ELECTRICIANS HEALTH AND WELFARE PLAN, IBEW 995

Summary Plan Description

January 1, 2019 Edition

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ELECTRICIANS HEALTH AND WELFARE PLAN, IBEW 995

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HOW TO FILE A CLAIM

If you or your eligible Dependent becomes ill or injured or dies and you believe you may be entitled to benefits under this Plan:

1. You should telephone the Fund Office at (225) 927-6340.

2. The Fund Office will tell you if you are eligible for benefits under the Plan.

3. At the start of each calendar year, the Fund Office will send you an initial medical claim form for completion. This form must be completed and returned to the Fund Office before the Plan will pay any claims submitted for you or your Dependents for that calendar year.

4. After you complete and return the initial medical claim form for a calendar year, you will not need to submit another claim form for non-accident related claims for that calendar year. These will be paid by the Plan upon receipt of the appropriate documents from your health care provider.

5. However, an additional claim form IS required for accident related claims, disability benefit claims, and life insurance or accidental death and dismemberment benefit claims.

A detailed explanation of the Claims Procedure is included in this booklet.

YOU AND YOUR DEPENDENTS ARE REMINDED THAT YOU MUST NOTIFY THE FUND OFFICE WHEN:

1. There is a change of address.

2. New Dependents are to be covered (and provide certified copies of birth certificates and/or adoption papers).

3. There is a divorce/legal separation (provide court certified divorce/legal separation papers).

4. There is a marriage (provide a certified copy of the marriage license).

5. There is a death (provide a certified copy of the death certificate).

6. A Dependent ceases to be a Dependent (e.g., your child attains age 26).

LETTER FROM THE BOARD OF TRUSTEES

We are pleased to present you with this Summary Plan Description ("SPD") booklet, which has been published to give you an up-to-date description of the benefits and certain information about Plan administration that is required by the federal law known as "ERISA". This SPD booklet reflects the amendments to the Plan since its last restatement, and replaces the SPD booklet dated January 1, 2013. It reflects the provisions that are effective January 1, 2019 unless otherwise stated.

You MUST satisfy all of the eligibility requirements in order to be eligible for benefits under the Plan. Possession of this SPD booklet does not automatically entitle you to benefits.

The Plan is not a contract of employment, nor does it give you a right to remain in the service of an Employer or interfere with an Employer's right to discharge you. Those issues are covered by the Collective Bargaining Agreement.

We urge you to read this SPD booklet carefully to understand fully the benefits to which you and your Dependents are entitled, as well as your obligations under the Plan. Please share this booklet with your family members and keep it in a safe place for future reference. **REMEMBER, THE FUND OFFICE SHOULD BE KEPT ADVISED OF YOUR CURRENT MAILING ADDRESS TO ENSURE THAT YOU RECEIVE ALL REQUIRED COMMUNICATIONS.**

This booklet summarizes the most important features of the Plan but does not give you all of the details. Your rights and your Dependents' rights can be determined only by referring to the full text of the Plan. In the event of a conflict between the Plan and this booklet, the Plan will control. We have the full and exclusive authority and discretion to determine all questions of coverage and eligibility, all methods of providing benefits and all other Plan matters, and to construe the provisions of the Plan and Trust Agreement by which the Fund is established. Any determination and construction adopted by us in good faith will be binding on all persons and entities. To be official, all communications to you must be in writing and signed by us as the Trustees of the Plan, or if applicable, by a person or entity duly authorized by us to act on behalf of the Plan.

The medical benefits described in this booklet are not insured by any contract of insurance. There is no liability of the Board or any Employer, Trustee, individual or entity to provide payment above the amount in the Fund that is available for such purpose. At present, the Life Insurance and Accidental Death and Dismemberment benefits are fully insured except for the surviving spouse's Life Insurance coverage after an active Employee's death, which is self-insured by the Fund.

If you, your Dependent or beneficiary has a question about your benefits or this booklet, please contact the Fund Office. The staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

SCHEDULE OF BENEFITS
Effective January 1, 2019
(Unless Otherwise Stated)

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT	
All Eligible Employees	
Life Insurance	$10,000.00
Accidental Death &Dismemberment (Active Employees only) Full Benefit Half the Full Benefit	 $10,000.00 $ 5,000.00
All Eligible Dependents	
Life Insurance: Dependent spouse during Employee's lifetime Eligible surviving spouse following Employee's death Dependent Children: 14 days but less than 6 months 6 months but less than 26 years	 $ 5,000.00 $ 500.00 $ 100.00 $ 1,000.00
MAJOR MEDICAL EXPENSE BENEFITS	
All Eligible Employees and Dependents	
Calendar Year Deductible	$1,000.00 per person
Out-of-Pocket Limit	$2,700.00 per Participant per calendar year and $5,400.00 per family per calendar year
Hospital Room and Board for all Accommodations	Average semi-private rate of confining Hospital or the lowest private room rate in the confining Hospital in the absence of semi-private facilities
Co-Payment Percentages:	
Out-of-Network Providers	75% of Covered Expenses after satisfy Calendar Year Deductible;100% of Covered Expenses after satisfy Calendar Year Deductible and Out-of-Pocket Limit
Network Providers	85% of Covered Expenses after satisfy Calendar Year Deductible;100% of Covered Expenses after satisfy Calendar Year Deductible and Out-of-Pocket Limit
Mental and Nervous Disorders (except for any such disorders completely excluded under Plan)	75% (Out-of-Network)/85% (Network) of Covered Expenses after satisfy Calendar Year Deductible; 100% of Covered Expenses after satisfy Calendar Year Deductible and Out-of-Pocket Limit
Alcohol, Drug or Substance Abuse (except for any such disorders completely excluded under Plan)	75% (Out-of-Network)/85% (Network) of Covered Expenses after satisfy Calendar Year Deductible; 100% of Covered Expenses after satisfy Calendar Year Deductible and Out-of-Pocket Limit

Additional Accident Benefit (non-occupational)	100% of the first $300.00 of Covered Expenses; Calendar Year Deductible waived
Preventative and Wellness Benefit	100% of Covered Expenses for preventative & wellness care covered by Plan; Calendar Year Deductible waived
Prescription Drugs: All specialty drugs require pre-authorization. For more information, contact Sav-Rx at 1-866-233-4239.	For approved pharmacies: 75% of cost after satisfy Calendar Year Deductible; 100% of cost after satisfy Calendar Year Deductible and Out-of-Pocket Limit. For non-approved pharmacies: 20% of cost is excluded as penalty (does NOT count toward Calendar Year Deductible);75% of cost minus 20% penalty (after satisfy Calendar Year Deductible); 100% of cost minus 20% penalty (after satisfy Calendar Year Deductible and Out-of-Pocket Limit)
Chiropractic Care: Outpatient treatment only	 20 visits per person per calendar year
Skilled Nursing Care Facility	120 days of confinement per 12-month period; room & board charges limited to 50% of semi-private room rate at Hospital where patient was confined
Infertility Treatment: Lifetime Maximum	 $500.00 per couple
Speech Therapy	20 visits per person per calendar year
Occupational Therapy	15 visits per person per occurrence
Physical Therapy	15 visits per person per occurrence
Wellness Colonoscopy (once every 10 years, beginning at age 50 or older)	Payable at 100% (without regard to deductible or Out-of-Pocket Limit)
Gastric Bypass Surgery/Vertical Sleeve Gastrectomy Procedure	$35,000.00 per surgery/procedure (limited to one every 10 years and the conditions set forth in the Plan)

Pre-Certification Requirements:
All non-emergency/non-maternity inpatient admissions and the following must be pre-certified: skilled nursing facilities; rehabilitation services; coordinated home care (including but not limited to physical therapy, occupational therapy, speech therapy and skilled nursing visits); private duty nursing; mental health partial day programs; mental health intensive outpatient programs, psychological/neuro psychological testing; electroconvulsive therapy. All emergency Hospital admissions must be certified within 48 hours of admission.

