ELECTRICAL WORKERS HEALTH AND WELFARE FUND

2002 London Road—Suite 300
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or 877-908-FUND (3863)

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IMPORTANT NOTICE

Benefits under this Plan will be paid only if the Board of Trustees (or its Plan Administrator) decides in its discretion that the applicant is entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including but not limited to, its Plan Administrator). Such decisions will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan.

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To All Eligible Employees:

We are pleased to provide you with this new Summary Plan Description and Plan Document that describes the Fund's health and vacation benefits available to you and your eligible dependents. This booklet includes the eligibility rules and benefits of our Plan as of January 1, 2021.

The Electrical Workers Health and Welfare Fund was originally established in 1952 and has been in continuous existence since that time. It is maintained as a result of Collective Bargaining Agreements entered into between the Twin Ports Arrowhead Chapter, National Electrical Contractors Association, and International Brotherhood of Electrical Workers Unions, Local 242, in Duluth, and Local 294, in Hibbing. In 2013, the Electrical Workers Health and Welfare Fund added vacation benefits for members of Locals 242 and 294.

This Booklet is designed to help you understand your Health Plan. It explains when you and your dependents are eligible for benefits, what your benefits are, and how to file a claim for your benefits.

Please take the time to read this Booklet now. There have been changes made since the last Booklet was printed that you should know about. Refer to it when you need to file a claim for benefits for yourself or your dependents.

IF YOU HAVE ANY QUESTIONS REGARDING ELIGIBILITY FOR PLAN BENEFITS, PLEASE CONTACT THE FUND OFFICE AT THE ADDRESS AND TELEPHONE NUMBER STATED ABOVE.

The Board of Trustees, representing the Union and Employers, strive to provide you with the best benefits possible consistent with the financial ability of the Fund.

Sincerely,

THE BOARD OF TRUSTEES

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SCHEDULE OF HEALTH BENEFITS

I. SHORT TERM AND EXTENDED DISABILITY – LOSS OF TIME BENEFITS

Available to Group I employees only – not available for dependent coverage.

Weekly Benefit:	50% of Participant's average weekly earnings to a maximum of $525.00 but not less than $300.00
Maximum Period of Disability:	26 weeks
Extended Disability Benefits:	Additional 2 years — available only to Group I employees regularly employed in the previous five years (not available to employees working under the Limited Energy Agreement).

II. PARENTAL LEAVE BENEFIT

Available only to Group I employees who take a leave of absence from work in conjunction with the birth or adoption of a child – not available for dependent coverage.

Weekly Benefit:	50% of participant's average weekly earnings to a maximum of $525 but not less than $300.
Maximum period of paid benefit:	Two weeks.

III. MAJOR MEDICAL BENEFITS

Available to all eligible employees, non-Medicare eligible retirees, and their eligible dependents.

Deductible Amount	$400 per family per calendar year (Counts towards Out-of-Pocket Family Maximum for Medical Benefits)
Insured Percentage	80%
Emergency Room Co-payment	$100 (co-payment subject to waiver, see Part I, Section Three, II.) (Counts towards Out-of-Pocket Family Maximum for Medical Benefits)
Out-of-Pocket Annual Family Maximum for Medical Benefits	$3,400

*Effective March 1, 2020, charges for items and services related to diagnostic testing for the detection of COVID-19 are paid at 100%. This provision does not cover COVID-19 testing for

surveillance or employment purposes. Such items and services related to the COVID-19 test must be medically appropriate for diagnostic purposes, as determined by your attending health care provider, and in addition to the diagnostic COVID-19 test may also include:

- Office, emergency room, urgent care or telemedicine visits/facility fees;
- COVID-19 antibody tests;
- Diagnostic tests panels for influenza A and B; and/or,
- Chest x-ray.

Coverage of COVID-19 related items and services at 100% will only apply for the duration of the COVID-19 public health emergency, as declared by the Secretary of Health and Human Services.

IV. PHYSICIAN SERVICES

Available to all eligible employees, non-Medicare eligible retirees, and their eligible dependents.

In-Person Physician Visit:	$25.00 co-payment, thereafter paid at 100%. The $25.00 co-payment does not apply towards the Major Medical $400 family deductible but does apply towards the $3,400 family out-of-pocket maximum.
In-Network Online or Telehealth Visit: (excluding Doctor on Demand)	$25.00 co-payment, thereafter paid at 100%. The $25.00 co-payment does not apply towards the Major Medical $400 family deductible but does apply towards the $3,400 family out-of-pocket maximum.
Doctor on Demand Telehealth Visit:	Paid at 100%

*Charges for items and services related to diagnostic testing for the detection of COVID-19 are paid as described under Section III, Major Medical Benefits, in this Schedule of Benefits.

V. WELLNESS/PREVENTIVE CARE

Available to all eligible employees, non-Medicare eligible retirees, and their eligible dependents.

Specified preventive care services: 100% coverage provided

VI. PRESCRIPTION DRUGS

Available to all eligible employees, non-Medicare eligible retirees, and their eligible dependents.

Insured Percentage: 80% coverage provided

	The 20% co-insurance paid by Participants does not apply towards the Major Medical $400 family deductible or the $3,400 family out-of-pocket maximum but does apply towards the Annual Family Maximum for Prescription Drug Benefits. Specialty drugs are not covered when purchased from an out-of-network provider.
Out-of-Pocket Annual Family Maximum for Prescription Drug Benefits	$4,500

VII. SUPPLEMENTAL BENEFITS

Vision Benefits

Available only to Group I employees and their dependents.

Adult Vision Benefits	$225 paid for all optical benefits (exams, frames, lenses, contacts, Lasik surgery) once per calendar year
Pediatric Vision Benefits	One vision exam per calendar year. One frame and pair of lenses for glasses OR contact lenses every two years. Paid at 100%.

Dental Benefits

Available only to Group I, II, III, and V employees, retirees, and their dependents.

Annual Maximum per Adult Participant	$950
Pediatric Dental Benefits	No Annual Maximum
Coverage A – Regular Diagnostic and Preventive Services	70% of the Fund's usual and customary schedule, with limitations on how frequently the services are provided (See Part I, Section Three, VI. B.)
Coverage B – Regular and Special Restorative Services	70% of the Fund's usual and customary schedule, after payment of a $25.00 deductible
Coverage C – Prosthetics	70% of the Fund's usual and customary schedule, after payment of a $25.00 deductible
Coverage D – Orthodontics	No coverage provided

VIII. MEDICARE ELIGIBLE RETIREE BENEFITS

Available only to Group V and VI retirees and their spouses.

A Medicare Supplement Plan is available to Group V and VI retirees and their spouses who are eligible for Medicare. The Fund determines eligibility for this program, but the Schedule of Benefits for medical and prescription drugs are determined by the insurer selected by the Fund. Please contact the Fund Office for details on the Medicare Supplement Plan including a booklet describing the benefits offered by the Plan.

Group V retirees and their spouses are also eligible for Dental Benefits as described under Section VII, Supplemental Benefits and Special Limited Benefits as described under Section VIII, paragraph C.

FOR A MORE COMPLETE EXPLANATION OF YOUR HEALTH BENEFITS INCLUDING ELIGIBILITY REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS, YOU MUST REFER TO THE FULL BODY OF THIS SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT.

PART I
HEALTH BENEFITS

The following sections of Part I of this Plan describe the health benefits covered under the Plan, subject to the Plan's terms, conditions, and exclusions.

Preferred Provider Organization (PPO)

To help manage certain health care expenses, the Plan contains a cost management feature – the Preferred Provider Organization (PPO) network. A PPO is a network of Physicians and Hospitals that have agreed to charge negotiated rates. When you use a network provider (or preferred provider), you save money for yourself and the Plan because the network provider has agreed to charge a discounted dollar amount.

The PPO may have agreements with network providers that may include financial incentives to promote the delivery of health care in a cost-efficient and effective manner; however, your coinsurance and deductible amounts will not be changed by any subsequent adjustments to the negotiated rate.

If you use an out-of-network provider, the out-of-network provider's charges can exceed the Reasonable and Customary Charges. Any amount above the Plan's Reasonable and Customary Charge is not covered under the Plan and you will have to pay the extra amount (called balance billing). If you have any questions regarding the Plan's preferred providers, please contact the Fund Office.

Identification Card

When you or a member of your family enter a hospital, or are treated by a doctor, present your identification card. The hospital or doctor will then verify your eligibility for Plan benefits through the Fund Office.

When you purchase prescription drugs at a participating pharmacy, present your identification card so you can enjoy the discounts the Fund has negotiated on your behalf. If you need help locating a participating pharmacy, you can call the Fund Office.

SECTION ONE
DEFINITIONS

Calendar Year:

As used herein, "Calendar Year" means that period commencing at 12:01 a.m. Standard Time, on the date the employee first becomes eligible and continuing until 12:01 a.m. Standard Time, on the next following January 1st. Each subsequent Calendar Year shall be the period from 12:01 a.m. Standard Time, on January 1st to 12:01 Standard Time, on the next January 1st. The time shall be that time at the address of the Trustees.

Contributing Employer:

An Employer who is entitled to participate in the Electrical Workers Health and Welfare Fund pursuant to an agreement with Local #242 or #294 of the International Brotherhood of Electrical Workers.

Dependents:

Dependents of a covered Employee include:

a. An Employee's spouse;

b. The Employee's children, with coverage beginning at the moment of birth and continuing until the end of the month in which the child attains his/her 26th birthday. The term "children" includes:

- A blood descendent of the first degree;
- A stepchild (a child of your spouse);
- An adopted child (beginning with the date of placement for the purpose of legal adoption); and
- A foster child (a child who is placed with you by an authorized placement agency or by judgment, decree, or other court order).

c. The Employee’s handicapped child.

An unmarried child who is fully handicapped and covered under the Plan at the time he/she reaches the maximum age for coverage of children as dependents will continue to be covered as long as he or she remains fully handicapped, until termination of the covered parent's coverage. A child is considered fully handicapped in determining eligibility for continued coverage if the child is unable to earn his/her own living because he/she is intellectually disabled or physically

handicapped, and is permanently residing in the household, and is an allowable dependent for income tax purposes of the covered parent.

Proof a child is fully handicapped must be submitted not later than 31 days after the child otherwise would have ceased to be covered as a dependent under this Plan. The Plan may require, at reasonable intervals, proof that the child continues to be fully handicapped as herein defined and failure to provide such proof or refusal to permit medical examination will be considered proof the child is no longer physically or mentally handicapped. The handicapped child's coverage will not be continued if an individual medical expense policy has been issued to him/her under any other plan.

Durable Medical Equipment:

As used herein, "Durable Medical Equipment" means equipment which:

- is prescribed by the attending physician;
- is medically necessary;
- is primarily and customarily used only for a medical purpose;
- is designed for prolonged use; and,
- serves a specific therapeutic purpose in the treatment of an illness or injury.

Durable Medical Equipment does not include services or supplies of a common household use, such as: vehicle lifts, waterbeds, hospital beds, air conditioners, heat appliances, dehumidifiers, exercise equipment, air purifiers, water purifiers, allergenic mattresses, blood pressure kits, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a physician.

Employee:

Any Employee coming within those job classifications which contributing Employers and the Local Union have agreed will be entitled to benefits under this Plan.

Fiscal Year:

As used herein, "Fiscal Year" means the same as Calendar Year.

Hospital:

As used herein, "Hospital" means an establishment which meets all of the following requirements:

- Holds a license as a hospital (if licensing is required in the State);

- Provides in-patient care and diagnostic and therapeutic services by or under the supervision of licensed physicians, and is organized for the surgical and medical

diagnosis and the treatment and care of injured or sick persons in exchange for payment from its patients;

- Provides 24-hour a day nursing service by registered or graduate nurses;

- Has a staff of one or more licensed physicians available at all times; and,

- It must not be mainly:

    - A place of rest;
    - A place for the aged;
    - A nursing or convalescent home; and,

- Is not substantially operated by a governmental agency, or county, state or federal government.

- Any licensed facility that cares for or treats alcoholism or drug addiction need not provide surgical facilities if it otherwise qualifies as a hospital.

Intensive Care Unit:

As used herein, "Intensive Care Unit" means a special area of a hospital exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:

- Personal care by specialized registered professional nurses and other nursing care on a 24-hour basis;

- Special equipment and supplies which are immediately available on a standby basis; and,

- Care required but not rendered in the general surgical or medical nursing units of the hospital.

The term "Intensive Care Unit" shall also include an area of the hospital designated and operated exclusively as a Coronary Care Unit, Cardiac Care Unit, or Major Care Unit.

In-Patient:

As used herein, "In-patient" means any covered person who, while confined in a hospital, is assigned to a bed in any department of the hospital other than its out-patient department and for whom a charge for room and board is made by the hospital.

Organ:

As used herein, "Organ" means any part of the body having a special function, such as the heart, bladder, kidney, etc.

Pediatric:

As used herein, “Pediatric” refers to services provided to children who are eighteen years of age and younger.

Physician or Doctor:

As used herein, "Physician" or "Doctor" means a doctor of medicine or doctor of osteopathy to the extent that benefits are provided while practicing within the scope of his/her license. Doctor will include a podiatrist or ophthalmologist. Doctor will not include an eligible person or any person who is the spouse, parent, child, brother, sister, or in-laws thereof of the Participant.

Skilled Nursing:

As used herein, “Skilled Nursing” means care or treatment provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

SECTION TWO
ELIGIBILITY PROVISIONS

I. Classes of Coverage

There are six separate groups of Participants each with different benefits available to them. These classes of coverage are defined below:

Group I: Active employees (including employees who are Medicare eligible and actively employed), who work under a labor contract in the electrical construction industry and their dependents. (Employees working under the Limited Energy collective bargaining agreement and manufacturing employees are considered Group I employees but are not eligible for Extended Disability Benefits).

Group II: Office employees and others not covered under a Collective Bargaining Agreement.

Group III: Retired employees who <u>are not</u> eligible for Medicare and who worked in the electrical construction industry under a collective bargaining agreement and their dependents.

Group IV: Retired office employees and other retired employees who <u>are not</u> eligible for Medicare and were not covered under a collective bargaining agreement when working.

Group V: Retired employees who <u>are</u> eligible for Medicare and who worked in the electrical construction industry under a collective bargaining agreement and their dependents.

Group VI: Retired office employees and other retired employees who <u>are</u> eligible for Medicare and were not covered under a collective bargaining agreement when working.

II. Eligibility for Participation and Commencement of Benefit Coverage

A. Group I Employees

1. **<u>Initial Eligibility</u>**: A new Group I Bargaining Unit Employee working under the Inside Construction Agreement, or a previously eligible Group I Bargaining Unit Employee who has lost coverage because the Fund received no contributions on his or her behalf for more than twenty-four (24) consecutive months, will satisfy initial eligibility and have coverage for benefits beginning as follows:

a. An Employee is first eligible to self-pay for benefits for the month in which the Fund receives or the Employee is credited with 435 hours of Employer Contributions on behalf of the employee.

b. If an employee does not self-pay, he or she will become eligible for benefits on the first day of any calendar month in which the Fund receives or the employee is credited with 580 hours of Employer Contributions, provided the employee is either employed by a contributing employer on the first day of the calendar month in which the Fund receives or the employee is credited with contributions for 580 hours of work or the employee is signed to the out of work list with the Local Union or, if an apprentice, actually participating in the apprenticeship program.

2. **Continued Eligibility**: A minimum of 145 hours is required to qualify for each month's coverage under the Plan after meeting the initial eligibility requirement. Contributions for hours worked by an Employee after he or she becomes eligible for benefits in excess of 145 hours shall be accumulated and credited to the Employee as banked hours. The maximum accumulation of banked hours for any Employee after April 1, 1985, is 2,015 hours.

3. **Working after Retirement:**

A. Temporary Annual Program. If after retirement you return to work for a contributing employer under a temporary annual program of the Electrical Workers Pension Fund, Part A that allows you to continue to receive a pension benefit, your retiree coverage in the Plan continues until you satisfy the requirements for initial eligibility as a Group I participant. The 580-hour requirement for initial eligibility applies to retirees returning to work under such a program, regardless of whether active contributions were made on your behalf in the previous 24 months.

B. Working Less Than 40 Hours a Month. If after retirement you return to work for a contributing employer but you work less than 40 hours per month and you continue to receive a pension benefit from the Electrical Workers Pension Fund, Part A, your retiree coverage in the Plan continues until you satisfy the requirements for initial eligibility as a Group I participant. The 580-hour requirement for initial eligibility applies to retirees working less than 40 hours per month, regardless of whether active contributions were made on your behalf in the previous 24 months.

4. **Continued Coverage by Self Contribution**: Your Plan coverage is lost when your Employer no longer makes contributions on your behalf to the Fund. You may continue coverage by drawing on your Hours Bank the required number of hours needed to be covered under the Plan, provided your Hours Bank is not exhausted.

