supports your appeal. If

you do not receive a decision on a claim within 90 days of filing the claim (or 180 days in special circumstances) you may request a review of that claim.

You, or your duly authorized representative, may review the pertinent documents upon which the denial is based.

The Trustees will render a written decision specifying the reasons for their decision on the appeal, in a manner calculated to be understood by an average plan participant, not later than 60 days after receipt of the appeal, unless additional documentation or information is required. In that event, a decision, as aforesaid, will be rendered no later than 120 days after receipt of the appeal.

A determination will be made by the Trustees on any question involved with the disputed claim. If an appeal is within the domain of the Trustees, the Trustees will render a decision at their next regularly scheduled meeting. However, if the appeal is received less than 30 days before the meeting, the decision on that appeal may be made at the second meeting following the receipt of the request. If special circumstances require an extension of time for processing, a decision may be made at the third meeting following the date the appeal is made. In any event, if you request a review of a denied claim, you will be notified of the approximate date that you can expect to receive a decision. The decision of the Trustees will be in writing.

The final decision of the Trustees with respect to the review of your appeal shall be final and binding upon you, since the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. However, if you disagree with the final decision of the Trustees with respect to your appeal, then you may request an external review of your claim by an independent third party, who will review the denial and issue a decision or commence a legal action against the Plan. However, no legal action of any type may be commenced or maintained against the Plan more than 180 days after the date of the Fund's written letter to you notifying you of the Plan Trustees final decision on appeal. The 180 days is calculated from the date of the Fund's letter; it is not calculated from the date you receive the letter or the date you have knowledge of the Trustee's decision on appeal.

For questions about your appeal rights, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program in NY State may be able to assist you at Community Service Society of New York, Community Health Advocates, 105 east 22nd Street, 8th Floor, New York, NY 10010; 888-614-5400; http://www.communityhealthadvocates.org/

E. INCOMPETENCE

In the event it is determined that you are unable to care for your affairs because of illness, accident, or incapacity, either mental or physical, payments due may, unless the claim has been made therefore by a duly appointed guardian, committee, or other legal representatives, be paid to your spouse or your custodian, as the Trustees will determine in their sole discretion.

F. COOPERATION

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

G. CLAIM REPRESENTATIONS

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

H. CLAIMS WHERE THIRD PARTY IS LIABLE

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

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills. The rules in this section govern how this Plan pays benefits in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to pay your covered expenses until your dispute with the third party is resolved.

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

Rights Of Subrogation And Reimbursement. If you incur covered expenses for which a third party may be liable, you are required to advise the Plan of that fact. By law, the Plan automatically acquires any and all rights, which you may have against the third party.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment or other payment that you obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment.

The Trustees may, in their sole discretion, require the execution of this Plan's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's lien forms, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney since that attorney must also execute the form. In no event shall the failure of the Trustees to require execution of the lien forms diminish or be considered a waiver of the Plan's rights of subrogation and reimbursement.

Assignment of Claim: The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

Failure To Disclose And/Or Cooperate: If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to

do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Fund for the reimbursement owed to this Fund by the third party. This Fund may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you.

I. RECOVERY OF CLAIM OVERPAYMENTS AND MISTAKEN PAYMENTS

In the event that you or a third party on your behalf is paid benefits from the Fund in an improper amount or otherwise receives Fund assets not in compliance with the Fund (hereinafter overpayments or mistaken payments), the Fund has the right to start paying the correct benefit amount. In addition, the Fund has the right to recover any overpayment or mistaken payment made to you or to a third party on your behalf. Such a recovery may be made by reducing other benefit payments made to or on behalf of you or your spouse or dependents, by commencing a legal action or by such other methods as the Trustees in their discretion, determine to be appropriate. You shall reimburse the Fund for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Funds in attempting to collect and in collection the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

J. MAILING ADDRESS OF CLAIMANT

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with you at the address last recorded by the Trustees and a letter sent by first-class mail to you is returned, any payments due the claimant will be held without interest until payment is successfully made.