All pre-certification and certification services are performed by the Plan's utilization review company. To obtain pre-certification or certification, you, a family member or your provider must contact Blue Cross Blue Shield of Illinois (BCBSIL) at 1-800-433-3232 or, if applicable, its successor.

8 WAYS TO CONTROL YOUR HEALTH CARE

You can control your health care expenses. Start now. Although you may already be a conscientious user of the health care system, by practicing all 8 ways to control your health care expenses you will positively affect your pocketbook and your health.

1. **Treat yourself right.** Many illnesses and injuries can be prevented. Major illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep and exercising regularly, you can be on the road to preventing illness, both major and minor. Remember to wear your seatbelt when driving and take the time to be careful around your home to avoid unnecessary household accidents.

2. **Ask "dumb" questions.** Actually, the only dumb questions are the ones you don't ask.

   - Ask about charges on your Hospital bill if you don't understand them. All Hospitals have people who can help answer your billing questions.

   - Patients who are informed about what to expect during their Hospital confinement usually recover faster and have fewer complications than patients who are uninformed. Many Hospitals have patient information programs to help you. Use them!

   - Inquire about the costs of medications. Generic drugs often cost less than name brands, and your Physician will usually prescribe them if you ask.

   - If you have any doubts or questions about a treatment or procedure your Physician has recommended for you, get a second opinion from another Physician or health care professional.

3. **Don't be in when you can be out.** Ask your Physician about the use of out-patient services in your Hospital or Physician's office for tests, treatments and many types of minor surgery. Out-patient care is always less expensive than a Hospital confinement and can often accomplish the same objective.

4. **Use the emergency room for "emergencies."** Your Hospital's emergency room is an expensive place to treat minor aches and ailments. When possible, contact your Physician before deciding to use the emergency room.

5. **Understand your coverage before you have to use it.** Make sure you understand your health care coverage. Read this Booklet. It describes how the benefits will work, and what is and is not covered.

6. **The shorter your Hospital confinement, the less you pay.** When it's practical, have tests performed before you enter the Hospital. Except in emergencies, avoid being admitted to the Hospital at night or on the weekend because you may spend unnecessary time waiting for surgery or special treatment. Also, it is important to leave the Hospital as soon as your Physician tells you that you are ready.

   Remember. All non-emergency/non-maternity inpatient admissions and the items and services listed in the Schedule of Benefits ***must*** be pre-certified. Emergency admissions ***must*** be certified within 48 hours of the Hospital admission. The utilization review company that performs the pre-certification and certification services for the Plan is listed in the Schedule of Benefits.

7. **Don't expect a "free lunch."** Be a cost-conscious consumer. Even though our Fund or the government may pay for most of your health care needs, the services and treatment you receive are never free. If you make an effort to control how you use health care services, everyone will benefit especially you.

8. **Watch for early warnings!** Learn the early warning signs of illnesses such as heart disease and cancer. Early detection of illnesses could save your life and will save you money. Take advantage of the Preventive and Wellness Benefit provided by the Plan.

DEFINITIONS

While reading this Booklet, you may come across terms that have a special meaning. We suggest that you read and become familiar with the following terms. Whenever these terms appear in this Booklet as capitalized terms, they will have the meaning set forth below.

"Alcohol, Drug or Substance Abuse" means a psychological or physiological dependence on or addiction to alcohol, drugs or medications, regardless of any underlying physical or organic cause, and any other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

"Alternate Recipient" means any child of a participating Employee who is recognized under a Qualified Medical Child Support Order as having a right to enroll in the Plan.

"Allowable Charge" means the amount of a provider's charge that the Plan recognizes as payable for services or supplies that are covered by the Plan (subject to any applicable deductible or limitation). The Allowable Charge will be the lowest of the following amounts: (i) the actual charge; (ii) the contractually agreed upon discounted rate for a Network Provider; and (iii) for an Out-of-Network Provider, the allowed amount as determined by the Board of Trustees in a reasonable and uniform manner in accordance with the methodology, fee schedule, percentile and/or adjustment for the geographical area and nature and severity of the condition being treated, as approved for use by the Board. It is anticipated that the Allowable Charge for an Out-of-Network Provider will be lower than the Allowable Charge for a Network Provider.

"Beneficiary" means the person or persons designated by you in writing on a form acceptable to and on file with the Plan, or if none, as otherwise determined through operation of the terms of the Plan, as the recipient of any Death Benefit payable by reason of your death. For any Death Benefit that is fully insured, the Trustees may delegate to the Insurer the authority to make a Beneficiary determination with regard to its payment.

"Chiropractor" means a person who holds the degree of Doctor of Chiropractic, is legally licensed and authorized to practice the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column, and acts within the scope of his or her license.

"COBRA" means the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 and corresponding regulations, as amended.

"Code" means the Internal Revenue Code of 1986 and corresponding regulations, as amended.

"Collective Bargaining Agreement" or "CBA" means the written bargaining agreement entered into by an Employer and the Union, which provides for Employer contributions to the Fund on behalf of the Covered Employment of its Employees, as extended, renewed or amended from time to time.

"Contribution Rate" means the amount an Employer agrees to pay to the Fund under the Collective Bargaining Agreement, for each hour of Covered Employment worked by its collectively bargained Employees.

"Cosmetic Surgery" means any surgical procedure or medical treatment that is not Medically Necessary and is performed primarily to improve or preserve physical appearance but not physical function.

"Covered Employment" means an Employee's employment by an Employer for which the Employer is obligated to contribute to the Fund, in accordance with the Collective Bargaining Agreement or a Participation Agreement.

"Covered Expense" means the Allowable Charge for a Covered Service that is incurred by you or your Dependent while covered by the Plan.

"**Covered Service**" means Medically Necessary medical care, services, supplies or treatment for injury or Illness that is not work related, or for preventive and wellness care, for which medical benefits are available under the Plan.

"Custodial Care" means any of the following: (1) non-health related care or services given mainly for personal hygiene or to perform or assist with the activities of daily living, including but not limited to bathing, feeding, dressing, walking and taking medicines that can be self-administered, regardless of where it is given or who recommends, provides or directs the care; (2) health-related services which do not seek to cure, or which are not likely to substantially reduce disability or enable the patient to

live outside an institution providing care; and (3) care or services which do not require administration by trained medical personnel in order to be delivered safely and effectively.

"Dependent" means any of the following:

(a) An Employee's lawfully married spouse;

(b) An Employee's child, stepchild or child who is legally adopted by or placed for adoption with the Employee (irrespective of whether the adoption becomes final), who is not yet age 26;

(c) An Employee's unmarried child, stepchild, or child who is legally adopted by or placed for adoption with the Employee before age 26 (irrespective of whether the adoption becomes final), who is incapable of self-sustaining employment because of a physical or mental handicap which begins before age 26, and who has over one-half of his or her support provided by the Employee. Satisfactory proof of the handicap must be given to the Fund Office within 31 days after the handicap begins and coverage would otherwise end because of the child's age, and whenever requested by the Fund Office; and

(d) An Alternate Recipient.