   Only after your Hours Bank is exhausted may you continue coverage by making self-contributions to the Fund at rates established by the Trustees. It is your responsibility to notify the Fund Office when you are not working and to verify when self-contributions must start. You will lose eligibility if you do not make timely self-contributions; the Fund does not accept retroactive or late contributions to the Fund.

   In order to make self-contributions for a duration longer than established by COBRA, you must be signed and available for work as defined by your Local Union rules.

5. **Termination of Coverage**: If any required contributions are not made for the following month (either through employer contributions, Hours Bank, or employee self-payments) coverage under the Plan will cease at midnight on the last day of the month for which the Fund receives contributions. If your employer is delinquent or otherwise fails to make required contributions on your behalf, your coverage will terminate unless Hours Bank or self-payments are made to the Fund.

6. **Limited Energy Employees**: Initial Eligibility, Continued Eligibility, and Termination of Eligibility are determined by the terms of the applicable Collective Bargaining Agreement.

7. **Forfeiture of Hours Bank and Self-Pay Coverage:** You will forfeit your Hours Bank and eligibility for self-payments if you stop working under a collective bargaining agreement requiring contributions to the Plan and all of the following occur:

   a. You go to work for an employer in the geographical area covered by the Plan; and,

   b. You are performing work in the electrical contracting industry and employer contributions would be due the Plan on account of the work you are performing but the employer is not signatory to a collective bargaining agreement requiring contributions to this Plan.

   If your eligibility is terminated under the above rule, you will forfeit your Hours Bank and will not be eligible for self-pay coverage. Any period of time that you were covered via self-pay or your Hours Bank will be counted against any remaining COBRA continuation coverage to which

you may be entitled. A participant will not forfeit their Hours Bank or eligibility for self-payments if they work for a non-union employer as part of an organizing campaign.

8. **Dependent Special Enrollment:** Group I Employees may add new dependents following initial eligibility by submitting to the Plan a written request for enrollment along with any enrollment information the Plan may require (for example, copy of marriage certificate, proof of loss of other coverage, etc.). If you are adding a new dependent because of:

- marriage, birth, adoption, or placement for adoption;
- termination of other health coverage due to loss of eligibility, or exhaustion of COBRA coverage under another health plan; or
- loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or eligibility to participate in a financial assistance program through Medicaid or CHIP;

you must submit a written request for enrollment along with any required enrollment information so that it is received by the Plan within 90 days of the event (for example, marriage, birth, loss of coverage, etc.) for coverage to be effective on the date of the qualifying event. If the written request for enrollment and required enrollment information is not received by the Plan within 90 days of the qualifying event, or if you are enrolling a new dependent for a reason other than those listed above, new dependent coverage will be effective on the first day of the month following the date the Plan receives the request for enrollment and the required enrollment information.

B. Group II Employees

1. **Eligibility**: Coverage is available to Office employees and others not covered under a collective bargaining agreement that have employer contributions made on their behalf pursuant to participation agreements with the Fund.

2. **Commencement and Continuation of Coverage**: The effective date of coverage for a Group II Employee is the first day of the month that follows 60 calendar days after the Fund first receives an employer contribution on the employee's behalf. In order to continue coverage, the Employer contribution must be paid in advance for each month.

3. **Termination**: Coverage terminates on the last day of the month for which a contribution is received on the Employee's behalf.

4. **Self-Payment**: A Group II employee's only self-pay contribution rights are COBRA Continuation Coverage set forth in Section Two, Part III of this Plan.

5. **Dependent Special Enrollment**: Group II employees may add new dependents following initial eligibility by submitting to the Plan a written request for enrollment along with any enrollment information the Plan may require (for example, copy of marriage certificate, proof of loss of other coverage, etc.). If you are adding a new dependent because of:

- marriage, birth, adoption, or placement for adoption;
- termination of other health coverage due to loss of eligibility, or exhaustion of COBRA coverage under another health plan; or
- loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or eligibility to participate in a financial assistance program through Medicaid or CHIP;

you must submit a written request for enrollment along with any required enrollment information so that it is received by the Plan within 90 days of the event (for example, marriage, birth, loss of coverage, etc.) for coverage to be effective on the date of the qualifying event. If the written request for enrollment and required enrollment information is not received by the Plan within 90 days of the qualifying event, or if you are enrolling a new dependent for a reason other than those listed above, new dependent coverage will be effective on the first day of the month following the date the Plan receives the request for enrollment and the required enrollment information.

C. Group III, IV, V, and VI Employees

1. **Eligibility**: Coverage is available to:

a. Retired employees receiving a monthly pension benefit from the Electrical Workers Pension Fund, Part A, Defined Benefit Plan, who were covered by the Electrical Workers Health and Welfare Fund at the time of their retirement; and

(i) have either twenty (20) years of vesting service with the Electrical Workers Pension Fund, Part A; or

(ii) work a minimum of 1250 hours per year (according to Electrical Workers Pension Fund Part A records) in four (4) out of the last seven (7) plan years immediately prior to retirement.

Or,

b. Persons who were covered for benefits with the Electrical Workers Health and Welfare Fund for at least ten (10) years immediately prior to retirement and are 62 years of age or older on the date of retirement, and who are no longer actively employed nor actively self-employed.

2. **Commencement and Continuation of Coverage**: Coverage begins and is continued by paying the monthly rate established by the Board of Trustees in advance of the month of coverage. Rates for Group III, IV, V, and VI are established based on each Participant's or dependent's eligibility for Medicare. Upon initial retirement a Group III retiree must exhaust his or her Hours Bank before making self-payments. Application must be made to obtain retiree coverage prior to the later of either the date of the first pension check from the Electrical Workers Pension Fund, or the date of retirement. In order to continue coverage, the full monthly cost at rates established by the Trustees must be paid in advance for each month.

3.
Working after Retirement:

a. Temporary Annual Program. If after retirement you return to work for a contributing employer under a temporary annual program of the Electrical Workers Pension Fund, Part A that allows you to continue to receive a pension benefit, your retiree coverage in the Plan continues until you satisfy the requirements for initial eligibility as a Group I participant. The 580-hour requirement for initial eligibility applies to retirees returning to work under such a program, regardless of whether active contributions were made on your behalf in the previous 24 months.

b. Working Less Than 40 Hours a Month. If after retirement you return to work for a contributing employer but you work less than 40 hours per month and you continue to receive a pension benefit from the Electrical Workers Pension Fund, Part A, your retiree coverage in the Plan continues until you satisfy the requirements for initial eligibility as a Group I participant. The 580-hour requirement for initial eligibility applies to retirees working less than 40 hours per month, regardless of whether active contributions were made on your behalf in the previous 24 months.

4. **Spouse Working**: If upon a retired Participant's initial eligibility for Group III, IV, V, or VI coverage the Participant's spouse has health coverage through employment, the Participant may choose to delay coverage for his or her spouse until the spouse's coverage ends. Upon enrollment in this Plan, the spouse must provide the Fund with a certificate of coverage indicating no lapse in coverage. Election of coverage for the Participant's spouse must be made within 30 days of the exhaustion or termination of the other coverage.

5. **Termination**: If a covered retired person fails to make the required contribution, coverage terminates at the end of the month for which the last contribution was made. A retired person whose coverage is terminated because of failure to make the required contribution shall not be allowed to reinstate coverage thereafter. If an eligible covered retired person dies, the widow or widower may maintain coverage by continuing to make payment of the required contribution.

6. **Dependent Special Enrollment Period**: If you are in Group III, IV, V, or VI you may add family benefits if you have a change in status that meets one of the following criteria:

   a. You are married. Election of family coverage must be made within 30 days from the date of marriage. Enrollment is effective the first calendar month beginning after the date the completed request for enrollment is received by the Plan.

   b. You become legally responsible for a dependent child or children through birth, adoption, or placement for adoption. Election for family coverage must be made within 30 days of the date of birth, adoption, or placement of adoption. Enrollment is effective on the date of birth, date of adoption, or date of placement for adoption.

   c. You have family coverage under another health plan under COBRA which was exhausted, or coverage was not under COBRA and was terminated due to loss of eligibility, including legal separation, divorce, death, termination of employment, or reduction in hours of employment, or termination of employer contributions. (However, lost eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or termination of coverage for cause.) Election for family coverage must be made within 30 days of the exhaustion or termination of the other coverage. Enrollment is effective the first day of the first calendar month beginning after the date the completed request for enrollment is received.

d. You have dependents who are eligible for coverage under the Fund, that are not enrolled, and either of the following occurs:

- The dependent loses eligibility under Medicaid or CHIP, and you or the dependent request coverage within 60 days after termination of Medicaid or CHIP, or

- The dependent becomes eligible to participate in a financial assistance program through Medicaid or CHIP and you or the dependent request coverage under the Fund within 60 days after becoming eligible for the assistance.

A written application must be filed specifying the change in status, along with a certified copy of the official document demonstrating such change in status, and any additional information the Trustees may require.

If you elect family benefits and then decide to terminate the benefits for some reason, you are not allowed to purchase family benefits in the future except as provided for under the special enrollment periods stated above.

7. **Requirement to Enroll in Medicare**: For those retired persons or their dependents that are Medicare eligible, plan benefit payment will be reduced by payments made by Medicare for the same disability. In order to continue as a retired person in this Plan, you must be enrolled in both Part A and Part B of Medicare when eligible.

III. COBRA Coverage

Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), gives you (the employee) and your eligible dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "continuation coverage," "COBRA continuation coverage," or "COBRA coverage." Below is an outline of the rules governing COBRA coverage, if you have any questions about COBRA, call the Fund Office.

A. Qualifying Events/Maximum Coverage Periods

1. **18-Month Maximum Coverage Period**. You and/or your eligible dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for a maximum period of up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):

- A reduction in your hours.

- Termination of your employment (which includes retirement).

2. **29-Month Maximum Coverage Period**. If you or an eligible dependent is disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or an eligible dependent becomes disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment may be higher for the extra eleven (11) months of coverage for the family. Also, you must notify the Fund Office within 60 days of such a determination by the Social Security Administration and within the initial 18-month period, and within 30 days of the date Social Security determines that the person is no longer disabled.

3. **36-Month Maximum Coverage Period**. Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following qualifying events:

   - You divorce from your spouse.

   - A dependent child's loss of dependent status.

   - Your death.

4. **Multiple Qualifying Events**. If your dependents are covered under COBRA coverage under an 18-month maximum coverage period due to termination of your employment or a reduction in your hours and then a second qualifying event occurs, their COBRA coverage may be extended as follows:

   - If you die, or if you are divorced, or if a child loses dependent status while your dependents are covered under an 18-month COBRA coverage period, your dependent(s) who are affected by the second qualifying event are entitled to COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation.

   - Only a person (spouse or child) who was your dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours) is entitled to make an election for this extended coverage when a second qualifying event occurs. Exception: If a child is born to you (the employee), or adopted by you, or placed with you for adoption during the first 18-month COBRA period,

that child will have the same election rights when a second qualifying event occurs as your other dependents who were eligible dependents on the day before the first qualifying event.

It is the affected dependent's responsibility to notify the Fund Office within 60 days after a second qualifying event occurs. If the Fund Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

B. Benefits Provided under COBRA Coverage

When you or a dependent elect and make self-payments for COBRA coverage, you will be eligible for the same medical, dental, and vision coverage you had when your qualifying event occurred. COBRA coverage does not include Weekly Disability Benefits.

C. Notification Responsibilities

1. If you get divorced, or if your child loses dependent status, you, your spouse or child must notify the Fund Office and request a COBRA election notice. The Fund Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later.

2. For purposes of extending an 18-month maximum coverage period to 29 months, the Fund Office must be notified of the person's determination of eligibility for Social Security disability benefits within 60 days of the Social Security notice of such determination and before the end of the initial 18-month period. The Fund Office must also be notified within 30 days of the date Social Security determines that the person is no longer disabled.

3. It is your employer's responsibility to notify the Fund Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a dependent should also notify the Fund Office and request a COBRA election notice any time any type of qualifying event occurs.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office or that the Fund Office sends to you.

D. Electing COBRA Coverage

1. When the Fund Office is notified of a qualifying event, and you request notification about your COBRA rights, an election notice will be sent to you and/or your dependent(s) who would lose coverage due to the event. The election notice tells you about your right to elect COBRA coverage, the due dates, the amount of the self-payments, and other pertinent information.

2. An election form will be sent along with the election notice. This is the form you or a dependent fill in and return to the Fund Office if you want to elect COBRA coverage.

3. The person electing COBRA coverage has 60 days after he or she is sent the election notice or 60 days after his or her coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is personally delivered or mailed back to the Fund Office (the postmark date will govern the date of mailing).

4. If the election form is not returned to the Fund Office within the allowable period, you and/or your dependents will be considered to have waived your right to COBRA coverage.

E. COBRA Self-Payment Rules

1. COBRA coverage self-payments must be made monthly and must be received by the Fund Office in a timely manner. Your self-payment will be considered on time if it is personally delivered or mailed by the due date. (Postmarks affixed by the U.S. Postal Service will be considered proof of date of mailing. Postage meter imprints or any other evidence of mailing date, including date imprints by overnight courier services such as UPS or Airborne, will not be considered proof of date of mailing unless payment is actually delivered to the Fund Office no later than the first business day immediately following the mailing date shown.)

2. The amounts of the monthly self-payments are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more than once a year unless substantial changes are made in the benefits.

3. A person electing COBRA coverage has 45 days after the signed election form is returned to the Fund Office to make the initial (first) self-payment for coverage provided between the date coverage would have terminated

and the date of the payment. (If a person waits 45 days to make the initial payment, the next monthly payment may also fall due within that period and must also be paid at that time.)

4. If a self-payment is not made within the time allowed COBRA coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

5. The due date for each following monthly self-payment is the first day of the month for which payment is made. You will have a 30-day grace period in which to make this payment. Your self-payment will be considered on time if it is received within 30 days of the due date.

F. Additional COBRA Coverage Rules

1. COBRA coverage may not be elected by anyone who was not eligible for Plan benefits on the day before the occurrence of a qualifying event.

2. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage.

3. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents.

4. If coverage is going to terminate due to your termination of employment or reduction in hours, and you do not elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA for up to 18 months for herself and any children within the time period that you could have elected COBRA coverage.

5. A person who is already covered by another group health plan or Medicare may elect COBRA coverage. However, if a person becomes covered under another group health plan or Medicare after the date of the COBRA election, his COBRA coverage will terminate (unless he has a pre-existing condition that would cause the other plan to limit or exclude benefits).

6. You do not have to show proof that you and/or your dependents are insurable in order to be entitled to COBRA coverage.

G. Termination of COBRA Coverage

Normally, COBRA coverage for a person will terminate at the end of the last month of the maximum period to which the person was entitled and for which correct and timely payments were made. However, COBRA coverage for a covered person will terminate before the end of the maximum period when the first of the following events occurs:

1. A correct and timely payment is not made to the Fund.

2. After an election of COBRA coverage, the person becomes entitled to Medicare benefits.

3. After an election of COBRA coverage, the person becomes covered under another group health care plan. Exception: This termination rule will not apply if the person has a pre-existing medical condition that would cause benefits to be excluded or limited under the other plan.

4. This Plan no longer provides group health coverage to any employees.

5. The person was receiving extended coverage for up to 29 months due to his or another family member's disability, and Social Security determines that he/she or the other family member is no longer disabled.

IV. Coverage for Employees and Their Dependents when Employee enters Military Service

A. Eligibility Status

1. You must submit advance written notice of military service to the Fund Office (unless circumstances of military necessity as determined by the Defense Department make it impossible or unreasonable to give such advance notice).

2. If you do not submit notice, your coverage will terminate on the date your eligibility has been exhausted.

3. For military leaves which are less than thirty-one (31) days in duration and for which you submit the required notice, you and your eligible dependents' coverage will be continued as though you are actively at work for the duration of such leave.

4. For military leaves which are thirty-one (31) or more days in duration and for which you submit the required notice, you and your eligible dependents' coverage will cease and your eligibility status will be frozen as of the date you enter military service with the uniformed services of the United States, unless you elect to continue coverage as described in the following subsection B.

5. You will not have your Hours Bank deducted for the month that you leave work with a contributing employer to enter military service.

6. Your eligibility will be reinstated on the date you return to work for a contributing employer (or you are available for work if no such work is available) within the applicable time limits stated in the following subsection C, provided you make any applicable self-payments required to continue eligibility.

B. Continuation Coverage

1. When the Fund Office has been notified that you are entering the military service, you and your eligible dependents will be given the option of continuing your same class of coverage under the Plan.

2. If your absence is less than 30 days due to military service, you may receive hour's bank credit for your time spent performing military service. You must provide the Fund Office with 30 days advance notice prior to your military service. Hour's bank credit will be granted at the rate of 40 hours per seven-day week (and pro-rata for partial weeks) for each day you are actively performing military service.