VI. COBRA Continuation Coverage Rights

A. COBRA CONTINUATION COVERAGE

Federal law requires that most group health plans (including this Plan) give you and your dependents the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include your spouse, and your dependent children.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

B. DURATION OF COBRA

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to your death, divorce or legal separation, your becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of your hours of employment, and your entitlement to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than yourself lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

C. TERMINATION OF COBRA BEFORE THE END OF THE MAXIMUM PERIOD

Your COBRA coverage will terminate if:

1. any required premium is not paid in full on time,

2. a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions are prohibited beginning in 2014 under the Affordable Care Act),

3. a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or

4. the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of you or your beneficiary not receiving continuation coverage (such as fraud).

D. EXTENSION OF COBRA

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the fund office of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

1. Disability

   An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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 a letter of determination of disability from the Social Security Administration to the fund office (at the address contained herein) before the end of the 18-month period to show that you are entitled to Social Security disability benefits. You must provide the disability determination to the fund office before the end of the 18-month COBRA coverage period and within 60 days after the latest of: the date the qualifying event occurs; the date the qualified beneficiary loses coverage; the date of the Social Security Administration's disability determination; or the date the qualified beneficiary is informed of the obligation to provide the disability notice. You may be required to pay 150% of the premium cost of coverage for months 19 through 29 (or through the 36th month if applicable).

   Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

2. Second Qualifying Event

   An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

E. ELECTION OF COBRA CONTINUATION COVERAGE

To elect continuation coverage, you must complete the election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, your spouse may elect continuation coverage even if you do not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. You or your spouse can elect continuation coverage on behalf of all of the qualified

beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

You are not required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your HRA. You will continue to have access to your HRA and to receive reimbursements from your HRA so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance.

In the event your spouse and/or dependent has a COBRA qualifying event as a result of your death, termination of covered employment, enrollment in Medicare, or reduction of hours they are not required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your HRA. They will continue to have access to your HRA and to receive reimbursements from your HRA so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance.

In the event your ex-spouse has a COBRA qualifying event as a result of divorce or judicial order, your ex-spouse must elect COBRA and pay the applicable HRA COBRA premium in order to continue to receive reimbursements from your HRA.

F. COST OF COBRA

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, possibly in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is as follows:

1. First payment for continuation coverage

   If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the fund office to confirm the correct amount of your first payment.

2. Periodic payments for continuation coverage

   After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each

coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the payment date for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

3. Grace periods for periodic payments

   Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and the retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Jaeger & Flynn Associates, Inc.
30 Corporate Drive
Clifton Park, NY 12065

G. SELF-PAYMENT OTHER THAN COBRA

If you qualify and elect to be covered under the retiree coverage provisions of this Plan (Self-Payment Other Than COBRA) you will not be eligible for COBRA as described above.

H. QUALIFIED MILITARY SERVICE

If you leave employment for full-time qualified military service, as defined by Federal Law, you and your eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal Law. This coverage, subject to the rules of the Plan, must last for up to eighteen (18) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the eighteen (18) month period if you enter qualified military service and are discharged earlier and fail to make a timely application for reemployment upon discharge. You will not forfeit any period of coverage for which you have previously qualified.

If you elect such continuation coverage, you will not be required to pay any premium for the first thirty (30) days of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan, which will be based on the average cost that the Plan incurs annually per participant plus a two percent (2%) administrative charge.

I. FOR MORE INFORMATION

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Fund Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

Local 236 Health & Benefit Fund Office
3000 Troy-Schenectady Road
Schenectady, NY 12309
Telephone: (518) 782-5499

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272 For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

J. KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Fund Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the fund office.

K. PAPERWORK REDUCTION ACT STATEMEN*T*

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

VII. Special Allocations

In addition to employer contributions on your covered work, there are other ways in which your account can grow. These are called “special allocations”.

A. FINANCIAL ACTIVITY ALLOCATION

When the Fund’s financial activity permits, the Trustees may declare a bonus to be credited to eligible accounts. This will happen no more than once a year. In determining whether or not to declare this bonus, and the amount of the bonus, the Trustees will take into consideration the investment results on the Fund’s assets, the expenses of administration of the Fund, the amount of any other allocations, and reserve requirements for the future.

B. DISABILITY ALLOCATION

In the event you are an Active Participant (not a retiree) and you become totally disabled while covered for the insurance benefit, and your account is not sufficient to pay the monthly insurance benefit insurance premium, you will qualify for a disability allocation.