The term "placed for adoption" means the Employee's assumption and retention of a legal obligation for the total or partial support of the child in anticipation of adoption. A child's placement for adoption with an Employee ends when his or her legal obligation for the child ends.

The Plan may from time to time require an Employee to provide satisfactory documentation that his or her Dependent satisfies the above requirements.

"Durable Medical Equipment" means medical equipment which (a) can withstand repeated use, and (b) is primarily and customarily used to serve a medical purpose rather than being mainly for comfort or convenience, and (c) generally is not useful to a person in the absence of an Illness or injury, and (d) cannot be used by anyone other than the person for whom it is intended.

"Employee" means any individual employed by an Employer, with respect to whom contributions are required to be made by the Employer to the Fund in accordance with the Collective Bargaining Agreement or a Participation Agreement.

"Employer" means each Employer that is a signatory to the Collective Bargaining Agreement and any successor that is bound by the Collective Bargaining Agreement, and each Employer signatory to a Participation Agreement, that contributes or is obligated to contribute to the Fund on behalf of its Employees, and is a party to or bound by the Trust Agreement for the Fund.

"ERISA" means the Employee Retirement Income Security Act of 1974 and corresponding regulations, as amended.

"Experimental or Investigational" means any drug, device or medical treatment, procedure or therapy that meets any of the following criteria in relation to the condition for which it is being dispensed or rendered: (a) it is not proven in an objective manner to have benefit for the patient; (b) it is restricted for use at medical facilities engaged primarily in carrying out scientific studies; (c) it is of questionable medical effectiveness; (d) for drugs, devices, services and supplies that are regulated by the FDA and cannot be legally marketed without FDA approval, FDA approval has not been granted at the time it is prescribed or provided; or (e) reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials may be necessary to determine the maximum tolerated dose, toxicity, safety or efficacy. Examples of reliable evidence include published reports and articles in the authoritative medical and scientific literature, written protocol(s) and written informed consents.

"**Fund**" means the trust fund established and maintained under the Trust Agreement, by and between certain Employers and the Trustees, for the purpose of holding contributions, providing authorized benefits to Participants and beneficiaries and defraying reasonable administrative expenses under the Plan.

"Fund Office" means the office of the Administrative Manager designated by the Board of Trustees.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and corresponding regulations, as amended.

"Hospital" means an institution which: (a) is primarily engaged in providing, by or under the supervision of Physicians, (i) diagnostic services or therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or (ii) rehabilitation services for the rehabilitation of injured, disabled or sick persons; (b) maintains clinical records on all patients; (c) has bylaws in effect with respect to its staff of Physicians; (d) has a requirement that every patient be under the care of a Physician; (e) provides 24-hour nursing services rendered or supervised by a registered professional nurse; (f) has in effect a hospital utilization review plan; (g) is licensed pursuant to any state or state agency responsible for licensing hospitals; and (h) has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Unless otherwise specifically stated, a "Hospital" does not include any institution, facility or part thereof used principally as a rest facility, nursing or extended care facility, convalescent facility, facility for the aged or facility for the care and treatment of alcohol, drug or substance abuse, or an institution that provides services and/or supplies for which there is no obligation to pay.

"Illness" means a bodily disorder or mental infirmity.

"Insurer" means the insurance company that issues the group insurance policy purchased by the Fund for the purpose of providing the Life Insurance and Accidental Death and Dismemberment benefits provided under the Plan.

"Medically Necessary" means the **s**ervices or supplies that are (a) required to identify or treat an Illness or injury which a Physician has diagnosed or reasonably suspects and that are consistent with the diagnosis and treatment; (b) in accordance with standards of good medical practice and required for

reasons other than the convenience of the individual or Physician; and (c) performed in the least costly setting required by the individual's condition. The fact that a service or supply is prescribed by a Physician does not necessarily mean that it is Medically Necessary for purposes of the Plan.

"Network Provider" means a Hospital, Physician or other health care provider that participates in the Plan's Preferred Provider Organization (PPO) and has agreed to provide health care services or supplies at discounted rates to Participants.

"Participant" means an individual who is eligible for coverage and is in fact covered by the Plan.

"Participation Agreement" means a written agreement between an Employer and the Trustees, and any extensions, renewals or amendments thereto, which obligate the Employer to make contributions to the Fund for its Non-Bargaining Unit Participating Employees who are covered by the agreement, and specifies the terms by which they will participate.

"Physician" means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, chiropodist, podiatrist, optometrist or certified consulting psychologist, to the extent that such person, under his or her license, is permitted to perform services covered by the Plan and is acting within the scope of that license at the time such services are performed.

"Plan" means the Electricians Health and Welfare Plan, IBEW 995, Rules and Regulations, as amended from time to time.

"Prescription Drug" means a drug that is purchasable only with a written prescription by a Physician (except for injectable insulin). The term does not include any of the following: (a) medical devices even if purchasable only with a written prescription; (b) immunization agents; (c) biological serum; (d) blood or blood plasma; (e) oxygen (or its administration); (f) allergens; (g) syringes or needles; (h) smoking cessation drugs; and (i) infertility medication once infertility is diagnosed.

"Qualified Ambulatory Surgical Facility" means a specialized facility that meets all of the following requirements: (a) it is established, equipped and operated primarily for the purpose of performing surgical procedures and operates as such in accordance with the applicable laws (including licensing requirements) of the jurisdiction in which it is located; (b) it is operated under the full time supervision of a Physician and permits a surgical procedure to be performed only by a Physician who is then privileged to perform the procedure in at least one Hospital in the area; (c) it requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics or supervise the anesthetist who is administering the anesthetics, and that he, she or they remain present throughout the surgical procedure; (d) it provides at least two operating rooms and a post-anesthesia recovery room; (e) it is equipped to perform diagnostic x-ray and laboratory examinations (or has an arrangement to obtain these services); (f) it has trained personnel and necessary equipment to handle emergency situations and has immediate access to a blood bank or blood supplies; (g) it provides the full-time services of one or more registered nurses (RNs) for patient care in the operating and post-anesthesia recovery rooms; (h) it maintains an agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post operative

confinement; and (i) it maintains adequate medical records for each patient including an admitting diagnosis, medical history, operative report and discharge summary.

“Qualified Medical Child Support Order” or **“QMCSO”** means a Qualified Medical Child Support Order within the meaning of Section 609(a) of ERISA.

“Required Amount” means the amount of contributions that must be accumulated by or credited to an Employee in order to continue coverage under the Plan for one (1) month. It is equivalent to the cost of one month’s coverage.

“Trustees” or **“Board of Trustees”** means, collectively, the individuals appointed from time to time to serve, and who are serving, in a trustee capacity for the Fund. The Trustees are the “administrator” of the Plan within the meaning of Section 3(16)(A) of ERISA, and named fiduciary within the meaning of Section 402(a)(2) of ERISA.

“Union” means the International Brotherhood of Electrical Workers, Local Union Number 995.