3. You are required to make timely self-payments if your absence due to military service is 31 days or more. The rate for self-payments is determined by the Trustees from time to time.

4. Your self-payments must be made by the last day of each month in which eligibility and coverage terminate, or within a thirty (30) day grace period.

5. Failure to make self-payments before the end of the grace period will cause eligibility and coverage to terminate at the end of the month for which you last made a timely self-payment.

6. You and your eligible dependents may continue coverage for a period ending the earlier of:

a. the first day of the month for which a timely self-payment has not been received;

b. 24 months from the first date of absence due to military services;

c. the day after the date you fail to apply for reemployment with a contributing employer within the applicable time period allowed under the following subsection C.

The right to freeze eligibility and make self-payments under this provision ceases when you provide written notice that you do not intend to return to work for a contributing employer after uniformed service.

C. Status Upon Returning from Military Service

If you are eligible for benefits when you enter the military service, you and your eligible dependents again will be eligible for benefits on the date of your return to work for a contributing employer within the following time periods:

1. For periods of military service of less than thirty-one (31) days, you must report to the employer not less than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of military service plus eight hours, after a period allowing for safe transportation from place of military service to place of your residence.

2. For periods of military service of more than 30 days but less than 181 days, you must apply for reemployment not later than 14 days after military service is completed.

3. For periods of military service of more than 180 days, you must apply for reemployment not later than 90 days after military service is completed.

Such time periods may be extended for injuries or sicknesses, as determined by the Secretary of Veteran Affairs, to have been incurred or aggravated during your service in the uniformed services.

You will be eligible for benefits on the date of your return to work within the required times periods, provided you make any applicable self-payments required to continue eligibility. Your Hours Bank will not be deducted for the month that you return to work for a contributing employer.

V. Continuation Coverage (QMCSO Coverage)

The Trustees will determine if a court order directing a Participant Parent to provide health coverage for a Dependent Child is a Qualified Medical Child Support Order (QMCSO). The Plan has procedures established for the determination and administration of QMCSO's.

QMCSO Coverage under the Plan will be provided to a Dependent Child upon application by the Participant Parent.

A. Benefits. The benefits provided under the Plan are those in effect for Dependents on the date QMCSO Coverage commences or, if there are thereafter amendments to the Plan, the benefits in effect on the date charges are incurred for treatment.

B. Payment for Coverage. The additional contribution uniformly required of a Participant Parent to cover a Dependent Child, if any, shall be paid in the amount and at such time as required under the rules of the Plan.

C. Termination. QMCSO Coverage for a Dependent Child will terminate (i) if any required contribution is not timely paid as required under the Plan rules; or (ii) on the date the Participant Parent's coverage terminates; or (iii) on the date the child is no longer a Dependent Child under the provisions of the Plan. See COBRA Continuation Coverage provisions for the limited conditions under which coverage may be continued thereafter for a Dependent Child.

VI. Coverage for Widows and Widowers

If you die while a Participant in the Fund, your spouse and dependents can continue coverage pursuant to COBRA for up to 36 months as explained in Section Two, Part III.

After expiration of the 36-month COBRA period your spouse (including dependents, if they meet the definition of dependent) can continue participation in the Fund by paying the COBRA contribution rate (as adjusted annually by the Trustees) until the earliest of the following events occur:

- Your spouse remarries,
- Your spouse reaches the age of 65, at which time they are eligible for retiree coverage with the Fund, or
- Your spouse fails to pay the monthly rate established by the Board of Trustees in advance of the month of coverage.

SECTION THREE
PROVISIONS DESCRIBING PLAN BENEFITS

I. WEEKLY DISABILITY AND EXTENDED DISABILITY BENEFITS

A. Benefit Amount

Weekly Disability Benefit	26 weeks at 50% of base wages up to a maximum of $525, but not less than $300 per week. Benefits for each day of a partial week is 1/7th of the weekly benefit. (See also exclusions for chiropractic care).
Extended Disability Benefit	Two years (beginning after 26 week waiting period is exhausted). Benefits are the same as for weekly disability benefit.

- Base pay is determined by multiplying the employee's straight-time hourly rate in effect under the applicable Collective Bargaining Agreement at the time the disability commenced by 40 hours per week.

- Weekly Disability Benefits cease as of the date eligibility is lost.

- Weekly Disability Benefits are taxable to the Participant, and Extended Disability Benefits are not taxable to the Participant.

B. Eligibility

A covered, active employee is entitled to weekly disability or extended disability benefits provided:

- He or she is not engaged in any work for renumeration or profit; and,

- Is treated by a licensed physician prior to the first period for which benefits will be payable and is continuing under the care of a physician.

- He or she is actively employed immediately prior to the commencement of total disability, except there shall be continued eligibility if on layoff because of lack of work, and the employee was exercising seniority rights under the Local Union's referral plan.

Office employees, retirees and dependents are not eligible for weekly or extended disability benefits. In addition, employees working under the Limited Energy Collective Bargaining Agreement and Manufacturing employees are not eligible for the extended disability benefits.

For an active employee to be eligible for extended disability benefits he/she must have been employed by employers that made contributions on his/her behalf for extended disability benefits for a period of at least 5,000 hours in the five years immediately preceding the commencement of total disability, 1,500 of which must have been worked in the two years immediately preceding the commencement of total disability.

C. When Benefits Begin

Benefits begin with the:

- First day of disability due to an accident or injury;
- Eighth day of disability due to an illness; or
- Eighth day of disability due to chemical dependency.

D. Exclusions

- Two or more periods of disability are considered as one (regardless of whether the two causes are related), unless they are separated by complete return to active, full-time work for at least two (2) weeks. The Trustees shall have the right to refuse to make payment for successive periods of disability if they find that the return to work was for the purpose of qualifying for further disability benefits.

Weekly or extended disability benefits are not provided for any loss caused by:

- Personal Injury for which any benefits, settlement, award or damages are received or payable (or can reasonably be expected to be received or payable);
- Injury which arises out of or occurs in the course of any occupational employment for wage or profits; or
- Sickness for which you are entitled to benefits under any worker's compensation law, occupational disease law, or from the Social Security Administration. You must notify the Fund Office if you apply for Social Security Disability benefits. If you receive a benefit award from the Social Security that covers the same time period in which you received weekly or extended disability benefits under this Plan, you must notify the Fund Office and you must repay the weekly or extended disability benefits provided by the Plan.

E. Treatment by Chiropractor

- If treated by a chiropractor, weekly disability benefits are limited to not more than eight (8) consecutive weeks during anyone-period of disability. Benefits will be paid beyond such period only if treatment is by a licensed physician. No extended disability benefits are payable for periods of treatment by a chiropractor.

F. Miscellaneous

- If hospital confinement occurs prior to the end of the month for which the last contribution was made, coverage will continue for the duration of the hospital confinement.

- Weekly disability benefits are not available for those Participants who have continuously made self-contributions for a period of one year or more.

- The Trustees may require a physical examination by a physician that they designate. Either when the application is submitted, or at any time during the period that benefits are being paid.

II. PARENTAL LEAVE BENEFIT

A. Benefit Amount

Benefit Amount:	Two weeks at 50% of base wages up to a maximum of $525, but not less than $300 per week. Benefits for each day of a partial week is one-seventh of the weekly benefit.

- Base pay is determined by multiplying the employee's straight time hourly rate in effect under the applicable Collective Bargaining Agreement at the time the benefits commence by 40 hours per week.

- Parental Leave Benefits cease as of the date eligibility is lost or the employee returns to work.

- Parental Leave Benefits are taxable to the participant.

B. Eligibility:

A covered, active employee is entitled to Parental Leave Benefits provided the employee:

- Is a biological or adoptive parent who is taking a leave of absence from work in conjunction with the birth, adoption, or placement for adoption of a child, and

- The leave begins within 3 months of the birth, adoption or placement for adoption of the child.

Only Group I employees are eligible for Parental Leave Benefits, this benefit is not available for office employees, retirees and dependents.

C. Miscellaneous:

- Eligible employees will receive a maximum of two weeks of paternal leave benefits per birth, adoption or placement for adoption of a child. The occurrence of multiple births, adoptions or placements (e.g., birth of twins, adoption of siblings) does not increase the two-week maximum benefit.

- The parental leave benefit cannot be taken concurrently with weekly or extended disability benefits. Participants who are receiving weekly or extended disability benefits because they are medically unable to work due to giving birth will be eligible for paid paternal leave benefits at the conclusion of the weekly or extended disability benefit. For example, a Participant who is medically able to return to work and no longer under the continuing care of a physician but takes an additional leave of absence from work to bond with child will be eligible for paternal leave benefits when disability benefits cease.

- The Parental Leave Benefit ends the earlier of the date the employee returns to work or the date the two-week benefit is exhausted.

- The Trustees may require written proof of the birth, adoption, or placement for adoption of the child.

III. MAJOR MEDICAL BENEFITS

A. <u>In General</u>: Certain charges are payable under the Major Medical benefit as follows:

Deductible Amount:	$400 per family per calendar year (counts towards Out-of-Pocket Annual Family Maximum for Medical Benefits).
Insured Percentage:	80%
Emergency Room Co-payment:	$100 co-payment (Co-payment subject to waiver, see Part I, Section Three, II., B. 5.) (counts towards Out-of-Pocket Annual Family Maximum for Medical Benefits).
Out-of-Pocket Annual Family Maximums for Medical Benefits:	$3,400

*Effective March 1, 2020, charges for items and services related to diagnostic testing for the detection of COVID-19 are paid at 100%. This provision does not cover COVID-19 testing for surveillance or employment purposes. Such items and services related to the COVID-19 test must be medically appropriate for diagnostic purposes, as determined by your attending health care provider, and in addition to the diagnostic COVID-19 test may also include:

- Office, emergency room, urgent care or telemedicine visits/facility fees;
- COVID-19 antibody tests;
- Diagnostic tests panels for influenza A and B; and/or,
- Chest x-ray.

Coverage of COVID-19 related items and services at 100% will only apply for the duration of the COVID-19 public health emergency, as declared by the Secretary of Health and Human Services.

B. **Eligible Expenses:** All necessary and reasonable charges for medical care rendered while under the care of a licensed physician are covered under this Major Medical Benefit, including:

1. In-patient hospital room charges. The Fund will pay 80% of the hospital's average semi-private room and board charges (including special care units) for an in-patient stay during a period of confinement.

2. Intensive care charges.

3. Out-patient surgery benefits.

4. Extra hospital charges. The Fund will pay extra charges for any one confinement for days when room and board charges are paid under this Plan, or where hospital charges are incurred in connection with an out-patient surgical procedure.

   Extra charges are defined as:

   a. Charges by the hospital for medical care and treatment (other than room and board charges, other professional charges, and charges made by a radiologist or a pathologist); and,

   b. Charges by a physician or professional anesthetist for the cost and administration of anesthetics.

5. Emergency room charges. There is a $100.00 co-payment for emergency room hospital charges. The co-payment is waived if the Participant is admitted to the hospital for the same illness or injury within 48 hours after the emergency room visit. The emergency room $100.00 co-payment is applied to the Major Medical annual family deductible and the out-of-pocket family maximum.

6. Charges for ambulance services.

7. Regular charges for skilled nursing services in such out-of-hospital cases where the attending physician certifies that the Participant would otherwise require hospitalization.

8. Charges for diagnostic x-ray examinations and laboratory tests. The Fund will pay for laboratory tests or x-ray examinations authorized by the attending physician and made solely for diagnostic purposes of a Participant's injury or illness.

   No benefits will be paid under this provision for the following:

   a. Any dental x-ray, except under the supervision of an oral surgeon for use in the treatment by an oral surgeon for any injury produced by accidental means.

   b. Any charge for diagnostic x-ray or laboratory test as part of a physical exam for occupation, school, travel, or the purchase of insurance.

9. Oral Surgery type procedures with the specific dental codes set forth below:

   a. General Anesthesia. General anesthesia as it pertains to procedures b, c, and d set forth below. (Code on dental procedure D9220).

   b. Apicoectomy/Periradicular Surgery. Surgery to the root of the tooth. (Code on dental procedure D3410, D3421, D3425, and D3426).

   c. Periodontic Surgical Procedure. Surgery to the supporting and surrounding tissue of the teeth. (Code on dental procedure D4210-D4276).

   d. Oral Surgery. Surgical extractions, surgical preparation of the ridge for dentures, surgical excision of lesions or bone tissue, treatment of fractures and other similar surgical suturing and repair procedures. (Code on dental procedure D7210-D7780, D7910-7999).

10. Chiropractic care for the usual and customary charges incurred for such services, subject to the following schedule:

    Maximum Visits per Calendar Year: 12

11. Physical, speech, and occupational therapy, subject to the following schedule:

    Cumulative Maximum Visits per Calendar Year: 10

    Upon reaching the maximum visits allowed for physical, speech, or occupational therapy, you may submit a request to the Fund Office for coverage of additional therapy visits. You will be required to provide clinical information and a treatment plan to the Fund Office in order for continued visits to be approved under the Plan upon a Medical Review. The Fund will not pay for additional therapy unless the treatment is expected to make significant measurable improvement to your condition within a reasonable and predictable period of time.

12. Treatment related to organ transplants of the heart, heart/lung, lung, liver, pancreas, kidneys, bone marrow, and cornea. The Fund will not pay for organ transplants or related services if the organ is not specifically listed

above. Only human organ or tissue transplants are eligible for coverage; animal organs or mechanical devices are not eligible for coverage.

When it is necessary to harvest from a donor any of the organs set forth above for an organ transplant, and the donor does not have coverage for the procedure from another plan, this Plan will pay up to $6,000 for the reasonable and customary medical expenses incurred by the donor.

13. Charges for oxygen and rental of equipment required for the administration of oxygen.

14. Charges for x-ray, radium, radioactive isotopes, and related therapy.

15. Charges for treatment of alcoholism, chemical dependency, or drug abuse, except the Plan does not cover charges for any treatment not provided at a licensed facility; any confinement or treatment not recommended by a doctor of medicine, any charge which represents an admitting fee or deposit; involving the family of the person eligible for whom a claim is submitted when they are made part of the therapy; or, educational material.

16. Charges for a limited selection of durable medical equipment, including the initial purchase price, or the rental up to the maximum benefit available (not to exceed the purchase price) for eligible durable medical equipment.

    Durable Medical Equipment includes equipment that:

    - is prescribed by the attending physician;
    - is medically necessary;
    - is primarily and customarily used only for a medical purpose;
    - is designed for prolonged use; and,
    - serves a specific therapeutic purpose in the treatment of an illness or injury that is a covered expense under this benefit.

    Items ordered by your physician, even if medically necessary, will not be covered if they do not meet all of the above criteria.

    The Fund will pay for the repair and/or replacement of Durable Medical Equipment only when:

a. The repairs, including the replacement of essential accessories, such as hoses, tubes, mouthpieces, etc. are necessary to continue to make the item/device serviceable.

b. Routine wear on the equipment renders it non-functional and the participant still requires the equipment. The Fund does not cover the upgrade or replacement of Durable Medical Equipment when the existing equipment is still functional or can be made functional through repair.

c. The physician documents the condition of the participant changes. (e.g., impaired function necessitates an upgrade to an electrical wheelchair from a manual wheelchair.)

17. Charges for casts, splints, trusses, braces, and crutches.

18. Charges for treatment by a physiotherapist under the supervision of a physician.

19. Charges for initial artificial eyes and limbs.

20. Charges for dental treatment to the extent necessary to repair injuries to sound natural teeth caused by an accident where treatment is rendered within 90 days after said accident or discovery of the effect of the accident.

21. Anesthesia and facility charges incurred in conjunction with dental care for eligible dependent children under age six.

C. Specific Benefits:

1. Pregnancy Stays:

Group Health Plans and health insurance issuers offering group insurance coverage (including this Plan) generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean Section, or require that a provider obtain an authorization from the Plan or the insurance issuer for a prescribed length of stay not in excess of the above periods.

Benefits for treatment of pregnancy are payable on the same basis as benefits for treatment of disease. All the limitations and other conditions and terms of the

Plan that apply to benefits payable for disease will apply to benefits payable for pregnancy.

2. Women's Health and Cancer Rights Act Of 1998

If you have had or are going to have a mastectomy, you may be entitled to obtain benefits under the Women's Health and Cancer Rights Acts of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and,
- Physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).
- Coverage is subject to the same annual deductible, co-insurance and maximums as other benefits under your health plan.

D. <u>Special Limitations Relating to Major Medical Benefits</u>:

1. <u>Deductible</u>: No payment will be made for the first $400 of eligible Major Medical expenses for each calendar year for the family unit comprised of the covered employee and his or her covered eligible dependents. Payment of the deductible amount will count towards satisfaction of the Out-of-Pocket Annual Family Maximum for Medical Benefits.

2. <u>Co-Insurance</u>: The Plan will pay 80% of the Eligible Medical Expenses.