The amount of the monthly disability allocation will be the amount necessary to pay the portion of the insurance benefit insurance premium which is not available in your HRA account. There will be no disability allocation for you if your HRA account is sufficient to cover their insurance benefit premium.

No more than 6 monthly disability allocations will be made for any one period of disability (including successive periods of disability due to the same or related causes not separated by return to active employment).

C. PREMIUM ADVANCE ALLOCATION

From time to time, when Covered Employment is below normal, the Trustees may declare a period of time to be an Advancement Window. Any such declaration will be made annually on a calendar year basis.

In the event your account runs out during an Advancement Window you may qualify for a Premium Advance Allocation. To qualify:

1. Your account balance in the Plan must be insufficient to pay the premiums for health and prescription drug insurance;

2. You must be out of work;

3. You must be on and remain on Book 1, ready and willing to take any job, and must be actively pursuing all calls on referrals; and

4. You must not have elected COBRA continuation coverage.

The limitations on the Premium Advance Allocation are as follows:

1. You must currently be a participant in the plan and currently receiving health insurance coverage under the Plan.

2. You must have been a participant in the Plan for at least one year. Qualifying participants can get an advance equal to up to the lesser of nine months applicable coverage or $9,000.

3. You must be willing to take any job offered (that will not unreasonably affect your standing on Book 1).

Obligation To Repay Advance

If you qualify for this benefit, the Fund will advance the amount of health insurance benefit premiums required to maintain your current health insurance coverage. The amount advanced shall be considered a loan to you, to be repaid from the employer contributions made on your behalf once you return to work.

When you are no longer actively pursuing Covered Employment, you are required to repay the Fund all premium amounts advanced on your behalf that were not already repaid from employer contributions made on your behalf.

VIII. Qualified Medical Child Support Order

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

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

IX. Rights Under ERISA

As a participant in the I.B.E.W. Local 236 Health & Benefit Fund you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

Receive a summary of the Fund's annual financial report. The Fund Administrator is required by law to furnish you with a copy of this summary annual report.

B. CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Fund 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 Fund on the rules governing your COBRA continuation coverage rights.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Fund, called "fiduciaries" of the Fund, 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.

D. ENFORCE YOUR RIGHTS

If your claim for a 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 Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the 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.

E. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor at:

JFK Federal Building
Room 3575
Boston, MA 02203
(617)565-9600

or

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

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

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

X. Technical Details

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

TECHNICAL DETAILS

1. PLAN NAME: I.B.E.W. Local 236 Health & Benefit Fund.

2. EDITION DATE: This Summary Plan Description is produced as of July 1, 2015.

3. PLAN SPONSOR: Board of Trustees of I.B.E.W. Local 236 Health & Benefit Fund.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 14-1442159.

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

6. TYPE OF PLAN: Health Plan under ERISA

7. PLAN YEAR ENDS: June 30

8. FUND ADMINISTRATOR: James Bennett, 3000 Troy-Schenectady Road, Schenectady, NY 12309, Telephone # (518) 782-5499.

9. AGENT FOR THE SERVICE OF LEGAL PROCESS: Board Of Trustees, IBEW Local No. 236 Health and Benefit Fund, 3000 Troy-Schenectady Road, Schenectady, NY 12309, Telephone # (518) 782-5499.

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

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

11. TYPE OF FUNDING: Life and short and long term disability benefits are insured, all others are self-funded.

12. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the I.B.E.W. Local 236 Health & Benefit Fund, certain benefit funds with whom this Fund has reciprocal agreements, and, in certain circumstances, participants.

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

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

15. PLAN BENEFITS PROVIDED BY: The I.B.E.W. No. Local 236 Health & Benefit Fund.

16. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: See Section I. through IV. of this booklet.

17. HOW TO FILE A CLAIM: See Section V. of this booklet.

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

If a denial takes place, you are entitled to appeal the decision by writing to the Trustees (or the insurance Company, if appropriate) within 60 days of the denial, at the Plan Office asking that a review of the denial be made.

More specific information regarding this procedure is described in Section V. of this booklet.

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