ELIGIBILITY RULES

A. ELIGIBILITY RULES FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

1. General Rule

As an active Employee, you will become eligible for coverage when the Required Amount of Employer contributions has been received by the Plan on behalf of your Covered Employment, as described below in greater detail.

2. Eligibility of Collectively Bargained Employees

You are a Collectively Bargained Employee if your work in Covered Employment is governed by a Collective Bargaining Agreement between your Employer and the Union. Your Employer is required to contribute to the Fund on your behalf, an amount equal to the Contribution Rate multiplied by your hours in Covered Employment.

(a) **Dollar Bank** – The Plan maintains, for record-keeping purposes only, a "Dollar Bank" account for each Collectively Bargained Employee. As the Fund receives Employer contributions that are made on behalf of your Covered Employment, your Dollar Bank account is credited with those amounts. The Dollar Bank is available for the purpose of satisfying your initial and continuing eligibility requirements.

There is a three month lag in time between the month in which you work in Covered Employment (called the "Hours Worked/Dollar Month"), and the month in which your Dollar Bank account is credited with the Employer contributions that are received by the Plan on behalf of that Covered Employment (called the "Benefit Month"). This is discussed in greater detail in the "Continued Eligibility" section. There is a limit on the total amount that may be credited to your Dollar Bank account at any one time. It is the amount needed to satisfy the cost of six months of coverage under the Plan, after subtraction of the cost for the current month's coverage. Any amount of contributions that are credited to your Dollar Bank account for more than 12 months will be forfeited.

(b) **Initial Eligibility** – As a Collectively Bargained Employee, you will initially become eligible for coverage when you accumulate a credit of at least $1,000 in your Dollar Bank account during a period of twelve (12) months or less. Your coverage will become effective as of the first day of the month after this initial eligibility requirement is satisfied, and the "Required Amount" for your first month of coverage (i.e., $1,000), will be deducted from the amount credited to your Dollar Bank account.

(c) **Continued Eligibility** – Once you satisfy the initial eligibility (or reinstatement of eligibility) requirements, your coverage will continue on a month-to-month basis as long as you have the Required Amount credited to your Dollar Bank account to subtract for the cost of coverage for the month. There is a lag in time between the month in which you work and the month in which you are credited with that work. That is

because it takes time for Employers to calculate their Employees' hours worked in a month and contribute the required contributions to the Plan, and for the Plan to account for those contributions. Employer contributions that are made on behalf of your hours worked in a month (called the "Hours Worked/Dollar Month"), are credited to your Dollar Bank account in the corresponding "Benefit Month" as shown in the following table. The amount credited may then be used to determine and satisfy your eligibility for that Benefit Month or a subsequent month as needed.

Hours Worked/ Dollar Month	Benefit Month
January	May
February	June
March	July
April	August
May	September
June	October
July	November
August	December
September	January
October	February
November	March
December	April

Once you satisfy the initial eligibility requirements and are covered, the Required Amount will automatically be deducted from your available Dollar Bank account balance for each succeeding month to continue your coverage for that month. Coverage will continue in this manner until your remaining account balance is not enough to satisfy the full Required Amount. If that happens and your coverage would otherwise terminate, you may elect to continue your health coverage on a self-payment basis in accordance with the federal law known as COBRA. If you timely elect COBRA Coverage, any remaining amount credited to your Dollar Bank account (i.e., something less than the cost of one month of coverage) will be applied to offset the amount of your first COBRA self-payment that is due.

3. Eligibility of Non-Bargaining Unit Participating Employees

You are a Non-Bargaining Unit Participating Employee if you are not a member of a collective bargaining unit represented by the Union, and are eligible to participate in the Plan pursuant to a Participation Agreement (not a Collective Bargaining Agreement) between your Employer and the Trustees.

(a) **General Eligibility Requirements and Enrollment** – In order to be eligible to participate, you must work in Covered Employment for at least 40 hours per week if you are paid by salary, or 35 hours per week if you are paid on an hourly basis. Your participation will also be subject to any additional conditions or requirements set forth in the Participation Agreement. If you meet these general eligibility requirements, you will be given an opportunity to enroll or waive enrollment, effective with the first day of the month immediately following your date of hire (or rehire). Thereafter, you may change your election to enroll or waive enrollment on an annual (calendar year) basis only, unless you qualify for a special enrollment period as described below.

If you wish to enroll, you must send a written request for enrollment, with any required documentation, to the Fund Office at the time you are hired (or rehired), or otherwise before any following January 1 to be effective for that calendar year, so that your Employer can begin to contribute to the Fund on your behalf.

Once you enroll, your Employer must contribute to the Fund on your behalf, at the current Contribution Rate in effect for Collectively Bargained Employees multiplied by 160 hours per month, regardless of the number of hours that you actually work.

Fund Office Employees are employed by the Fund and participate in accordance with the rules established by the Trustees. They are notified of these rules at the time of hire. Additional information is available upon written request to the Administrator.

(b) **Initial Eligibility** - If you satisfy the general eligibility requirements and enroll in the Plan, you will initially qualify for coverage once you are credited with at least $1,000 in Employer contributions during a four (4) consecutive month period. Coverage will actually begin on the first day of the month following the four (4) month period in which the $1,000 is credited and will continue for four (4) months. Thereafter, you must satisfy the continuing eligibility requirements in order for your coverage to continue.

(c) **Continuing Eligibility** – Once you satisfy the initial eligibility (or reinstatement of eligibility) requirements and participate in the Plan, you will continue to be covered in each Benefit Month that follows, as long as you continue to satisfy the general eligibility requirements and the Plan receives the required Employer contributions on your behalf for the corresponding Hours Worked/Dollar Month. The required monthly Employer contribution is the amount determined by multiplying the current Contribution Rate by 160 hours. The “Hours Worked/Dollar Month” and corresponding

"Benefit Month" will be determined in accordance with the table shown above under Continued Eligibility for Collectively Bargained Employees.

If your coverage would otherwise terminate because the Plan does not receive the required monthly Employer contribution on your behalf, you may elect to continue your health coverage on a self-payment basis to the extent required by COBRA.

(d) **Special Enrollment Rights Under HIPAA** - If you do not enroll in the Plan when you are first eligible because you have other health coverage under COBRA or under another health plan, you will qualify for a special enrollment period in addition to the Plan's annual enrollment period in the following two instances: (i) when your COBRA coverage is exhausted; and (ii) when your other non-COBRA health coverage terminates because you are no longer eligible or because your employer has stopped contributing toward the other coverage. Special enrollment rights will NOT apply if you lose eligibility for cause or because of non-payment of premium.

If you qualify for special enrollment and want to enroll, you must send a written request for enrollment, with any required documentation, to the Fund Office within 60 days after the exhaustion or termination of your other health coverage. If you enroll timely, coverage under this Plan will be effective retroactive to the date COBRA was exhausted or your other health coverage terminated. If you fail to enroll during the 60-day special enrollment period, you will have to wait for the next annual enrollment period to enroll. These special enrollment rights will be interpreted and administered in accordance with the requirements of the federal law known as "HIPAA".

4. Eligibility of Dependents

(a) Eligibility and Enrollment

An Employee's eligible Dependent(s) will become covered under the Plan, without cost to the Employee, on the latest of the following dates to occur, provided a completed Plan enrollment form and any required documentation is submitted to the Fund Office (or as otherwise indicated on the form) within 60 days from the date the Dependent is first eligible for coverage:

(i) The date the Employee's coverage becomes effective;

(ii) The date the Employee first acquires the Dependent; or

(iii) The date specified in a Qualified Medical Child Support Order.