3. <u>Other Exclusions</u>: Major Medical Benefits are also subject to the Exclusions and Limitations contained in Section Four of this Plan.

IV. PHYSICIAN SERVICES BENEFITS

A. In General

For in-person physician services and in-network online or telehealth visits, there is a $25.00 co-payment, thereafter the charges are paid at 100% of the usual and customary as determined by the Fund. This applies to:

1. In-patient hospital physician charges;

2. Out-patient hospital physician charges;

3. Doctor's visits; and,

4. Emergency room physician charges.

The physician services $25.00 co-payment is not applied towards the Major Medical $400 annual family deductible but does count towards the $3,400 out-of-pocket annual family maximum.

Doctor on Demand telehealth visits are covered at 100%.

*Effective March 1, 2020, charges for items and services related to diagnostic testing for the detection of COVID-19 are paid at 100%. This provision does not cover COVID-19 testing for surveillance or employment purposes. Such items and services related to the COVID-19 test must be medically appropriate for diagnostic purposes, as determined by your attending health care provider, and in addition to the diagnostic COVID-19 test may also include:

- Office, emergency room, urgent care or telemedicine visits/facility fees;
- COVID-19 antibody tests;
- Diagnostic tests panels for influenza A and B; and/or,
- Chest x-ray.

Coverage of COVID-19 related items and services at 100% will only apply for the duration of the COVID-19 public health emergency, as declared by the Secretary of Health and Human Services.

B. Definition of "Physician"

As used herein, "Physician" means a doctor of medicine or doctor of osteopathy to the extent that benefits are provided while practicing within the scope of his/her license. Doctor will include a podiatrist or ophthalmologist. Doctor will not include an eligible

person or any person who is the spouse, parent, child, brother, sister, or in-laws thereof of the Participant.

For the purposes of the Plan's payment responsibility, "Physician" shall also mean services performed by a nurse practitioner or a physician's assistant who is licensed under State Law to provide the services rendered.

V. WELLNESS/PREVENTIVE CARE BENEFITS

A. Annual Preventive Exam through Health Dynamics

One preventive exam per year for participants and spouses (not dependent children) is covered at 100%, and a $200 Visa gift card is provided, if the exam is done through the Health Dynamics program. This benefit is not available to Medicare eligible retirees. Please contact the Fund Office for information on scheduling an annual preventive exam through Health Dynamics.

This benefit is provided to encourage participants and their spouses to have routine physical examinations to maintain good health. Routine physical examinations can help identify potential medical problems during the early stages.

B. In General

Pursuant to the Patient Protection and Affordable Care Act (the "Affordable Care Act"), the Fund will pay the in-network preventive items or services listed below at 100%. These benefits are provided without any cost-sharing, except with regard to physician's charges for an office visit, as discussed below.

1. Covered Preventive Services For All Adults

- Abdominal aortic aneurysm one-time screening for men between 65-75 who have ever smoked
- Diabetes (Type 2) screening for adults aged 40-70 who are overweight or obese
- Low-dose aspirin use to prevent cardiovascular disease and colorectal cancer for adults aged 50-59 with a high cardiovascular risk
- Colorectal cancer screening for adults aged 50-75 (may include fecal occult blood testing, sigmoidoscopy, colonoscopy or virtual colonoscopy)
- Depression screening
- Annual preventive eye exam
- Falls prevention exercise interventions for community-dwelling adults aged 65 years and over

- Healthy diet intensive behavioral counseling interventions for overweight or obese adults at higher risk for chronic disease
- Hepatitis B virus screening in persons at high risk for infection
- Hepatitis C virus screening in adults aged 18-79
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- High blood pressure screening for adults age 18 or older
- Latent tuberculosis screening in populations at increased risk
- Lung cancer annual screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Obesity screening (BMI of 30 or higher) and for those determined obese, intensive multicomponent behavioral interventions
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Skin cancer prevention behavioral counseling for young adults and parents of young children about minimizing exposure to UV radiation to reduce risk for skin cancer for persons aged 6 months to 24 years with fair skin types
- Low to moderate dose statin medication for the prevention of cardiovascular disease for adults ages 40 – 75 with certain risk factors
- Syphilis screening for adults at higher risk
- Tobacco use screening, behavioral interventions, and Food and Drug Administration-approved pharmacotherapy for cessation (up to two cessation attempts per year)

2. Covered Preventive Services For Pregnant Women Or Women Who May Become Pregnant

- Asymptomatic bacteriuria screening using urine culture
- Breastfeeding: Comprehensive lactation support services from a trained provider, including counseling, education, and breastfeeding equipment, during pregnancy and the postpartum period (breastfeeding equipment requires prior authorization and is subject to specific restrictions, contact the Fund office for information)
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant, while those at high risk of developing gestational diabetes may be screened at the first prenatal visit
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening
- Preeclampsia screening throughout pregnancy and low-dose aspirin as preventive medication after 12 weeks gestation in women at high risk for preeclampsia

- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening for all pregnant women
- Tobacco use screening and behavioral interventions for cessation

3. Other Covered Preventive Services For Women

- BRCA-related cancer: One office visit risk assessment for women with a personal or family history associated with certain cancers or ancestry associated with breast cancer susceptibility (BRCA1/2 gene mutations), and up to two sessions of genetic counseling and evaluation for BRCA testing
- Breast cancer medication: Risk reducing medications, such as Tamoxifen and Raloxifene, to women who are at increased risk for breast cancer and low risk for adverse medication effects
- Breast cancer biennial screening (mammography) for women over 40
- Cervical cancer screening
    - Pap test (also called a Pap smear) every 3 years for women 21 to 65
    - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years
- Chlamydia and gonorrhea screening for sexually active women aged 24 and younger and for older women at increased risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs)
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Interpersonal and domestic violence screening
- Osteoporosis screening for postmenopausal women younger than 65 who are at increased risk, and all women 65 years and older
- Urinary incontinence screening for women yearly
- Well-woman visits to get recommended services for women

4. Covered Preventive Services For Children

- Alcohol, tobacco, and drug use assessments for adolescents
- Anemia risk assessment or screening, as appropriate
- Autism screening for children at 18 and 24 months
- Behavioral assessments throughout childhood
- Bilirubin concentration screening for newborns
- Blood pressure screening throughout childhood
- Blood screening for newborns
- Cervical dysplasia screening for sexually active females
- Depression screening for adolescents beginning routinely at age 12
- Developmental screening throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Annual preventive eye exam
- Fluoride varnish for all infants and children as soon as teeth are present to age 5
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing and vision screening for all children
- Height, weight and body mass index (BMI) measurements throughout childhood
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at high risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Lead screening for children at risk of exposure
- Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Obesity screening in children age 6 and older and up to three office visits a year for counseling and behavioral interventions
- Oral fluoride supplements for children without fluoride in their water source
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling for sexually active adolescents
- Skin cancer prevention behavioral counseling for adolescents
- Tuberculin testing for children at higher risk of tuberculosis

- Vision screening for children under age 5 to detect amblyopia or its risk factors

5. Covered Preventive Immunizations

Immunization vaccines, according to the recommended schedule:	Adults	Children
• Diphtheria, Tetanus, Pertussis (Whopping cough)	X	X
• Haemophiles Influenza Type B		X
• Hepatitis A	X	X
• Hepatitis B	X	X
• Herpes Zoster (Shingles)	X	
• Human Papillomavirus (HPV)	X	X
• Inactivated Poliovirus		X
• Influenza (Flu shot)	X	X
• Measles, Mumps, Rubella	X	X
• Meningococcal	X	X
• Pneumococcal	X	X
• Rotavirus		X
• Varicella (Chickenpox)	X	X

6. **Co-payment Rules**

There is a $25.00 co-payment for office visits under the Plan. The co-payment rules that apply when preventive services are provided as part of an office visit are as follows:

- If a preventive care item or service is billed separately from an office visit, you will be required to pay the $25.00 co-payment for the office visit.

  - For example, if you have a cholesterol test during an office visit and the provider bills for the office visit separately from the lab work associated with the cholesterol screening test, you will be responsible for a $25.00 co-payment for the office visit, but the lab work will be covered at 100%.

- If a preventive care item or service is not billed separately from an office visit, whether you are responsible for the $25.00 co-payment for that office visit depends on the primary purpose of the visit. If the primary purpose of the office visit is to obtain the preventive item or service, then the entire bill is paid by the Fund at 100%. If the primary purpose is not to obtain a preventive care item or service, you will be responsible for the $25.00 co-payment for the office visit.

- For example, if you see a doctor to discuss reoccurring abdominal pain and you have a blood pressure screening during that visit, you will be responsible for the $25.00 co-payment for the office visit because the blood pressure check was not the primary purpose of your visit.

7. **Exclusions**

a. Vocational or employment physicals.
b. A physical for determination of insurance, disability, or pension benefits.

VI. PRESCRIPTION DRUGS

A. In General: Prescription drugs are covered when ordered by a health professional authorized by law to prescribe the drug. Prescription drugs are drugs that are required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription," and are covered as follows:

Insured Percentage:	80%
Maximum Amount:	34-day Supply
Maximum Amount (Maintenance Drugs):	90-day Supply
Out-of-Pocket Annual Family Maximum for Prescription Drug Benefits	$4,500

The co-insurance payment for prescription drugs applies towards the Out-of-Pocket Annual Family Maximum for Prescription Drugs. It does not apply towards the Out-of-Pocket Annual Family Maximum for Medical Benefits. Specialty drugs are not covered when purchased from an out-of-network provider.

B. Preventive Care Prescriptions: Pursuant to the Affordable Care Act, there will be no co-insurance costs imposed on prescription drugs prescribed as a preventive care item and they will be paid at 100%. For example, FDA-approved contraceptives will be paid at 100%. However, the Fund will continue to charge the co-insurance amount for branded drugs prescribed as a preventive care item if a generic version is available, unless medically inappropriate as determined by individual's health care provider.

C. Diabetic Supplies: This Prescription Drug Benefit includes diabetic supplies (i.e., insulin, needles and syringes, glucose monitors and meters, test strips and lancets) when prescribed by a physician, but excludes durable medical equipment as listed under Paragraph G, "Exclusions."

D. Participating Pharmacies: If you utilize a participating pharmacy, you must present your identification card to the pharmacy at the time you receive your prescription and make your co-insurance payment. If you do not utilize a participating pharmacy, you must pay the amount of the prescription in full and seek reimbursement from the Fund Office subject to the applicable co-insurance amount. When using a participating retail or mail order pharmacy, the Participant's co-insurance amount is determined at the time of purchase and is not reduced by subsequent rebates or adjustments received by the Fund.

E. Mail Order Plan: Participants may use the Mail Order Plan for long-term or maintenance drugs. Maintenance medications are generally prescription drugs that are used on only an on-going or long-term basis and are associated with the treatment of such illnesses as arthritis, diabetes, heart disorders, high blood pressure, high cholesterol, ulcers, and other chronic conditions.

F. Specialty Drugs: The Fund participates in Prime Therapeutics Specialty Drug Co-Pay Solution programs and the Fund only provides coverage for specialty drugs through Prime Therapeutics' specialty drug vendor. Specialty drugs purchased from out-of-network providers are not covered. This program allows the Fund and participants to maximize the value of co-pay assistance programs that drug manufacturers offer for certain high-cost specialty drugs. Your usual co-pay as set forth in the Schedule of Benefits will be modified for select specialty medications that qualify for third party co-payment assistance from the drug manufacturer. Under this program, the Plan will reduce the amount it pays for the specialty medication by an amount which is equivalent to the maximum benefit of the applicable coupon. For specialty drugs that offer a manufacturer coupon and are filled through Prime Therapeutics' specialty drug vendor, your copay is $0. The coupon amounts that are applied towards your claim do not count towards your prescription drug out-of-pocket maximum.

Prime Therapeutics will contact any participant or dependent taking a drug that is part of this program to help them pursue third party co-payment assistance. If a participant is unable to participate in a manufacturer coupon program their co-payment for the specialty drug will be as set forth in the Schedule of Benefits. The list of specialty drugs eligible for co-payment assistance and this program is subject to change.

G. Exclusions: The Fund will not pay for the following charges under the Prescription Drug Benefit:

1. Non-prescription (over the counter) drugs or medicines, vitamin therapy, or treatment, unless required under Part I, Section Three, IV.;

2. Any drug or medicine that is not medically necessary, or is not administered according to generally accepted standards of practice in the medical community, or is determined not to be appropriate to the treatment of an illness or injury;

3. Charges that exceed the approved amount for covered drugs;

4. Drugs or medicines that are considered investigative, including those that are provided in relation to an investigative treatment;

5. Drugs or medicines that are provided without charge (i.e. drug samples);

6. Any drugs or medicines dispensed before your coverage is effective or after your coverage terminates, even though your illness started, or your injury was incurred while coverage is in force;

7. Drugs that exceed a 34-day supply at any one time, or in the case of maintenance drugs, in excess of a 90-day supply;

8. Drugs that are lawfully obtainable without a prescription except injectable insulin;

9. Therapeutic devices or appliances, including hypodermic needles, syringes, (except where prescribed to treat diabetes) support garments and other non-medical substances regardless of their intended use;

10. Administration of prescription legend drugs;

11. Refilling of a prescription in excess of the number specified by the prescribing health professional;

12. Vitamins, whether prescribed or not prescribed, unless required under Part I, Section Three, IV.;

13. Cosmetic or beauty aids, treatment of hair loss, dietary or food supplements, special formulas and food substitutes;

14. Drugs prescribed for weight loss or weight gain, unless required under Part I, Section Three, IV.;

15. Drugs and medicines to treat sexual dysfunction, including but not limited to Viagra;

16. Growth hormones, unless the person has a documented hormone deficiency due to pituitary origin;

17. Charges in excess of the usual, reasonable, and customary for the area as determined by the Fund;

18. Mail Order Drugs purchased from any vendor that is not in the Network selected by the Fund, except where the cost to the Fund is less from the alternative mail order vendor; and

19. Durable Medical Equipment, including such things as insulin pumps and supplies such as tubing and reservoirs, continuous glucose monitoring systems, sensors, and transmitters

VII. SUPPLEMENTAL BENEFITS

A. Vision Benefits

Vision benefits are available only to Group I employees and their dependents.

1. Adult Vision Benefits: Adult vision benefits are payable up to $225 once every calendar year for reasonable expenses related to vision exams, lenses, frames, contacts and Lasik surgery. Services and supplies must be furnished by an optician, optometrist, or ophthalmologist acting within the usual scope of such practice.

2. Pediatric Vision Benefits: Pediatric vision benefits include one vision exam per calendar year and one frame and one pair of lenses for glasses OR contacts every two years. Pediatric vision benefits are not subject to the $225 calendar year limit applicable to adults.

3. Limitations:

    a. No other parts of the Plan provide coverage for vision benefits and the sum total of the coverage provided under this Plan are as set forth above.

    b. Vision benefits do not cover expenses incurred for services performed or supplies furnished by other than an optician, optometrist, or ophthalmologist.

B. Dental Benefits

Dental benefits are available only to Group I, II, III, and V employees, retirees, and their dependents.

1. **In General:** The Fund covers dental benefits for the usual and customary charges incurred by the eligible Participant or dependent subject to the following schedule:

Annual Calendar Year Maximum per Adult Participant:	$950
Pediatric Dental Benefits:	No annual max
Coverage A – Diagnostic and Preventive Services:	70%
Coverage B – Regular and Special Restorative Services:	70%
Coverage C – Prosthetics (removable and fixed):	70%
Deductible per Participant per Calendar Year: (Deductible does not apply to Coverage A)	$25
Maximum Family Deductible per Calendar Year:	$75

(Deductible does not apply to Coverage A)

Benefit Time periods for Coverage A:

Routine Periodic Examination:	Twice in a calendar year
Prophylaxis:	Twice in a calendar year
Four Bitewing X-Rays:	Once in a calendar year
Topical Fluoride Applications (up to 18 years of age):	Once in a calendar year
Oral Hygiene Instruction:	Once in a calendar year
Full Mouth X-Rays:	Once every 3 years

2. **Services Covered:** The Fund covers services as described below subject to the service limitations described within each coverage, and also the exclusions and limitations set forth in Section Three, Part VI., B. 3.

COVERAGE A
REGULAR DIAGNOSTIC AND PREVENTIVE SERVICES

a. Routine periodic examinations limited to twice in a calendar year, and four bitewing x-rays limited to once per calendar year.

b. Full mouth x-rays once in any three-year interval, unless special need is shown.

c. Dental prophylaxis as prescribed by the dentist, limited to twice in a calendar year.

d. Topical fluoride applications as prescribed by the dentist, limited to once in a calendar year up to age 18.

e. Oral hygiene instruction as prescribed by the dentist, limited to once in a calendar year.

COVERAGE B
REGULAR AND SPECIAL RESTORATIVE SERVICES

a. Regular Services:

    i. Emergency treatment for relief of pain.

    ii. Amalgam, preformed crowns, synthetic porcelain, plastic and composite restorations.

    iii. Routine oral surgery (removal of tooth structure and soft tissue retained coronal remnants), including pre-operative and post-operative care. (Code on dental procedure D7111-D7140).

    iv. Endodontics, to include pulpal therapy and root canal procedures. (Code on dental procedures D3000-D3999).

b. Special Services:

    i. Gold restorations when the teeth cannot be restored with another filling material; crowns and jackets when the teeth cannot be restored with a filling material.

    ii. Non-surgical periodontics to include procedures necessary for the treatment of diseases of the gingival (gums). (Code on dental procedure D4320-D4999).

COVERAGE C
PROSTHETICS (REMOVABLE AND FIXED)

a. Prosthetics:

   i. Provides bridges, partial dentures, and complete dentures. Crowns when used as abutments to a bridge.

   ii. Charges for implantable teeth and related procedures.

   EXCLUSION: The Fund does not cover the replacement of misplaced, lost or stolen dental prosthetic appliances.

b. Replacement Benefit:

   The Plan will not cover replacement of an existing appliance more often than once in any five-year period, and then only if the existing appliance is not, and cannot be, made satisfactory. The five-year period will be measured from the date on which the appliance was last supplied, whether under this Plan or not. Services which are necessary to make an appliance satisfactory will be provided. The term "existing" is intended to include an appliance that was placed at the inception of the five-year period, but which, for whatever reason is no longer in the possession of the patient.

3. <u>General Dental Provisions</u>:

a. Covered Fees: Under the Plan a Participant or a dependent is free to go to the dentist of his or her choice. However, payment is based on the usual, customary and reasonable fees charged for similar services as determined by the Board of Trustees. Amounts in excess of the usual, customary, and reasonable fees are not considered eligible expenses by the Plan.

b. Exclusions:

   i. If a Participant is entitled or could have been entitled if proper application had been made, to any dental benefit provided under the authority of any governmental agency, such benefit shall discharge the obligation of the Plan as though it had been paid under this Dental Coverage.

   ii. Services performed for purely cosmetic purposes, or to correct congenital conditions.

   iii. Charges for programs of treatment, including prosthetics, which were undertaken prior to the date the person became covered under this Plan.

iv. Services of anesthesia, except by a dentist or by an employee of the dentist when the service is performed in his office, all in conjunction with covered services.

v. Charges for any services not specifically covered under this Plan (including any hospital charges or prescription drug charges).

vi. Services performed other than by licensed dentists, their employees, or agents.

vii. Orthodontics — treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

viii. Charges for treatment of temporomandibular joint dysfunction, to include treatment of jaw joint problems, and craniomandibular disorders, or other conditions of the joint lining the jawbone and skull and the complex of muscles, nerves, and other tissues related to that joint.

ix. Services performed by a member of the Participant's or dependent's family.

c. Limitations:

i. In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment with the balance of the treatment cost remaining the responsibility of the patient.

ii. No other part of the Plan provides coverage for Dental Benefits and the sum total of the coverage provided under this Plan is as set forth in this section.

VIII. MEDICARE ELIGIBLE RETIREE BENEFITS

A. Medicare Supplement Plan.

Available only to Group V and VI retirees and their spouses.

A Medicare Supplement Plan is available to Group V and VI retirees and their spouses who are eligible for Medicare. The Fund determines eligibility for this program, but the Schedule of Benefits for medical and prescription drugs are determined by the insurer selected by the Fund except for Special Limited Benefits as set forth in this Part VIII, Section C. Please

contact the Fund Office for details on the Medicare Supplement Plan including a booklet describing the benefits offered by the Plan.

B. Dental Benefits.

Group V retirees and their spouses are also eligible for Dental Benefits as described under Section VII, Supplemental Benefits.

C. Special Limited Benefits for Medicare Participants.

Group V and VI retirees and their spouses who are eligible for the Medicare Supplement Plan described in Section A of this Part, are also eligible for the following Special Limited Benefits:

1. Implantable hearing aids. Implantable hearing aids and charges for the examination and fitting thereof are payable when as a result of a growth, tumor or other disease it is medically necessary to restore hearing loss. The Fund does not cover hearing aids or audio aids (whether external or internal) or charges for the examination or fitting of such aids that are prescribed to treat normal degenerative hearing loss.

2. Continuous glucose monitors. Continuous glucose monitors and their sensors are covered when medically necessary to treat diabetes.

In order for the Fund to pay or reimburse the charges for a Special Limited Benefit you must first submit the claim to the Medicare Supplement Plan and receive a denial. The Fund will either pay the charge on your behalf or reimburse you up to the usual and customary amount of the covered charges minus the deductible and/or co-payment you would have paid had the charges been covered by the Medicare Supplement Plan. If you have questions about the Special Limited Benefits, please call the Fund Office.

D. Prescription Drug Reimbursement

1. Specialty Drugs. For Group V and VI retirees and their spouses, the Fund will reimburse out-of-pocket prescription drug expenses where:

    a. While covered for benefits through the active plan and prior to becoming eligible for Medicare you were prescribed a specialty drug that offered a coupon or rebate that reduced your per prescription out-of-pocket costs; and

    b. After becoming enrolled in the Medicare Supplement Plan offered by the Fund you are prescribed the same specialty drug but the coupon or rebate is disallowed and your out-of-pocket costs increase as a result.

For each specialty drug prescription described above, the Fund will reimburse you the difference between the per prescription out-of-pocket costs that you currently would pay if you were still on the active plan and the amount you actually pay on the Medicare Supplement Plan based upon the coupon or rebate being disallowed. Your claim for reimbursement should be filed within 90 days after the end of the Plan Year, but you may file it as soon as you have a reimbursement due under this section.

IX. POST-RETIREMENT PERSONAL CARE ACCOUNTS

A. Establishment of Post-Retirement Personal Care Accounts

This portion of the Plan is designed to permit Participants to use their Post-Retirement Personal Care Account ("PCA") to pay for Qualifying Premium Expenses on a nontaxable basis after retirement.

1. The PCA benefits described in this section are available if your local union has negotiated a contribution for those benefits or where contributions are received on your behalf through reciprocal agreements when you work outside the jurisdiction of your local union.

2. The PCA cannot be funded by a Medicare-eligible or Non-Medicare-eligible retiree. If you funded the PCA as an active employee and then you retired, you may use the balance of your PCA for payment of your Qualifying Premium Expenses after retirement.

3. Legal Status: This PCA is intended to qualify as an employer-provided medical reimbursement plan under Code § 105 and § 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45 and shall be interpreted to accomplish that objective. Employer contributions and Qualifying Premium Expenses payable under the PCA are intended to be eligible for exclusion from the participating employees' gross income under Code § 105(b) and § 106(a).

4. Definitions:

   a. **"Code"** means the Internal Revenue Code of 1986, as amended.

   b. **"Health FSA"** means a health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-2, Q/A-7(a).

   c. **"Highly Compensated Individual"** means an individual defined under Code §105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

   d. **"PCA"** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

   e. **"PCA Account"** means the health reimbursement arrangement account described later in this section under "Establishment of Account."

f. **"PCA Participant"** means a person who is eligible for benefits from the Electrical Workers Health and Welfare Fund and for whom the required contributions have been negotiated and paid into the PCA portion of this Plan.

g. **"Retired Employee"** means an employee satisfying the conditions for retirement pursuant to the Plan's eligibility rules for retirees.

B. Benefits Offered and Method of Funding

1. **Account Balances.** Each Employee who has money paid into his PCA either through employer contributions (specifically identified in the Collective Bargaining Agreement as a post-retirement contribution) or reciprocal contributions shall have an individual account established in his or her name. If there is any balance remaining in the account after all reimbursements have been paid for the calendar year, such balance shall be carried over to the subsequent calendar year. The Trustees shall determine, in their sole discretion, whether and to what extent to credit earnings and/or assess administrative charges to the accounts. The Employer or any other individual may not assign, transfer or alienate any interest in the accounts except to pay Qualifying Premium Expenses after retirement.

2. **Benefits Offered.** When an Active Employee becomes a PCA Participant through the Plan's receipt of contributions, an account will be established but Qualifying Premium Expenses shall only be payable after retirement or to the Participant's beneficiary upon death. In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Qualifying Premium Expenses.

3. **Benefits Payable Only After Retirement.** Active employees are not eligible for payments from the PCA until after they retire.

4. **Benefits Payable to Beneficiary Upon Death.** If an employee dies, the entire balance of his or her PCA Account immediately becomes available to the Employee's spouse and/or other individuals who qualify as dependents for the reimbursement of Qualifying Premium Expenses. In no event shall amounts in the Post-Retirement Reimbursement Account be paid in cash to any person for other than reimbursement of Qualifying Premium Expenses. (For example, there are no lump sum distributions of the account balance as a death or termination benefit). The balance shall be forfeited if the Employee has no spouse or other dependents. The account balance is also subject to the Account Forfeiture provision of this section.

5. **Plan and PCA Participant Contributions.**

   a. Plan Contributions. When the required contributions have been negotiated the Contributing Employer will submit the contributions in the appropriate manner.

b. PCA Participant Contributions. There are no PCA Participant contributions for benefits allowed under this PCA.

6. **Qualifying Premium Expenses.** After retirement a participant's account balance can be used for the payment of retiree, self-pay or COBRA premiums under this Plan or any other plan so long as the premium payments are for accident or health insurance as defined in Code § 213(d). Premium expenses do not include premiums for fixed indemnity, cancer or hospital indemnity insurance, for long term care insurance premiums paid by an Employer or premiums that are for or could be deducted pre-tax through a § 125 Cafeteria Plan (including a spouse's plan.) In no event shall Qualifying Premium Expenses be provided in the form of cash other than reimbursement.

7. **No Funding Under Cafeteria Plan.** Under no circumstances will the benefits be funded with salary reduction contributions, employer contributions (*e.g.*, flex credits) or otherwise under a cafeteria plan.

C. PCA Account Benefits

1. **Benefits.** The Plan will reimburse PCA Participants for Qualifying Premium Expenses after their date of retirement as defined in the Plan's eligibility provisions, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees. A Participant cannot be reimbursed for Qualifying Premium Expenses incurred before the establishment of this provision or before becoming a PCA Participant.

2. **Other Out-of-Pocket Health Care Expenses.** The PCA does not reimburse general out-of-pocket health care expenses for active or retired employees, such as deductibles, co-payments, prescription or over-the-counter drugs, dental or vision expenses or any other similar expense.

3. **Cannot be Reimbursed or Reimbursable from Another Source**. Qualifying Premium Expenses can only be reimbursed to the extent that the PCA Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Plan, other insurance, or any other accident or health plan (including if the other health plan is a Health FSA).

4. **Maximum Benefits.** There will not be a maximum dollar amount that may be credited to a PCA Account for an Active Employee. Amounts may be carried over to the next calendar year.

5. **Nondiscrimination.** Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Board of Trustees in its sole discretion.

6. **Establishment of Account**. The Fund Office will establish and maintain a PCA Account with respect to each PCA Participant but will not create a separate Fund or otherwise segregate assets for this purpose. The PCA Account so established will merely be a recordkeeping account with the purpose of keeping of contributions and available reimbursement amounts.

7. **Crediting of Accounts**. A PCA Participant's account will be credited at the beginning of each month with an amount equal to the contributions received. Accounts shall be denominated in dollars, and not hours.

8. **Debiting of Accounts.** A PCA Participant's account will be debited for any reimbursement of Qualifying Premium Expenses to include self-pay premiums, COBRA premiums, retiree self-payments or premiums of another Plan incurred by the covered PCA Participant or his or her dependent.

9. **Available Amount.** The amount available for reimbursement of Qualifying Premium Expenses is the amount credited to the Participant's PCA as described above reduced by prior reimbursements debited as described above.

D. Reimbursement Procedure

1. Claims Substantiation. A PCA Participant who seeks benefits may apply for reimbursement by submitting an application in writing to the Fund Office in such form as the Board of Trustees may prescribe, but no later than March 31 following the close of the Plan Year in which the Qualifying Premium Expense was incurred, setting forth:

a. the person or persons on whose behalf Qualifying Premium Expenses have been incurred;

b. the nature and date of the Qualifying Premium Expenses so incurred;

c. the amount of the requested reimbursement; and

d. a statement that such Qualifying Premium Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Qualifying Premium Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Qualifying Premium Expenses have been incurred and the amounts of such Qualifying Premium Expenses, together with any additional documentation that the Fund Office may request. Except for the final reimbursement claim, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25.

2. **Timing.** Within thirty (30) days after receipt by the Fund Office of a reimbursement claim from a PCA Participant, the Fund Office will reimburse the PCA Participant or the Fund Office will notify the PCA Participant that his/her claim has been denied.

a. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Fund Office, including in cases where a reimbursement claim is incomplete.

b. The Fund Office will provide written notice of any extension, including the reasons for the extension, and will allow the PCA Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

3. **Claims Denied.** For claims that are denied, see the "Claims Appeal Procedure" provision in this document.

E. Recordkeeping and Administration

1. **Inability to Locate Payee.** If the Fund Office is unable to make payment to any PCA Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such PCA Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such PCA Participant or other person shall be subject to the provisions set forth in the "Account Forfeiture" section described later in this section.

2. **Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Active Employee, or the allocations made to the account of any PCA Participant, or the amount of benefits paid or to be paid to a PCA Participant or other person, the Fund Office shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such PCA Participant or other person the credits to the PCA or distributions to which he/she is properly entitled under the Plan. Such action by the Fund Office may include withholding of any amounts due to the Plan from any future benefits.

3. **Account Forfeiture.** Any account that remains inactive (no money coming in or money going out) for sixty (60) consecutive months, will have a $100 per year administrative fee assessed beginning on the first day of the year that follows sixty (60) months of inactivity until the account balance is exhausted. In the event an account balance is $25 or less, and no monies have been contributed or withdrawn for six consecutive months, the money will be forfeited, and the account will be closed.

   Your account will be forfeited if: 1) you go to work for an employer in the geographical area covered by the Plan, and 2) you are performing work in an industry where employer contributions would be due to the Plan on account of the work you perform but the

employer is not signatory to a collective bargaining agreement requiring contributions to this Plan.

4. **No Guarantee of Tax Consequences.** Neither the Fund Office nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of the Participant under this portion of the Plan will be excludable from the PCA Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each PCA Participant to determine whether each payment under this portion of the Plan is excludable from the PCA Participant's gross income for federal, state and local income tax purposes, and to notify the Fund Office if the PCA Participant has any reason to believe that such payment is not so excludable.

SECTION FOUR
MEDICAL EXPENSES EXCLUDED UNDER ALL PARTS OF THE PLAN

I. Charges

The Plan will not pay benefits for any charge incurred unless:

A. It is for treatment that is generally accepted medical practice and the charge is usual, customary, and reasonable in amount;

B. It is for treatment that is medically necessary;

C. It is for treatment or diagnosis of a bodily injury or disease and the service or supply is prescribed by a physician; and,

D. You are obligated to pay for it, and you would have been billed for it even if you did not have these benefits.

II. The Plan Will Not Pay Benefits For:

A. Services, supplies, or materials of any type rendered or provided to a Participant by the Participant or his or her spouse, parent(s) or parent(s)-in-law, child(ren), brother(s), or brother(s)-in-law, sister(s) or sister(s)-in-law, or grandparent(s);

B. Weight loss programs and all charges related to weight loss programs, unless required under Part I, Section Three, IV.;

C. Premarital tests or examinations, to include premarital counseling and/or marital counseling;

D. Routine physical examinations for occupation, school, travel, purchase of insurance, and health check-ups;

E. Any treatment related to sexual dysfunction;

F. Charges for infertility treatment or in-vitro fertilization, artificial insemination, or related professional or diagnostic services;

G. Vision care for the correction of vision, the fitting of glasses, or contact lenses, unless required under Part I, Section Three, IV.;

H. Hearing aids, audio aids, examinations or any charges for the fitting thereof, including external or implantable hearing aids, except the Plan will pay benefits when, as a result of a growth, tumor or other disease (not including degenerative

hearing loss) an implantable hearing aid is medically necessary to restore hearing loss;

I. Charges for a prosthetic appliance to treat temporomandibular joint disorder (TMJ) and craniomandibular joint disorder unless the treating physician or oral surgeon certifies in writing that prosthetic is necessary to prevent joint deterioration or surgery;

J. Sickness for which the Participant is entitled to benefits under any workers' compensation occupational disease law, employer's liability or similar law or act, or no-fault auto insurance;

K. Bodily injury which arises or occurs in the course of any occupation or employment for profit or wage;

L. Charges incurred in excess of specified limitations provided in this Plan for treatment and any related services or supplies including, but not limited to those for chiropractic physician's visits, extended post-hospital care, prescription drugs, dental and vision benefits;

M. Surgery for obesity, including gastric bypass, gastric stapling, intestinal bypass, lipectomy, suction lipectomy, or any other surgical procedure which is simply to reduce fat tissue, except the Fund will pay for gastric bypass surgery or a lap-band adjustable gastric banding system if the procedure is medically necessary as defined by the Managed Care guidelines. A determination of medical necessity will be decided after a review of a number of factors, including body mass index (BMI), morbid obesity, failure to sustain weight loss, and patient expectations and understanding of the risks and benefits of surgery. To ensure your surgery will be covered, you must contact the Fund Office in advance of your surgery to find out if you meet the requirements for coverage.