Dependents who are timely enrolled will be covered retroactive to the date they are first eligible for coverage as set forth above. If an eligible Dependent is not timely enrolled, the Dependent will not be eligible for enrollment in the Plan until the next Annual Enrollment Period or, if applicable, a Special Enrollment Period. The Plan will not verify coverage or pay benefits until it receives a timely completed enrollment form and any required documentation.

(b) **Annual Enrollment Period**

The Plan will have an Annual Enrollment Period each year from November 1 through December 31 (unless the Trustees establish other dates) for Dependents to be enrolled in coverage for the next calendar year. Enrollment forms will be provided or made available to Employees. These completed forms and any required documents must be returned to the Fund Office (or as otherwise directed on the form), on or before the last day of the Annual Enrollment Period, for enrollment to be effective for the next calendar year. Participating Employees who do not return a completed enrollment form in a timely manner will be deemed to have continued their then current Dependent enrollment election for the next calendar year.

(c) **Special Enrollment Under HIPAA**

The Plan will provide a Special Enrollment Period to Employees and Dependents to the extent required by HIPAA. The special enrollment rights described in this Section will be interpreted and administered in a manner that complies with HIPAA. Individuals with both general and special enrollment rights will be enrolled as of the earliest date for which they qualify.

Acquisition of Dependent: If a covered Employee acquires a Dependent because of birth, adoption, placement for adoption or marriage, the Employee may enroll that Dependent and any Dependent spouse who is not already enrolled. Enrollment is accomplished by sending a completed enrollment form and the required documents to the Fund Office (or as otherwise indicated on the form). They are due within 60 days after the date of birth, adoption, placement for adoption or marriage. The required documents will include (as applicable) a marriage license and birth certificate. The coverage of Dependents who are timely enrolled will be effective (a) retroactive to the date of birth, adoption or placement for adoption, or (b) for marriage, as of the first day of the calendar month after enrollment. If the required enrollment form and documents are submitted late (i.e., after this 60-day period), the Dependent will *not* be eligible for coverage under the special enrollment rules and must wait until the next Annual Enrollment Period.

Other Group Health or COBRA Coverage: If a covered Employee does not enroll a Dependent spouse or child(ren) for coverage under this Plan when they are first eligible because they have other employer sponsored group health coverage or COBRA coverage, and the other coverage terminates because of a loss of eligibility (for employer coverage) or because the employer stops contributing towards it, or because the COBRA coverage is exhausted, the Employee may enroll such Dependent(s) in this Plan effective as of the date the other coverage terminates. Enrollment must be made by sending a completed enrollment form and the required documents to the Fund Office (or as otherwise indicated on the form). They are due within 60 days after the date the other coverage terminates. Special enrollment rights do not apply if the other group

health or COBRA coverage terminates because of the failure to pay a premium or required self-payment timely or for cause.

Medicaid or CHIP Coverage: If an Employee or Dependent who is eligible but not covered under this Plan (a) has coverage through Medicaid or a State Children's Health Insurance Program ("CHIP") and loses eligibility for such coverage, or (b) becomes eligible for a premium assistance program through Medicaid or CHIP, the Employee will have 60 days after (a) the loss of Medicaid or CHIP coverage or (b) a determination of eligibility for the premium assistance program, to enroll himself or herself and his or her Dependents in the Plan. To exercise this right, a written request for enrollment must be provided to the Fund Office within this 60-day period. Coverage will then be effective as of the first day of the calendar month after such enrollment request.

5. Notification Requirements

All Participants must notify the Plan in writing of any change in address or change in Dependent status affecting coverage under the Plan. These changes include (but are not limited to) a loss of Dependent status due to divorce or a child ceasing to qualify. Notice is due within 30 days after such change. If the Plan pays benefits in error because of a Participant's failure to provide this required notice, it may recover this overpayment from the Participant. Recovery of the improper payments may be made by notice and demand to the Participant, by legal action, or by withholding payment of other benefits due to or for the Participant for related or unrelated claims as an offset against the amount owed.

6. Reinstatement

(a) **Collectively Bargained Employees** – If you lose coverage because your Dollar Bank account falls below the Required Amount (i.e., the amount needed to satisfy the continuing eligibility requirement for one month), you will qualify for reinstatement of coverage if, within 12 months after your coverage terminates, your Dollar Bank is again credited with the Required Amount. If that happens, your coverage will be reinstated as of the first day of the following month. If your Dollar Bank account is not credited with the Required Amount within 12 months after your coverage terminates, you will again have to satisfy the initial eligibility requirements in order to be covered.

(b) **Non-Bargaining Unit Participating Employees** – If you lose coverage because the Plan does not receive enough Employer contributions on your behalf to maintain coverage, you will again have to satisfy the initial eligibility requirements in order to be covered.

(c) **Dependents** – In general, your Dependents will be reinstated at the same time your coverage is reinstated, as long as they continue to qualify as your Dependents.

7. Disability Service Credits

If you are an Employee and you become disabled and unable to work in Covered Employment for more than seven continuous days while you have Plan coverage through your employment or Dollar Bank, you may qualify for a "disability service credit" under the Plan. This service credit is available solely to enable you to maintain your eligibility for coverage under the Plan, for up to a maximum of 12 weeks per disability. To qualify, you must: (a) notify the Fund Office; (b) provide it with satisfactory documentation of your disability, initially and on a continuing basis; and (c) remain under the care of a Physician. If you qualify for the disability service credit while you are receiving COBRA Coverage, you will be credited with the number of hours needed to offset the required self-payment, so that your COBRA Coverage continues during disability without self-payment for up to the 12-week maximum. The disability service credit may NOT be used for any of the following: (a) to give you more COBRA Coverage than you would otherwise be entitled to receive; (b) to reinstate your active Employee coverage; (c) to continue coverage for a retired employee who is receiving extended coverage on a self-payment basis; or (d) to give you service credit for more than a total of 12 weeks for the same disability.

B. CONTINUATION COVERAGE RIGHTS UNDER COBRA

This Section generally explains COBRA Coverage, when it may become available to you and your Dependents, and what you need to do to protect the right to receive it. COBRA, and the description of COBRA Coverage contained in this Section, applies only to the group health benefits offered under the Plan. COBRA does not apply to any other non-health benefits. The Plan provides no greater COBRA rights than what COBRA requires. It will be administered in a manner that complies with COBRA.

COBRA Coverage is a continuation of the Plan's health coverage when it would otherwise end because of certain events known as "qualifying events". The qualifying events are listed below. The right to continue health coverage is on a self-payment basis and for a limited time. After a qualifying event occurs and any required notice of that event is properly provided to the Plan, COBRA Coverage must be offered to each person who is a "qualified beneficiary" and would otherwise lose health coverage. You and your Dependents who are covered by the Plan could become qualified beneficiaries and be entitled to elect COBRA Coverage if your health coverage is lost because of the qualifying event.

We use the pronoun "you" in this Section B to refer to each person covered under the Plan who is or may become a qualified beneficiary, unless otherwise indicated.