N. Cosmetic surgery, except for repair of disfigurement due to an accident. Examples of cosmetic surgery include but are not limited to:

1. Reduction Mammoplasty — (breast reduction surgery) unless medically necessary because of an organic condition as to create a symmetrical appearance with the other breast following a mastectomy.

2. Augmentation Mammoplasty — (breast enlargement surgery) unless part of reconstruction following breast surgery due to cancer.

3. Rhinoplasty — (plastic surgery of the nose) unless the result of an accident occurring while the individual is covered, and the surgery is within one year of the accident or chronic nasal obstruction.

4. Otoplasty — (plastic surgery of the ears) sometimes referred to as lop or cauliflower ears.

5. Blepharoplasty — (repair of drooping eyelids) unless the droop restricts the field of vision as verified by an ophthalmologist.

6. Keratectomy or keratotomy — diagnosis of myopia (nearsightedness) when the myopia is correctable by lenses.

7. Rhytidectomy — face lift.

8. Dyschromia — (tattoo removal).

9. Panniculectomy or Lipectomy — abdomen (removal of layer of excess fat) sometimes called "tummy tuck".

10. Genioplasty — (chin augmentation)

O. Charges for therapeutic acupuncture, experimental surgery, recreational or educational therapy, and services of the clergy;

P. Charges for rehabilitation services such as physical, occupational, and speech therapy that are not expected to make measurable or sustainable improvement within a reasonable period of time;

Q. Charges for hypnosis or biofeedback;

R. Recreational or educational therapy or forms of non-medical self-care or self-help training including health club memberships, exercise classes, aquatic therapy, smoking cessation products (including nicotine transdermal patches or Nicorette Gum), unless required under Part I, Section Three, IV.;

S. Purchase of radioactive materials for x-rays, radium, or cobalt treatment;

T. The following Durable Medical Equipment items are specifically excluded under the Plan, unless expressly limited:

1. Vehicle lifts;

2. Services or supplies of a common household use, including but not limited to waterbed, hospital bed, air conditioner, to include central air conditioning, heat appliances, dehumidifiers, exercise equipment, air and/or water purifiers, allergenic mattress, blood pressure kit, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a physician.

3. Replacement of items due to malicious damage, neglect or abuse;

4. Replacement of lost or stolen items;

5. Routine periodic maintenance (e.g. testing, cleaning, regulating and checking of equipment) for which the owner is generally responsible;

6. Arch supports and inserts;

7. Breast prosthesis; form limited to one every two (2) year period and bra limited to two per year;

8. Foot orthotics, including but not limited to, biomechanical and negative mold foot impressions; orthopedic shoes unless required immediately following surgery, or shoes recommended for support, unless the shoe is an integral part of a brace.

U. Purchase of non-durable medical supplies that are not medically necessary for treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member; (i.e., alcohol swabs, cotton balls, incontinence liner/pads, Q-tips, adhesives, and informational material);

V. Charges for personal services or supplies such as television, slippers, lotion, Kleenex, food supplements, or oral hygiene products;

W. Charges for any disability resulting from war, whether declared or undeclared, to include riots, and civil unrest;

X. Expenses incurred for rest cares, domiciliary care, nursing home or extended care facilities, or for the convenience of the household, or expenses incurred for treatment not generally recognized by the American Medical Association or the United States Department of Health or that is not authorized and provided from health providers within the United States;

Y. Drugs that can be purchased over the counter, to include Stop Smoking aids, vitamins, drugs for treatment of infertility, whether prescribed or not prescribed, unless required under Part I, Section Three, IV.;

Z. Arch supports, foot orthotics, and orthopedic shoes, including, but not limited to, biomechanical evaluation, range of motion measurements and reports and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery, or charges for routine foot care such as treatment of corns, calluses, and paring of toe nails, except required because of a diagnosis of disease or illness;

AA. Charges for failure to keep a scheduled visit, completion of any form, or for medical information;

BB. Treatment of compulsive gambling;

CC. Gene therapy as a treatment for inherited or acquired disorders;

DD. Growth hormones, except due to a hormone deficiency due to pituitary only; and,

EE. Charges for any service not specifically covered under the Plan.

FF. Charges for implantable teeth and related procedures except as specifically provided under Dental Benefits – Coverage C.

SECTION FIVE
GENERAL PROVISIONS

I. COORDINATION OF BENEFITS

If you or your eligible dependents are entitled to benefits under any other group health care plan, the amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed 100% of the medical expenses incurred. In no event will this Plan's payment exceed the amount which would have been paid if there were no other plan involved. Benefits payable under another plan include the benefits that would have been payable even if no claim actually was filed.

When another plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an allowable expense and a benefit paid.

A. Order of Benefit Calculation

If the other group plan does not contain a coordination of benefits or similar provision, then that plan always will calculate and pay its benefits first. When duplicate coverage arises and both plans contain a coordination of benefits or similar provision, the eligible Employee must report such duplicate group health care coverage on the claim form that is submitted to secure reimbursement of allowable expenses incurred. For prescription drug benefits allowable expense does not include the Participant's co-insurance responsibility as set forth in Section Three, Part V. This Plan has established the following rules to decide which group plan will calculate and pay its benefits first.

1. If a patient is eligible as an Employee in one plan and as a dependent in another, the plan covering the patient as an Employee will determine its benefits first.

2. If a patient self-pays contribution to this Plan and is covered by another plan, this Plan is secondary, and the other plan pays first.

3. If a patient is eligible as a dependent child in two plans, the plan covering the patient as the dependent of that parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will determine its benefits first.

4. When parents are divorced or separated, the order of benefit determination is:

    a. The plan of the parent having custody pays first.

b. If the parent having custody has remarried, the order is:

i. the plan of the parent having custody;

ii. the plan of the spouse of the parent having custody;

iii. the plan of the parent not having custody; then,

iv. the plan of the spouse of the parent not having custody.

However, when a Qualified Medical Child Support Order names and directs one of the parents to be responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any order given here.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses OR if the court decree states that both parents will be responsible for the health care needs of the child but gives physical custody of the child to one parent (and the entities obligated to pay or provide the benefits of the respective parent's plans have actual knowledge of those terms), benefits for the dependent child will be determined according to the prior subsection 3.

5. If the rules above do not determine which plan will calculate and pay its benefits first, then the plan that has covered the patient for the longer period of time will determine its benefits before a plan that has covered the patient for a shorter time.

There is one exception to this rule: A plan that covers a person other than as a laid-off or retired Employee, or a dependent of such person, will determine its benefits first, even if it has covered the eligible person for the shorter time.

In addition, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the benefits of the plan which covers the person as an Employee will be determined before the benefits under the continuation coverage.

Benefits of this Plan will be reduced to the extent necessary to prevent the other group plan from refusing to pay benefits available under its policy.

B. Coordination of Benefits with Automobile Insurance

This Plan will coordinate benefits with automobile insurance carriers as follows:

1. Benefits payable under the Plan are not in lieu of those that would be payable under no-fault automobile insurance and do not affect any legal requirement that an individual maintain the minimum no-fault automobile insurance coverage within the jurisdiction in which that individual resides.

2. For any expenses arising from the maintenance or use of a motor vehicle, no-fault automobile insurance will calculate and pay its benefits first and this Plan will calculate and pay benefits second. The amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed 100% of the expenses incurred.

3. Benefits that otherwise might be payable under no-fault automobile insurance will not be payable by the Plan merely because no claim for no-fault benefits was filed. If you or an eligible dependent fails to maintain the legally required amount of no-fault automobile insurance within the jurisdiction where you or your dependent resides, Plan benefits will not be payable for amounts which the legally required no-fault insurance otherwise would have paid.

4. An individual injured in an automobile accident which is or should be covered by no-fault automobile insurance must timely protest any, notice of discontinuance of no-fault insurance, or benefits for those injuries will not be payable under this Plan.

II. MEDICARE PROVISIONS

Eligible persons who are retired or disabled are required to enroll in Part A and Part B of Title XVIII of the Social Security Amendments of 1965 (more commonly known and described as "Medicare") in the event they become entitled to such coverage by reason of attained age, qualifying disability, or End Stage Renal Disease (ESRD). In no event will benefits paid by the Plan exceed the applicable amounts stated in the Schedule of Benefits, nor will the combined amounts payable under Part A and Part B of Medicare and the Plan exceed the eligible expenses incurred by the eligible person as the result of any one injury or sickness. Benefits payable by Part A or Part B of Medicare include those which would have been payable if the eligible person had properly enrolled when eligible to do so.

For eligible persons for whom Medicare is the primary source of coverage, the benefits payable under this Plan for services incurred at a Veterans Administration (VA) facility for non-service-connected disabilities will be reduced by the amount that would have been payable by Medicare had the services been rendered by a Medicare-approved facility.

For eligible persons for whom Medicare is the primary source of coverage, the benefits payable under this Plan for services otherwise covered by Medicare, but which are privately contracted with a provider, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

For eligible persons for whom Medicare is the primary source of coverage and who have enrolled in a Medicare+ Choice plan: the benefits payable under this Plan for services otherwise covered by Medicare, but which are not covered under the Medicare+ Choice plan because the eligible person did not obtain services at a network provider and/or did not comply with that plan's managed care requirements, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

To facilitate Plan payments in the absence of Medicare payments, it may be necessary for the Trustees to estimate Medicare payments.

Neither you nor the Plan will be responsible for paying any charges which exceed legal limits set by the Medicare Physician Payment Reform Act which limits the amount that physicians can bill Medicare patients above the Medicare allowance for a particular procedure or service, unless services are privately contracted.

A. Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Under the Plan Through Self-Payments. If a person eligible under the Plan solely because of self-payments becomes initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD), benefits payable under this Plan will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

   If such person subsequently becomes entitled to Medicare due to ESRD, Medicare will continue to be the primary source of coverage.

B. Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Under the Plan Through Employer Contributions. Plan benefits are not reduced for persons eligible through employer contributions even though they also may become initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD). In the event such person subsequently becomes entitled to Medicare due to ESRD, the Plan will continue to be the primary source of coverage for the full 30-month coordination period specified in the following subsection C.

   However, an active Employee or dependent spouse eligible through employer contributions who becomes initially entitled to Medicare due to attained age will have the right to reject the Plan and retain Medicare as their primary source of

coverage. In such case, the Plan is legally prohibited from supplementing Medicare coverage.

C. Persons Initially Entitled to Medicare by Reason of ESRD and Eligible under the Plan through Either Self-Payments or Employer Contributions. In the event an eligible person becomes initially entitled to Part A or Part B of Medicare because of ESRD (or when ESRD-based Medicare entitlement occurs simultaneously with attained age or other qualifying disability-based entitlement), benefits will be provided subject to the following terms. The same terms will apply in the event an eligible person becomes initially entitled to Medicare due to ESRD and subsequently becomes entitled to Medicare due to attained age or another qualifying disability.

1. The Plan will be the primary source of coverage for covered charges incurred for up to 30 consecutive months from the date of ESRD-based Medicare entitlement.

2. Benefits payable under the Plan beginning with the 31st month of ESRD-based Medicare entitlement will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

III. SUBROGATION AND REIMBURSEMENT

A. Fund's Subrogation and Reimbursement Rights; Obligation of Participant to Reimburse Fund from Third Party Recoveries and To Cooperate

Whenever the Electrical Workers Health and Welfare Fund has been or is providing Benefits under the Plan to a Plan Participant or eligible dependent as a result of an occurrence which results in the injury, sickness, or death to the Plan Participant or eligible dependent and for which a Plan Participant or eligible dependent could possibly recover damages, indemnity, or any other benefits or payments from any Responsible Third Party (including without limitation any person; any legal entity; any liability insurer, health insurer, Workers Compensation insurer, self-insurer, or any other insurer, whether first-party or third-party; any provider of no-fault, underinsurance, or uninsurance; or any indemnitor), the Fund will be subrogated to the rights of the Plan Participant and eligible dependent against such Responsible Third Party to the extent the Fund has paid benefits on behalf of the Plan Participant and eligible dependent and to the extent the Fund has incurred reasonable attorneys' fees and costs in the representation of its interests. The Fund may make a claim or commence and prosecute a legal action against any Responsible Third Party to recover benefits it has paid and to recover any fees and costs (including attorneys' fees) the Fund may have incurred in obtaining such a recovery.

If a Plan Participant or eligible dependent recovers any payments from any Responsible Third Party (whether through settlement, judgment, or otherwise, and whether or not denominated as medical damages), the Fund has a first priority subrogation and reimbursement claim against any such recovery. The proceeds from any such recovery, however denominated, from any Responsible Third Party will be allocated as follows:

> First, the Fund will be paid that amount that fully reimburses the Fund for all benefits it has paid on behalf of the Plan Participant or eligible dependent and for the Fund's reasonable attorneys' fees and costs incurred by the Fund in the representation of its interests.
>
> If there is any balance then remaining from such recovery, the Plan Participant or eligible dependent will receive such balance, but the Plan Participant or eligible dependent will be fully responsible for payment of his fees and costs of collection, including but not limited to his attorneys' fees.

The payment of proceeds will be made in the order described whether or not the Plan Participant or eligible dependent or those claiming under him have been fully compensated for damages arising from the injury, sickness, or death. Furthermore, this allocation will apply to any claim of any eligible dependent, regardless of whether the Plan Participant or eligible dependent was legally responsible for expenses of treatment. Unless it agrees in writing, the Fund will not be liable for any expenses, costs, or fees (including attorneys' fees) a Plan Participant or eligible dependent may incur in connection with his recovery.

If a Plan Participant or eligible dependent recovers from a Responsible Third Party and does not fully reimburse the Fund the amount of benefit payments the Fund has made and the reasonable attorneys' fees and costs incurred by the Fund in the representation of its interests, the Plan Participant or eligible dependent is personally liable to the Fund for the full amount of benefits paid on behalf of the Plan Participant or eligible dependent by the Fund, along with all costs and attorneys' fees incurred by the Fund to recover that amount.

A Plan Participant or eligible dependent must not settle or compromise any claims they might have against any Responsible Third Party without obtaining the prior written consent of the Fund. A Plan Participant or eligible dependent must cooperate fully with the Fund in the prosecution of any claims against any Responsible Third Party, and must provide the Fund with the names and addresses of all potential Responsible Third Parties and their insurers; all accident reports; and all authorizations and other papers and information the Fund might request from a Plan Participant or eligible dependent. A Plan Participant or eligible dependent must notify the Fund if they pursue a claim to recover damages

and/or reimbursement of expenses related to the injury, sickness, or death that necessitated their request for and receipt of benefits.

If a Plan Participant or eligible dependent does not provide the Fund with information the Fund has requested or is entitled to receive, or fails to reimburse the Fund out of any recovery, or fails to assign to the Fund their rights of recovery, or fails to promise to reimburse the Fund, or in any way prejudices the Fund's reimbursement and subrogation rights, the Fund in its discretion may withhold payment of present and future benefits to the Plan Participant or eligible dependents until they provide the requested information, reimburse the Fund, or otherwise cease prejudicing the Fund's reimbursement and subrogation rights.

The Fund will have the right to intervene in any legal action (wherever located) that a Plan Participant or eligible dependent might commence against any Responsible Third Party. The Fund will have the right to seek equitable or legal relief in order to enforce its reimbursement and subrogation rights that exist pursuant to law or equity, pursuant to the Summary Plan Description, or pursuant to any other document. A Plan Participant or eligible dependent or their attorney or agent must hold in trust the Fund's first priority interest in any recovery they might obtain from any Responsible Third Party. By virtue of applying for and accepting benefits from the Fund, a Plan Participant or eligible dependent authorizes the Fund to seek the imposition of a constructive trust or file a claim for equitable restitution against any recipient of monies recovered from any Responsible Third Parties, or to seek any other relief (whether characterized as legal or equitable) in any court or tribunal in order to protect the Fund's interest in any such recovery.

Any rights the Fund may possess pursuant to this section will be enforceable against the heirs, successors, and assigns of the Plan Participant or eligible dependent. As a condition precedent to providing benefits, the Fund may require the Plan Participant or eligible dependent to acknowledge their responsibilities and the Fund's rights under the Summary Plan Description, to assign to the Fund the Plan Participant's or eligible dependent's rights to recovery, and to promise to reimburse the Fund.