1. Qualifying Events

(a) **Employee** – If you are a covered Employee, you will be entitled to elect COBRA Coverage if you lose your group health coverage under the Plan because of any of the following qualifying events:

- you are not credited with enough hours of employment to satisfy the Plan's eligibility requirements and maintain group health coverage; or

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

(b) **Dependent Spouse** – If you are a covered Dependent spouse of an Employee, you will be entitled to elect COBRA Coverage if you lose your group health coverage under the Plan because of any of the following qualifying events:

- your spouse-Employee dies;
- your spouse-Employee is not credited with enough hours of employment to satisfy the Plan's eligibility requirements and maintain group health coverage;
- your spouse-Employee's employment ends for any reason other than gross misconduct; or
- you become divorced or legally separated from your spouse-Employee.

(c) **Dependent Children** – If you are a covered Dependent child of an Employee, you will be entitled to elect COBRA Coverage if you lose your group health coverage under the Plan because of any of the following qualifying events:

- your parent-Employee dies;
- your parent-Employee is not credited with enough hours of employment to satisfy the Plan's eligibility requirements and maintain group health coverage;
- your parent-Employee's employment ends for any reason other than gross misconduct; or
- you stop being eligible for coverage under the Plan as a Dependent child.

2. **Qualified Beneficiary** – A "qualified beneficiary" is an Employee or Dependent who, on the day before a qualifying event, has health coverage under the Plan and would otherwise lose such health coverage due to the qualifying event.

It also includes any Dependent child who is born to, adopted by, or placed for adoption with, a covered Employee during a period of COBRA Coverage, provided that if the Employee is a qualified beneficiary, the Employee has elected COBRA Coverage for himself or herself. The child's COBRA Coverage begins when the child is enrolled in the Plan, and it lasts for as long as COBRA Coverage lasts for other family members of the Employee. To be enrolled, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

If a qualified beneficiary with COBRA Coverage acquires a family member for which open enrollment would be available if the qualified beneficiary were an active Employee, the qualified beneficiary may add that Dependent to COBRA Coverage for the remainder of the COBRA Coverage period.

If a qualified beneficiary with COBRA Coverage has a Dependent:

- who was eligible but did not enroll for COBRA Coverage when the qualified beneficiary enrolled because the Dependent had other health coverage (under COBRA or another health plan); and
- who loses the other coverage because (a) it was COBRA Coverage and has been exhausted, or (b) it was other health coverage that has ended because of a loss of eligibility (and not because of nonpayment of premium or for cause), or (c) it was other health coverage that has ended because employer contributions for the other coverage have ended,

the qualified beneficiary may enroll that Dependent for the remainder of the COBRA Coverage period. The qualified beneficiary must send a written notice to the Fund Office, within 60 days after the Dependent's loss of the other health coverage. Failure to satisfy this 60-day enrollment period will result in a forfeiture of the right to enroll. If COBRA Coverage ends for a qualified beneficiary, it will also end for any family members who are enrolled but not qualified beneficiaries in their own right.

3. Length of COBRA Coverage

COBRA Coverage is a temporary continuation of coverage. The COBRA Coverage periods described below are maximum periods of coverage. COBRA Coverage can end earlier than the maximum period of coverage for several reasons, as described under "Earlier Termination of COBRA Coverage Before the Maximum Coverage Period Ends".

(a) **18-Months of COBRA Coverage for End of Employment or Insufficient Hours of Employment Qualifying Event** – When Plan coverage is lost due to the Employee's end of employment or insufficient hours of employment, COBRA Coverage can last for up to a total of 18 months.

(b) **Additional 18-Months of COBRA Coverage under Plan Rule For Collectively Bargained Employees** - Under a special Plan rule, a Collectively Bargained Employee who (i) loses Plan coverage due to the end of employment or insufficient hours of employment qualifying event and (ii) elects and exhausts the initial 18-months of COBRA Coverage, may continue health coverage for up to an additional 18 months provided the Employee is available for work in Covered Employment during this extended period. This 18-months of extended coverage is subject to self-payment in an amount determined by the Trustees, and to the provisions described under "Earlier Termination of COBRA Coverage Before the Maximum Coverage Period Ends".

(c) **Additional 18-Months of COBRA Coverage if the Covered Employee Becomes Entitled to Medicare within 18 Months Before End of Employment or Insufficient Hours of Employment Qualifying Event** - Under a special COBRA rule, if Plan coverage is lost due to the end of employment or insufficient hours of employment and the Employee became entitled to Medicare benefits less than 18 months before

such qualifying event, COBRA Coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event, can last for the longer of (i) 36 months from the date the Employee first became entitled to Medicare benefits, or (ii) 18 months from the end of employment or insufficient hours of employment qualifying event.

For example, if a covered Employee becomes entitled to Medicare eight (8) months before the date on which employment ends, COBRA Coverage for the Employee's Dependents who lose coverage as a result of such termination can last for up to 36 months after the date of Medicare entitlement. This equals 28 months of COBRA Coverage after the date of the end of employment qualifying event (36 months minus eight (8) months). This special rule applies only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the end of employment or insufficient hours of employment qualifying event.

(d) **36-Months of COBRA Coverage for Death, Divorce, Legal Separation or Loss of Dependent Status Qualifying Event** – When Plan coverage is lost due to the covered Employee's death, divorce or legal separation, or a Dependent child losing Dependent child status, COBRA Coverage can last for up to a total of 36 months.

(e) **Disability Extension of COBRA Coverage** – If the qualifying event that results in the COBRA Coverage election is the covered Employee's end of employment or insufficient hours of employment qualifying event, the 18-months of COBRA Coverage may be extended for up to 11 months (for a total of 29 months) if a qualified beneficiary who is receiving COBRA Coverage is totally disabled. The qualified beneficiary must be determined by the Social Security Administration to be totally disabled. The disability must have started at some time during or before the first 60 days of COBRA Coverage, and must last at least until the end of the first 18 months of COBRA Coverage. Each qualified beneficiary who is receiving COBRA Coverage by reason of the same qualifying event will be entitled to this disability extension if one of them qualifies.

The disability extension is available only if you notify the Fund Office in writing of the Social Security Administration's determination of disability and provide it with a copy of the determination, before the end of the initial 18-months of COBRA Coverage and within 60 days after the latest of the following:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's end of employment or insufficient hours of employment qualifying event; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of such qualifying event.

IF THE REQUIRED NOTICE OF DISABILITY IS NOT PROVIDED TO THE FUND OFFICE IN A TIMELY MANNER, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

This disability extension will operate to extend the 18 months of COBRA Coverage to 29 months, unless the disabled qualified beneficiary ceases to be totally disabled before that time. If that occurs, COBRA Coverage will extend for 30 days after a final determination by the Social Security Administration that the qualified beneficiary is no longer totally disabled (or if later, through the end of the calendar month in which this 30th day occurs). You are required to notify the Fund Office of a final determination by the Social Security Administration that a qualified beneficiary is no longer totally disabled, within 30 days after the determination.

(f) **Second Qualifying Event Extension of COBRA Coverage** – An extension of COBRA Coverage will be available to your Dependents who are receiving COBRA Coverage if a second qualifying event occurs during the first 18 months of COBRA Coverage (or for a disability extension, the first 29 months) following a covered Employee's end of employment or insufficient hours of employment qualifying event. The maximum amount of COBRA Coverage that is available when more than one qualifying event occurs is 36 months. The second qualifying event may include the covered Employee's death, divorce or legal separation, or a Dependent child's ceasing to qualify as a Dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her end of employment or insufficient hours of employment qualifying event.

This extension of COBRA Coverage due to a second qualifying event is available only if you notify the Fund Office in writing of the second qualifying event within 60 days after it occurs. **IF THE REQUIRED NOTICE OF THE SECOND QUALIFYING EVENT IS NOT PROVIDED TO THE FUND OFFICE IN A TIMELY MANNER, THERE WILL BE NO EXTENSION OF COBRA COVERAGE.**

(g) **Earlier Termination of COBRA Coverage Before the Maximum Coverage Period Ends** – COBRA Coverage will automatically terminate before the end of the maximum 18, 29 and 36-month periods described above, upon the happening of any of the following:

- the first day of the first month for which a required self-payment is not paid in full on time (if the failure to pay timely relates to the first self-payment, COBRA coverage will not take effect); or
- the date, after electing COBRA coverage, on which a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both), or first becomes covered under another group health plan (but only after any

exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied); or

- the date the Plan terminates, and the Employer and employee organization cease to provide any group health plan for Employees, as permitted under COBRA; and
- during an 11-month disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer totally disabled, as described under the subsection entitled "Disability Extension of COBRA Coverage" (in this case, COBRA Coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Coverage.

You must notify the Fund Office in writing within 30 days after a qualified beneficiary first becomes entitled to Medicare (Part A, Part B or both) or first becomes covered under other group health plan coverage, after electing COBRA Coverage. The Plan will provide a written notice of termination to each qualified beneficiary whose COBRA Coverage terminates before the end of the maximum coverage period.

4. Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA Coverage due to a disability, 150%) of the cost to the Plan for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA Coverage. The Trustees will determine the amount of the required COBRA Coverage self-payment. The amount may change from time to time during the period of COBRA Coverage and will most likely increase over time. You will be notified of any changes in the required self-payment amount. If a COBRA self-payment is not paid in full within the grace period, eligibility for COBRA Coverage will end and cannot be reinstated.

5. Payment for COBRA Coverage

(a) **How Self-Payments Must Be Made** – All COBRA Coverage self-payments must be paid by check. Your first payment and all monthly payments must be mailed or hand-delivered to the Fund Office, at the address specified in the Election Notice provided to you at the time of your qualifying event, or to any new address of which you are subsequently notified by the Plan.

(b) **When Self-Payments Are Considered To Be Made** – If mailed, your self-payment is considered to have been made on the date it is postmarked. If hand-delivered, your self-payment is considered to have been made on the date it is received at the Fund

Office. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

(c) **First Self-Payment for COBRA Coverage** – If you elect COBRA Coverage, you do not have to send any self-payment with the Election Form. However, you must make your first self-payment for COBRA Coverage no later than 45 days after the date of your election (this is the date your Election Form is postmarked, if mailed, or received by the Fund Office, if hand-delivered).

Your first self-payment must cover the cost of COBRA Coverage from the date your Plan coverage would have otherwise terminated through the end of the month before the month in which you make your first payment. For example, suppose your coverage under the Plan terminates on September 30, and you elect COBRA Coverage on November 15. Your initial self-payment is due on or before December 30 (the 45th day after the date of your COBRA Coverage election). If you make your first self-payment in December, it must equal the amount due for October and November. You are responsible for making sure that the amount of your first self-payment is correct. You may contact the Fund Office to confirm the correct amount of your first self-payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA Coverage and made the first self-payment. **If you do not make your first self-payment for COBRA Coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.**

(d) **Monthly Payments for COBRA Coverage –** After you make your first self-payment for COBRA Coverage, you are required to make monthly self-payments for each subsequent month of COBRA Coverage. The amount due for each month for each qualified beneficiary will be included in the election notice provided to you at the time of your qualifying event. Each of these monthly self-payments is due on the first day of the month for that month's coverage. If you make a monthly self-payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break. The Plan will not send you bills or notices of self-payments due for the coverage periods. It is your responsibility to pay your COBRA self-payments on time.

(e) **Grace Periods for Monthly COBRA Coverage Self-Payments** – Although monthly self-payments are due on the first day of each month of coverage, you will be given a grace period of 30 days after the first day of each month to pay it. Your COBRA Coverage will be provided for each month as long as payment for that month is made before the end of the grace period. However, if you make a self-payment later than the first day of the month to which it applies but before the end of the grace period, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when payment is received. This means that any claim you submit for benefits while your coverage is

suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly self-payment in full before the end of the grace period for the month, you will lose all rights to COBRA Coverage under the Plan.

6. Notice Requirements

(a) **Required Notice from Plan** – When the qualifying event is the end of employment, insufficient hours of employment, or death of the covered Employee, the Plan will offer COBRA Coverage to the qualified beneficiaries. You do not have to notify the Plan of any of these qualifying events.

(b) **Required Notice from Employees and Dependents** – When the qualifying event is divorce or legal separation of the Employee and Dependent spouse, or a Dependent child losing eligibility for coverage as a Dependent child, a COBRA Coverage election will be available to you only if you notify the Fund Office in writing, within 60 days after the later of (i) the date of the qualifying event, or (ii) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The notice must include your name, the qualified beneficiary's name, the type of qualifying event and date it occurred and if applicable, a copy of the divorce decree or written proof of legal separation. If you do not provide this required notice to the Fund Office during the 60-day notice period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE.**

If you provide the required notice of the qualifying event to the Fund Office in a timely manner, the Fund Office will notify you and all qualified beneficiaries, within 30 days after receiving the required notice, of your right to elect COBRA Coverage. Any notice that is given to you or your Dependent spouse will be treated as having been given to all affected Dependent children who live with you or your Dependent spouse.

The Employee or former Employee who is or was covered under the Plan, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either, may provide the required notice. A notice provided by any of these individuals will satisfy the responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

(c) **Financial Responsibility for Failure to Give the Required Notice** – If the required notice of the qualifying event is not given in a timely manner and the Plan pays a claim in error after coverage should have terminated due to the qualifying event, you will be obligated to reimburse the Plan for the claim paid in error. If you fail to do so, the Plan

may deduct the amount that is owed from other benefits that are payable for you or your Dependent.

7. Electing COBRA Coverage

(a) **How to elect COBRA Coverage** – After the Fund Office is notified that a qualifying event has occurred, it will send an Election Form to the affected individuals explaining when and how to elect COBRA Coverage and the amount of the required self-payment. To elect COBRA Coverage, you must complete and sign the Election Form and return it to the Fund Office.

(b) **Deadline for COBRA Coverage Election** – If mailed your Election Form must be postmarked, and if hand-delivered your Election Form must be received by the Fund Office, no later than 60 days after the later of (i) the date Plan coverage ends because of the qualifying event, or (ii) the date the COBRA Coverage election notice is provided to you at the time of your qualifying event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE.**

(c) **Independent Election Rights** – Each qualified beneficiary will have an independent right to elect COBRA Coverage. Any qualified beneficiary for whom COBRA Coverage is not elected within the 60-day election period described in the COBRA election notice **WILL LOSE THE RIGHT TO ELECT COBRA COVERAGE**.

8. Terms and Conditions

(a) COBRA Coverage is always optional, and each qualified beneficiary has an independent right to elect or reject it;

(b) The cost of COBRA Coverage must be paid entirely by the qualified beneficiary electing coverage. No contributions will be made by the Fund for COBRA Coverage; and

(c) The health benefits available to a qualified beneficiary during the COBRA Coverage period will be the same as those provided by the Plan to similarly situated Participants with respect to whom a qualifying event has not occurred.