In the event that a Plan Participant or eligible dependent recovers any sums from any third party or any insurance company for claims related to a specific event or health condition before making a claim for benefits under the Plan related to that specific event or health condition, the Plan will be:

1. responsible to make payments for benefits only in excess of the Participant or dependent’s net recovery (gross amount less actual costs of collection); or

2. entitled to reimbursement from the Participant or dependent for payment of any benefit up to the amount of their net recovery.

B. Right of Recovery

Whenever the Plan has made payments in excess of its contractual obligations, the Plan has the right to recover such overpayments from any person or legal entity to or for whom such payments were made, including by making deductions from benefits which may be payable to or on behalf of an eligible person in the future.

IV. FAMILY AND MEDICAL LEAVE ACT

The federal Family and Medical Leave Act of 1993 (FMLA) requires certain covered employers to provide unpaid, job-protected leave to "eligible" Employees for certain family and medical reasons.

If you become eligible for leave according to the FMLA, your coverage under the Plan may be continued for the number of weeks mandated by law, provided your employer:

(a) is subject to the FMLA;

(b) makes the required contribution (or you do so); and

(c) files the appropriate notification and certification forms with the Fund Office.

If your leave is eligible under the FMLA, and you do not return to work after the leave, then for COBRA continuation coverage purposes, the date of the qualifying event will be the last day of your FMLA leave or the day you give notice of your intent not to return to work, if earlier. This provision will apply whether or not you elect to continue coverage under the Plan during the leave.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. Certain states, including Minnesota, have laws providing additional rights concerning parental leave.

For additional information regarding your rights under the Family and Medical Leave Act, you may contact your employer or the U.S. Department of Labor, Wage and Hour Division.

V. MEDICAL DATA PRIVACY

A. Introduction

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

1. The Plan's uses and disclosures of Protected Health Information ("PHI");

2. Your privacy rights with respect to your PHI;

3. The Plan's duties with respect to your PHI;

4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and,

5. The person or office to contact for further information about the Plan's privacy practices.

B. Plan's Use and Disclosure of PHI

The Plan will use PHI to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") adopted under HIPAA, including for purposes related to *Treatment, Payment,* and *Health Care Operations*. These terms are defined below.

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Payment includes the Plan's activities to obtain premiums, contributions, self-payment, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include, but are not limited to, the following:

1. Determining eligibility or coverage under the Plan;

2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);

3. Subrogation;

4. Coordination of Benefits;

5. Establishing self-payments by persons covered under the Plan;

6. Billing and collection activities;

7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;

8. Obtaining payment under stop-loss or similar reinsurance;

9. Reviewing whether claims are Medically Necessary, Reasonable and Customary, or otherwise payable under the Plan;

10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;

11. Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective reviews;

12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and,

13. Reimbursement to the Plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of the following activities (such as numbers 1, 2 and 5 below), it may do so in the future to perform health care operations of the Plan.

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population

based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.

2. Reviewing the competency or qualifications of health, care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;

3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan.

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

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

6. Management and general administrative activities of the Plan, including but not limited to:

    a. Managing activities related to implementing and complying with the Privacy Regulations;

    b. Resolving internal grievances;

    c. Merging or consolidating the Plan with another Plan, including related due diligence; and,

    d. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

C. Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

D. Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the plan documents, including this Summary Plan Description, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law.

2. Ensure that any agents (such as union business agents), including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

6. Make PHI available to a person who is the subject of the information according to the Privacy Regulations requirements;

7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

8. Make available the PHI required to provide an accounting of disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and,

10. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

1. The Board of Trustees, including any alternate Trustees

   The Plan will release PHI to the Trustees, and the Trustees will be able to see PHI, for purposes of hearing and determining claim appeals; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

2. The Trustees' agents, such as clerical staff of each Trustee, only to the extent reasonable to assist the Trustee in fulfilling his or her duties as a Trustee consistent with the above uses and disclosures of PHI.

3. Business agents of the union, acting as agents of the Trustees, pursuant to a signed authorization when feasible, for the purpose of assisting covered persons with eligibility and benefit issues.

F. Noncompliance Issues

If the persons described above do not comply with this Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

G. Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints concerning the use or

disclosure of your PHI. If you have any questions or complaints concerning your PHI or want to know the name of the Privacy Officer or Contact Person, please contact the Fund Administrator and ask to speak with the Plan's Contact Person.

VI. SELF AUDIT

If you find an error when examining your medical bills, the Fund will reimburse you 50% of the savings to a maximum of $250 provided your account is credited and the Fund Office receives a refund from the Provider.

SECTION SIX
BENEFIT APPEALS

I. BENEFIT APPEALS PROCEDURE

A. Filing Claims, Proof of Loss and Payment of Claims:

Filing Claim. You should file your claims within 90 days after the expenses are incurred. Claims will still be considered for payment when it is not possible to provide notification within 90 days, but you should always file your claims as soon as possible. A claim shall be considered filed as soon as it is received at the Fund Office, provided it is substantially complete with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, you will be notified as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a claim involving Emergency Care) of what is necessary to complete the claims.

Claims will not be paid if they are submitted more than 12 months after the expense was incurred, except in the absence of legal capacity.

Claim Forms and Proof of Loss: All claims for benefits must be filed on forms provided by the Plan, which are available from the Fund Office, except as required by law. Your medical provider may also submit a claim on your behalf if it is a participating provider. The Plan may, for example, require supplementary documentation or the results of a physical examination or laboratory test in order to adjudicate a medical claim. If the patient fails to cooperate with such requests, the claim may be denied.

Payment of Claims. When the Fund receives written proof of loss, claims will be paid immediately unless periodic payments are provided; these will be paid as they accrue and at least once a month. Where the statement of the medical provider shows a balance due, payment shall be made directly to the provider.

Amounts payable for accidental death will be paid in accordance with the beneficiary provisions. Any other amounts unpaid at the time of your death may, at the option of the Fund, be paid either to your beneficiary or to your estate, except as provided in the following paragraph. All other amounts will be payable to you.

If any benefits are payable at the death of the Participant to a dependent or a beneficiary who is a minor or is incompetent or incapable of executing a valid release and for whom no guardian has been appointed, the Fund may pay up to $500 of any such benefit to any person or institution determined by the Fund to be the proper recipient of such payment.

B. Claim Denials:

If your claim for benefits is wholly or partially denied, you will receive a written notice of an adverse benefit determination which will contain the following:

- Information sufficient to identify the claim involved, including date of service, health care provider, and claim amount;
- A statement that diagnosis and treatment codes, and their corresponding meanings, are available upon request;
- The specific reason for the denial with the applicable denial code and its corresponding meaning and specific reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;
- The specific rule, guideline protocol, or other similar criterion, if any, relied upon in making the determination;
- An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation; and,
- A description of the available internal appeal and external review process, how to initiate an appeal, and a statement of your right to bring a civil action under ERISA Section 502(a).

If your claim for disability benefits is wholly or partially denied, you will receive a written notice of an adverse benefit determination which will contain the following:

- The specific reason(s) for the adverse determination, along with reference to specific plan provisions on which the determination is based;
- A description of additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by you to the health care professionals treating you and vocational professionals who evaluated you;

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- A disability determination made by the Social Security Administration if you provided one to the Plan.

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols standards or other similar criteria do not exist;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim of benefits; and

- A description of the available internal appeal and external review process and a statement of your right to bring a civil action under ERISA Section 502(a).

1. Emergency Care Claims. In the case of an Emergency Care claim, the Fund Office shall notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the seriousness of your medical condition, but not later than 72 hours - after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan In the case of such a failure, the Fund Office shall notify you within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You shall be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specific information. The Fund Office shall notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specific information; or (2) the end of the period given to you to provide the specified additional information.

2. Pre-Service Claims. The benefit determination, whether adverse or not, shall be given within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is filed, unless special

circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days from the receipt of the notice within which to provide the specified information.

3. Post-Service Claims. The notice of denial shall be given within 30 days after the claim is filed, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 30-day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days from the receipt of the notice within which to provide the specified information.

4. Concurrent Care Decision. If you are receiving an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such treatment shall be deemed an adverse benefit termination. Notice of such determination shall be sent at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

5. Disability Claims. In the case of a claim for disability benefits, you will be notified of an adverse benefit determination no later than 45 days after receipt of the claim by the Plan.

Any request by you to extend the course of treatment beyond the period of time or number of treatments involving an Emergency Care claim shall be decided as soon as possible, taking into account the seriousness of your medical condition, and the Fund Office shall notify you of the benefit determination, whether adverse or not, within 24 hours prior to the expiration of the prescribed period of time and number of treatments. The appeal procedure is stated below.

C. Claims Appeal Procedure:

In accordance with federal law, the Plan provides for a two-step appeal. The first step is an internal appeal to the Board of Trustees or their designee. The second step is an external appeal to an Independent Review Organization ("IRO").

The Fund has engaged IROs on behalf of the Plan and any external appeal shall be assigned to such IROs in accordance with federal law.

1. First Level Appeal ("Internal Appeal")

a. In General:

i. You have 180 days following the receipt of a notification of an adverse benefit determination from the Fund Office to appeal such determination pursuant to the rules regarding the Internal Appeal provided in this section.

ii. You shall submit the Internal Appeal in writing to the Fund Office.

iii. You shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

iv. You shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

v. A de novo review of your Internal Appeal shall be conducted by the Board of Trustees or a committee of the Full Board. Such review shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

vi. In deciding an Internal Appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Board of Trustees or a Committee of the Board shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any such health care professional consulted shall not be an individual who was consulted in connection with the adverse benefit determination at issue nor the subordinate of any such individual.

vii. The identification of all medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided.

viii. You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or at the Plan's direction in connection with your claim and any with new or additional rationale as soon as possible and sufficiently in advance of the date the final internal

adverse benefit determination must be provided in order to provide you with an opportunity to respond prior to that date.

b. Time for Decision and Notification of Appeal:

i. Except as hereinafter provided, the Board of Trustees or a Committee of the Board shall make a decision on the Internal Appeal no later than the date of the next regularly scheduled Trustees' meeting that immediately follows the Fund's receipt of the appeal, unless the Internal Appeal is filed within thirty (30) days preceding the date of such meeting. In such case, the decision may be made by no later than the date of the second meeting following the Fund's receipt of the Internal Appeal. If special circumstances require further extension of time for processing, a decision on the Internal Appeal shall be rendered not later than the third meeting of the Trustees following a receipt of the appeal. If such an extension is required, the Board of Trustees or a Committee of the Board shall provide you with written notice of the extension which describes the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. The Board of Trustees or a designated fiduciary shall notify you as soon as possible but no later than five (5) days after a decision is made.

ii. Expedited Internal Appeals for Urgent Care Claims. In the case of the Internal Appeal of an Urgent Care claim, the Board of Trustees or a designated fiduciary shall notify you of the decision on the Internal Appeal as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the receipt of your Internal Appeal.

iii. In the event you receive an adverse benefit determination that involves a medical condition for which the timeframe for completion of an Expedited Internal Appeal would seriously jeopardize the life or health of you or your dependents or would jeopardize you or your dependents ability to regain maximum function and you have filed a request for an Expedited Internal Appeal, the Fund shall waive the Internal Appeal determination and proceed to Section Six, Part I., C. 2. e.

iv. Pre-service Claims. In the case of a Pre-service Claim, the Board of Trustees or Committee of the Board shall notify you of the decision on the Internal Appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of your Internal Appeal.

v. Calculation of Time Periods. The time period within which a decision on the Internal Appeal is required to be made shall begin at the time an appeal

is filed in accordance with the procedures provided in the Plan, without regard to whether all the information necessary to make a decision on the appeal accompanies the filing. However, in the event a period of time is extended due to your failure to submit information necessary to decide an appeal, the period for making a decision on appeal shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

c. Notification of Final Internal Adverse Benefit Determination:

The Board of Trustees or a Committee of the Board shall provide you with written notification of the Internal Appeal decision. In the case of an adverse determination, such notice shall include, in addition to the information contained in a notice of adverse benefit determination:

- A statement that you are entitled to receive, upon request, free access to and copies of all documents relevant to the claim;

- A description of the available external review process and how to initiate an external review request; and

- A statement that you may have the right to bring a civil action under ERISA Section 502(a) and a description of the contractual limitations period that applies to your right to bring such an action, including the calendar date that period expires.

2. Second Level Appeal ("External Review")

a. Deadline for External Review:

You may file a request for External Review with the Fund Office within four months after the date of receipt of the adverse Internal Appeal decision. If there is no corresponding date four months after the date of receipt, i.e., received on October 30th and there is not a February 30th, the request must be filed by the first day of the fifth month following the receipt of the notice. If the last date falls on a Saturday, Sunday, or a Federal Holiday, the filing deadline is extended to the next business day.

b. Preliminary Review:

Within five (5) business days following the date of receipt of your External Review request the Trustees, or the Fund Office as its designee, must complete a preliminary review of the request to determine whether it is eligible for External

Review. In order to be eligible for External Review the following factors must be met:

i. You are or were covered under the Plan at the time the health care item, service, or other benefit was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item, service, or other benefit was provided;

ii. The adverse benefit determination or the final adverse Internal Appeal determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

iii. You have exhausted the Plan's Internal Appeal process unless you are not required to exhaust the Internal Appeals process under the federal interim final regulations or in accordance with Section Six, Part I., C. 1. b. iii.;

iv. You have provided all of the information and forms required to process an External Review; and,

v. Your adverse benefit determination or final adverse benefit determination involves medical judgment (including, but not limited to, determinations of medical necessity, appropriateness, or experimental or investigational nature of the treatment), or a rescission of coverage.

c. Notice of Preliminary Review:

Within one (1) business day after completion of the Preliminary Review, the Trustees, or the Fund Office as their designee, will issue a notice in writing to you. If the request for External Review is complete, but not eligible for External Review, such notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notice will describe the information or materials needed to make the request complete and the Plan shall allow you to perfect the request for External Review within the later of the four-month filing period or within 48 hours following the receipt of the Notice of Preliminary Review.

d. External Review by an Independent Review Organization:

In accordance with federal law, the Trustees, or the Fund Office as their designee, shall assign an accredited Independent Review Organization ("IRO") to conduct the External Review. The IRO shall be assigned in accordance with the Fund's rules, which provide an assignment or rotation method that ensures independence and protection against a bias towards the Fund.

Upon receipt of the External Review, the IRO will:

i. Timely notify you in writing of the request's eligibility and acceptance for external review.

ii. This notice will include a statement that you may submit in writing to the assigned IRO within ten (10) business days following the date you received this notice any additional information that the IRO must consider when conducting the External Review. The IRO may, but is not required, to accept and consider additional information submitted after ten (10) business days.

iii. Within five (5) business days after the date of assignment to the IRO, the Trustees, or the Fund Office as their designee, must provide to the IRO any documents and any information considered in making the adverse benefit determination or the adverse Internal Appeal determination. Failure by the Fund (or the Fund Office) to provide documents must not delay the External Review. If the Fund, or the Fund Office fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the adverse benefit determination or the adverse Internal Appeal determination. Within one (1) business day after making such decision, the IRO must notify you and the Trustees.

iv. Upon receipt of any information submitted by you in accordance with provision ii. above, the IRO must within one (1) business day forward such information to the Trustees. Upon receipt of any such information, the Trustees may reconsider its adverse benefit determination or adverse Internal Appeal determination that is the subject of the External Review. Any reconsideration by the Trustees must not delay the External Review. External Review may be terminated if the Trustees determine during reconsideration to reverse the previous determination and provide coverage or payment as requested by you. The Trustees will provide written notice to the IRO and you of its reversal of the previous determination within one (1) business day of such reversal. Thereafter, the IRO will terminate the External Review proceedings.

v. The IRO will review all information and documents timely received and review the claim and all evidence de novo. The IRO is not bound by any decisions or conclusions reached during the initial benefit determination or the Internal Appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, in reaching an External Review decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, you or your treating provider;
- the terms of the Plan (unless contrary to applicable law);
- appropriate medical practice guidelines, including evidence-based standards;
- any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law); and
- the opinion of the IRO's clinical review.

vi. The IRO will provide written notice of the final External Review decision to you and the Trustees within 45 days after the IRO receives the request for External Review.

vii. The IRO's final External Review decision notice will contain:

- a general description of the reason for the request for External Review, including sufficient information to identify the claim (date or dates of service, Provider, claim amount, diagnosis code and corresponding meaning, treatment code and corresponding meaning, and reason for previous denial);
- the date the IRO received the assignment to conduct the External Review;
- the date of the IRO's final External Review decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;
- an explanation of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

- a statement that the determination is binding except to the extent that other remedies may be available under federal law to either the Plan or you;

- a statement that judicial review may be available to you; and

- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

viii. The IRO must maintain records of all claims and notices associated with the External Review for six (6) years. An IRO must make such records available for examination by you, Plan, or state or federal government oversight agency upon request unless such disclosure would violate state or federal privacy laws.

e. Expedited External Review

i. Expedited External Review shall be undertaken when you have a medical condition that necessitates Expedited External Review because the timeframe for completion of the standard External Review would seriously jeopardize the life or health of you or would jeopardize your ability to regain maximum function, or if the final adverse Internal Appeal determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but you have not been discharged from a Provider's facility.

ii. The Trustees, or the Fund Office as their designee, shall immediately upon receipt of the request for the Expedited External Review, perform the Preliminary Review provided in Section Six, Part I., C. 2. b, and shall complete such review as soon as possible without regard to the five (5) business days referred to therein. Upon its determination of the Preliminary Review, the Trustees, or the Fund Office as their designee, will immediately send the notice described in Section Six, Part I., C. 2. c.

iii. Upon a determination that the request is eligible for Expedited External Review, the Trustees, or Fund Office as their designee, shall assign an IRO in accordance with Section Six, Part I., C. 2. d., and transmit or provide all documents and information described in Section Six, Part I., C. 2. d., electronically or by telephone or facsimile or by any other available expeditious method.

iv. The IRO must provide its final External Review decision in accordance with Section Six, Part I., C. 2. d., and notice of such decision as

expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an Expedited External Review. If the notice of the Expedited External Review decision is provided by the IRO other than in writing, then within 48 hours of the date such notice is provided the IRO will provide written confirmation of the decision to you and the Trustees in accordance with Section Six, Part I., C. 2. d.

f. Reversal of Adverse Determination.

In the event the adverse benefit determination or the adverse Internal Appeal determination is reversed by the Trustees or the IRO, respectively, the Plan will provide coverage or payment for the claim in accordance with applicable law and regulations, but reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law and regulations.

D. Limitations on Actions Against the Fund:

No lawsuit shall be brought to recover benefits under this Plan unless:

1. You have exhausted the appeal procedure provided by the Plan; and

2. Such lawsuit is filed within two years from the date of the Board of Trustees' written notification of its decision on your Internal Appeal. This contractual limitations period shall begin to toll from the date of the Board of Trustees' written notification of its decision on your Internal Appeal regardless of whether you seek an External Appeal through an IRO.

PART II
VACATION BENEFITS

How do I become eligible for vacation benefits?

Answer: If you are working for an Employer that makes contributions to this Health and Welfare Fund pursuant to a collective bargaining agreement with IBEW Local 242 or 294, you are eligible to receive vacation benefits.

Who pays for my vacation benefits?

Answer: The cost of your vacation benefits are entirely paid for by Employer contributions made under such collective bargaining agreements.

How is money credited to my individual Vacation Account?

Answer: Each Participant has contributions credited to his or her vacation account as contributions are received from the Employers.

How is my Vacation Account valued?

Answer: The amount in each vacation account consists of:

1. Contributions made on behalf of the Participant for hours worked beginning January 1st that are received and processed by the Fund Office as of the date the checks are issued to Participants; *plus*

2. Any additional interest dividend, as determined by Fund income and as declared by the Board of Trustees. Such additional interest dividend is not guaranteed and will be paid in the sole discretion of the Trustees as the financial condition and performance of the Fund warrants; *minus*

3. An annual service charge as determined by the Trustees.

I am a member of IBEW Local 294, how will I receive my vacation benefits?

Answer: There are two ways to receive payments for your vacation benefits if you are a member of IBEW Local 294.

Monthly Payments

If you desire to have access to your Vacation Account on a monthly basis, you must complete a Direct Deposit ACH Credit Authorization Form. Once you have

completed and turned in the form to the Fund Office you will receive a monthly deposit in the account you designate provided contributions are received by your employer. If you need a copy of the Direct Deposit ACH Credit Authorization form or you have questions, please contact the Fund Office.

Annual Payments

If you do not complete the necessary form for Direct Deposit with the Plan in order to receive monthly payments, you will receive the monies in your Vacation Account on an annual basis on March 1st of each year for contributions earned in the previous year. A check will be automatically mailed to your last known address. It is essential that you keep the Fund Office informed of your current address at all times.

I am a member of IBEW Local 242, how will I receive my vacation benefits?

Answer: You will receive the monies in your Vacation Account on an annual basis on March 1st of each year for contributions earned in the previous year. A check will be automatically mailed to your last known address. It is essential that you keep the Fund Office informed of your current address at all times.

How are vacation benefits distributed in the event of my death or retirement?

Answer: Upon a Participant's death, any money in his or her Vacation Account will be paid to the Participant's spouse, and if none, to the Participant's children in equal shares, and if none, to the beneficiary designated under the Electrical Workers Pension Fund, Part A, and if none of the above apply then to your estate.

Upon retirement, a Participant may apply for and receive payment of his or her Vacation Account.

The Fund will not pay an additional interest dividend on any Vacation Benefit requested and paid to a retired Participant or a Participant's beneficiary or estate prior to March 1st of any given year. A retired Participant or a beneficiary or estate may delay receipt of a vacation benefit until the following March 1st in order to receive the additional interest dividend.

Does the Fund deduct taxes from my Vacation Account?

Answer: No. Applicable payroll taxes are not deducted by the Fund from the amount in the Vacation Account before the distribution is made. Employers are obligated to make payroll tax deductions and withhold applicable income tax before contributions are made to the Fund.

I believe I am entitled to payment, but I did not receive a check, or I believe the check was in the wrong amount. How do I make a claim for such benefits?

Answer: All claims for such benefits by a Participant or a beneficiary under the Plan must be in writing and sent to the Fund Office, within 120 days of the date the claim for benefits arose.

A decision regarding the claim will be made by the Fund Office within 90 days from the date the claim is received by the Fund Office, unless it is determined that special circumstances require an extension of time for processing the claim, not to exceed an additional 90 days. If such an extension is required, written notice of the extension will be furnished to you prior to the expiration of the initial 90-day period. The notice of extension will indicate the special circumstances requiring the extension of time and the date by which the Fun Office expects to make a determination with respect to the claim. If the extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the date on which you respond to the Fund Office's request for information.

If the Fund Office denies your claim, in whole or in part, you will be provided with written notification of the determination, setting forth:

i. The specific reason(s) for the adverse benefit determination, with references to the specific Plan provisions on which the determination is based;

ii. A description of any additional material or information necessary for you to perfect the claim (including an explanation as to why such material or information is necessary); and,

iii. A description of the Fund's review procedures and the applicable time limits, as well as a statement of your right to bring a civil action under ERISA following an adverse benefit determination on review.

Can I appeal an adverse ruling?

Answer: Yes. If the Fund Office denies your claim, you, or your duly authorized designee, may request a review of the determination. This is called an *appeal*. All appeals must be sent in writing to the Trustees within one hundred eighty (180) days after receipt of the notice of denial or other adverse benefit determination. In connection with the appeal, you (or your duly authorized representative) may submit written comments, documents, records, and other information relating to the claim. In addition, you will be provided, upon written request and free of

charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim. The review by the Trustees will take into account all comments, documents, records, and other information that you submit relating to the claim.

A decision on review will be made by the Trustees (or a committee designated by the Board of Trustees) at their next regularly scheduled meeting following receipt of the request for review, unless the appeal is filed less than thirty (30) days prior to the next regularly scheduled meeting, in which case, a decision will be made by no later than the date of the second regularly scheduled meeting following receipt of such request for review. If special circumstances require an extension of time for processing the appeal, the decision may be made at the third meeting following receipt of such request. You will be notified in advance of any such extension. The notice will describe the special circumstances requiring the extension and will contain information of the date as of which the determination will be made. If the extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the date on which you responded to the Fund Office's request for information.

You will be notified in writing of the determination on review within five (5) days after the determination is made. If an adverse benefit determination is made on review, the notice will include:

i. The specific reason(s) for the adverse benefit determination, with references to the specific Plan provisions on which the determination is based;

ii. A statement that you are entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the claim; and,

iii. A statement of your right to bring civil action under Section 502(a) of ERISA.

The decision of the Trustees (or their designated committee) on review shall be final and binding on all parties.

Who will finally decide whether I am eligible for payment from the Fund?

Answer: The Trustees decide who is eligible to receive benefit payments. They have the responsibility of making sure all of the rules of the Plan are followed.

Can the Plan be terminated?

Answer: Yes, the Trustees are empowered to terminate the Plan if they deem it necessary or prudent to do so, as might be the case if the Union and Employers decided to discontinue future contributions to the Fund. Should that occur, since the rights of all Participants are non-forfeitable, the assets then remaining in the Fund after providing for administrative expenses and for the payment of any vacation account theretofore approved, would be allocated to each Participant. In no event, however, can any of the assets of the Fund on termination revert to the Employers or be paid to the Union.

PART III
INFORMATION REQUIRED BY ERISA

I. STATEMENT OF PARTICIPANTS' RIGHTS UNDER ERISA

In 1974, Congress passed, and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA.

ERISA sets forth certain minimum standards for the design and operation of privately sponsored welfare plans. The law also spells out certain rights and protections to which you are entitled as a Participant.

The Trustees of the Electrical Workers Health and Welfare Fund want you to be fully aware of your rights, and for this reason, a statement of your rights follows.

As a Participant in the Electrical Workers Health and Welfare Fund:

A. You automatically will receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

B. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.

Federal regulations under HIPAA require that Participants and beneficiaries receive a summary of material modifications of any modification or change that is a material reduction in covered services or benefits under a group health plan within 60 days after the adoption of the modification or change, unless the Plan sponsor regularly sends out summaries of the modifications or changes at regular intervals of 90 or fewer days.

C. Each year you automatically will receive a summary of the Plan's latest annual financial report. A copy of the full report also is available upon written request.

D. You may examine, without charge, all documents relating to the operation of this Plan. These documents include: the legal Plan Document, insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports (Form 5500 Series) and Plan descriptions.

Such documents may be examined at the Fund Office (or at other required locations such as work sites or union halls) during normal business hours.

In order to ensure that your request is handled promptly and that you are given the information you want; the Trustees have adopted certain procedures that you should follow:

1. your request should be in writing;

2. it should specify what materials you wish to look at; and,

3. it should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any work site or union location at which 50 or more Participants report to work. Allow 10 days for delivery.

E. You may obtain copies of any Plan document upon written request to the Trustees, addressed to the Fund Office. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any document you request. However, you are entitled to know what the charge will be in advance. Just ask the Fund Office.

F. You have the right to continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

G. You are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. See Section Two, Part III. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

H. No one may take any action that would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

I. In accordance with Section 503 of ERISA and related regulations, the Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim.

Basically, the appeal procedures provide that:

1. If your claim for a benefit is denied, in whole or in part, you will receive a written explanation of the reasons(s) for the denial.

2. Then, if you still are not satisfied with the action on your claim, you have the right to appeal.

These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented in your behalf.

J. In addition to creating rights for Plan Participants, ERISA also defines the obligations of people involved in operating Employee Benefit plans. These persons are known as "fiduciaries." They have the duty to operate your Plan with reasonable care and to look out for your best interests as a Participant under the Plan.

The duties of a fiduciary are complex and are constantly changing as new laws and regulations are adopted, as applicable to Employee Benefit plans. Be assured that the Trustees of this Plan will do their best to know what is required of them as fiduciaries and to take whatever actions are necessary to ensure full compliance with all state and federal laws.

K. Under ERISA, you may take certain actions to enforce the rights previously listed.

1. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court.

Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

- the request was actually received;

- the material was mailed to the right address; or,

- the failure to send the material was not due to circumstances beyond the Trustees' control.

If you still are not able to get the information you want, you may wish to take legal action. The court may require the Trustees to provide the materials promptly or pay you a fine of up to $110 for each day's delay until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).

2. Although the Trustees will make every effort to settle any disputed claims with Participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

   For this reason, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. However, before exercising this right, you must take advantage of all the benefit appeals procedures provided under the Plan at no cost.

3. If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

   a. 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.

   b. If you are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be expected to pay legal costs and fees.

Additional ERISA Information

The Name and Address of Plan Administrator

The Plan is administered and maintained by the Board of Trustees. The Fund Office is located at:

ELECTRICAL WORKERS HEALTH AND WELFARE FUND
2002 London Road — Suite 300
Duluth, Minnesota 55812
Telephone: (218) 724-8883
or 877-908-FUND (3863)

Type of Plan

This Plan is a welfare plan. It is maintained for the exclusive benefit of the Employees and provides weekly disability benefits and vacation benefits for Employees and health care benefits for Employees and Dependents. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Plan Sponsor

The Plan Sponsor is the Board of Trustees of the Electrical Workers Health and Welfare Fund. This Fund is maintained by several employers and one or more Employee organizations and is administered by a Joint Board of Trustees. A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by Participants and beneficiaries upon written request to the Plan Administrator and is available for examination by Participants and beneficiaries at the Fund Office.

Type of Plan Administration

Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrative Manager.

The Administrative Manager maintains the eligibility records, accounts for the employer contributions, answers Participant inquiries about the benefit programs, files required government reports, handles other routine administrative functions, and is primarily responsible for the processing of claims and benefit payments.

The Names and Addresses of the Trustees

Union Trustees

Dan Hendrickson
IBEW Local 294
503 East 16th Street
Hibbing, MN 55746

Carey Young
IBEW Local 294
2510 4th Avenue West
Hibbing, MN 55746

Dave Domagala
IBEW Local 242
2002 London Road, Rm. 111
Duluth, MN 55812

Donald Smith
IBEW Local 242
2002 London Road, Rm. 111
Duluth, MN 55812

Employer Trustees

David Orman
Twin Ports NECA
2230 London Road, Suite 200
Duluth MN 55812

Jeff Hart
Hart Electric
10963 Meadow Lark Lane
Hibbing, MN 55746

Harris B. Mahan (Blair)
Benson Electric
1102 North Third
Superior, WI 54880

Rick Osbakken
Holden/Agate Electric
925 Twentieth Avenue
Two Harbors, MN 55616

Parties to the Collective Bargaining Agreement

The Plan is maintained pursuant to one or more collective bargaining agreements between your employer and Local 242 and 294 of the International Brotherhood of Electrical Workers. A copy of any such agreement may be obtained by Participants and beneficiaries upon written request of the Plan Administrator and is available for examination by Participants and their beneficiaries at the Fund Office during normal business hours.

Internal Revenue Service Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 41-6024782 and the Plan Number (PN) is 501.

Name and Address of the Persons Designated as Agents for Service of Legal Process

Timothy W. Andrew
Andrew, Bransky & Poole, P.A.
302 West Superior Street, Suite 300
Duluth, Minnesota 55802

Service of legal process also may be made upon any Plan Trustee.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules in this booklet. Circumstances which may cause the Participant to lose eligibility are explained in the Eligibility Rules.

Sources of Trust Fund Income

Sources of Health and Welfare Fund income include employer contributions, self-payments, and investment earnings.

All employer contributions are paid to the Health and Welfare Fund subject to provisions in the collective bargaining agreements between the Union and employers. The labor agreements specify the amount of contribution, due date of employer contributions, type of work for which contributions are payable, and the geographic area covered by the labor contract.

Method of Funding Benefits

All Plan benefits are self-funded from accumulated assets and are provided directly from the Health and Welfare Fund. A portion of Fund assets is maintained in reserve to cover unexpected or unusually high expenses that the Fund may experience from time to time, such as a catastrophic claim.

Contributions are accumulated and invested in insured depository accounts and high quality, marketable securities. Benefits are paid from Plan assets and income from investments.

Fiscal Year of the Plan

The Plan's fiscal year begins January 1st and ends the following December 31st.

Procedures to Be Followed in Presenting Claims for Benefits Under the Plan

The procedures for filing for benefits are described in Section Six, Part I., A. of this booklet. If a Participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are found in Section Six, Part I., C. of this booklet.

We hope this booklet has provided you with the most important information about your Plan and your rights under ERISA.

If you have any questions about your Plan, you should contact the Trustees by writing to:

The Board of Trustees
Electrical Workers Health and Welfare Fund
2002 London Road, Suite 300
Duluth, Minnesota 55812

Or phone: (218) 724-8883
or (877) 908-FUND (3863)

Or, if you have questions about this statement or your rights under ERISA, you may contact the nearest office of the Pension and Welfare Benefits Administration at U.S. Department of Labor, PWBA, Kansas City Regional Office, City Center Square, 1100 Main Street, Suite 1200, Kansas City, MO 64105-2122, (816) 426-5131. Or, you may contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration at 1-800-998-7542, or through PWBA's website on the internet at www.dol.gov/dol/pwba/.

Fund Administrative Manager

Wilson-McShane Corporation
2002 London Road, Suite 300
Duluth, MN 55812

Fund Legal Counsel

Andrew, Bransky & Poole, P.A.
Timothy W. Andrew, Attorney at Law
Jane C. Poole, Attorney at Law
302 West Superior Street, Suite 300
Duluth, MN 55802

Fund Certified Public Accountant

Legacy Professionals LLP
6800 France Avenue So., Suite 550
Edina, MN 55435