9. Option To Continue Your Life Insurance Coverage Concurrent With Your COBRA Coverage

Employees and Dependents who are eligible for COBRA Coverage will have the following options:

(a) Continue both Life Insurance coverage and COBRA Coverage on a self-pay basis; or

(b) Continue COBRA Coverage only on a self-pay basis.

You may not choose to continue only your Life Insurance coverage. These two options, with the required self-payment amounts, will be included in the COBRA Coverage Notice and Election Forms that are provided to you. They will be subject to the same election time periods and payment due dates. The Life Insurance coverage that is available to you during the COBRA Coverage period, will be the same as the Life Insurance coverage that is being provided by the Plan to similarly situated Participants with respect to whom a qualifying event has not occurred.

If elected, your Life Insurance coverage will continue until termination on the earliest of the following dates to occur: (i) the last day of the last period for which a timely self-payment is made; (ii) the date COBRA Coverage ends; or (iii) the date the Life Insurance benefit under the Plan terminates.

C. EXTENDED COVERAGE FOR RETIRED AND DISABLED EMPLOYEES AND THEIR DEPENDENTS

1. Retired Employees and Their Dependents

You are eligible to extend health and life insurance coverage under the Plan, for yourself and your Dependents on a self-payment basis, if you satisfy the following requirements:

(a) You are retired and receiving a benefit under the Electricians Pension Plan, IBEW 995 or the National Electricians Benefit Fund; and

(b) You are under age 65, have terminated employment, are eligible for Medicare, and eligible to receive a pension from the Electricians Pension Plan, IBEW 995.

The amount of the required self-payment is determined by the Trustees (the "Retiree Rates"). If elected, this extended coverage will continue until terminated, as provided below in Section E(2).

If you die while you and your Dependent spouse have extended coverage under this Section, your surviving spouse may elect to continue health coverage for the spouse and any Dependent children who are covered at your death and continue surviving spouse life insurance coverage. This continued coverage, if elected, will be on a self-payment basis at the Retiree Rates and will continue until the earliest of the following to occur: (a) failure to pay a required self-payment in full timely; (b) the surviving spouse's remarriage or death, (c) the surviving spouse's eligibility for coverage under another group health plan, or (d) for a Dependent child, the date the child ceases to qualify as a Dependent under the Plan. The Life Insurance coverage available to the surviving spouse will be reduced to the amount set forth in the Schedule of Benefits and may be self-insured by the Fund.

This extended coverage option, for Retired Employees and their Dependents, is available only instead of, and not in addition to, COBRA Coverage. It must be elected during the COBRA election period or, if COBRA Coverage is elected, at any time through the date COBRA Coverage ends. In order to elect this extended coverage at the Retiree Rates, the Retired

Employee or surviving spouse (as applicable) must make the required self-payment in full timely and waive all remaining rights to COBRA Coverage in the form required by the Plan.

The self-payment for this extended coverage option is payable on a monthly basis and must be received at the Fund Office by the first day of each month in order to be timely. For purposes of determining the self-payment rate, a Retired Employee will be treated as an active Employee for any period during which coverage is paid through Employer contributions or exhaustion of the Dollar Bank account. A Retiree with a Dependent child will be charged the highest self-payment rate established by the Trustees. If a self-payment is not paid in full timely, the extended coverage will terminate as of the last day of the last period for which timely payment in full is made and cannot be reinstated.

2. Disabled Employees and Their Dependents

If you become totally disabled while covered by the Plan and satisfy the following requirements, you will be eligible to extend health and life insurance coverage for you and your Dependents who are covered when your active Employee coverage ends (after you exhaust your Dollar Bank account):

(a) You must present satisfactory proof to the Plan that you are totally disabled from gainful employment within the meaning of the Social Security Act; and

(b) You must earn at least 1,200 hours in Covered Employment in any five of the seven years immediately before the date your disability begins.

This extended coverage option is available on a self-payment basis at the rates established by the Trustees. If elected, the extended coverage will continue until terminated as provided below in Section E (2).

If you die while you and your Dependents have this extended coverage, your surviving Dependents who are covered at your death may elect to continue their health coverage, and your surviving spouse who is covered at your death may elect to continue the extended life insurance coverage. This extended coverage option is available on a self-payment basis at the rates established by the Trustees. If elected, the coverage will continue until the first of the following to occur: (a) failure to pay a required self-payment timely; (b) eligibility for other group health coverage; or (c) the end of the 36-month period that begins with the first calendar month after your death. The extended life insurance coverage available to your surviving spouse will be reduced to the amount set forth in the Schedule of Benefits and may be self-insured by the Fund.

This extended coverage option is available only in lieu of, and not in addition to, COBRA Coverage. It must be elected during the COBRA Coverage election period or, if COBRA Coverage is elected, at any time through the date COBRA Coverage ends. In order to exercise this extended coverage option, the eligible persons must make the required self-payment in full timely and waive all remaining rights to COBRA Coverage in the form required by the Plan.

The self-payment for this extended coverage option is payable on a monthly basis and must be received at the Fund Office by the first day of each month in order to be timely. For purposes of determining the self-payment rate, you will be treated as an active Employee for any period during which coverage is paid through Employer contributions or exhaustion of your Dollar Bank account. A disabled Employee with a Dependent child will be charged the highest self-payment rate established by the Trustees. If a self-payment is not paid timely, the extended coverage will terminate as of the last day of the last period for which timely payment is made and cannot be reinstated.

D. EXTENDED COVERAGE FOR SURVIVING SPOUSES

If you should die (whether you are an active or retired Employee) while you and your Dependent spouse are covered, the health coverage for your Dependents (spouse and children) and the life insurance coverage for your spouse, will continue without charge as described in this Section, before COBRA Coverage or any other extended coverage available under the Plan. It will continue for 90 days from the last day of the month of your death, or if applicable and it results in a longer period, until coverage would otherwise end after using any remaining credit in your Dollar Bank account.

At the end of this extended coverage period, your surviving spouse and any other covered Dependents may elect COBRA Coverage. In addition, if your spouse is receiving a surviving spouse's pension benefit from the Electricians Pension Plan, IBEW 995 and is not eligible for extended coverage as described in Section C(1), your spouse will also have the option to extend health and life insurance coverage, on a self-payment basis at the Retiree Rates, until the earliest of the following: (a) remarriage or death; (b) becoming eligible for coverage under another group health plan; or (c) failure to make a self-payment timely. This extended coverage option is available in lieu of, not in addition to, COBRA Coverage. It may be exercised at any time during the COBRA Coverage election period or, if COBRA Coverage is elected, at any time through the date COBRA Coverage ends. In order to elect this extended coverage option, the surviving spouse must make the required self-payment in full timely and waive all remaining rights to COBRA Coverage in the form required by the Plan.

The self-payment for this extended coverage option is payable on a monthly basis and must be received at the Fund Office by the first day of each month in order to be timely. The life insurance coverage available to the surviving spouse will be reduced to the amount set forth in the Schedule of Benefits and may be self-insured by the Fund. If a self-payment is not paid timely, the extended coverage will terminate as of the last day of the period for which timely payment was made and cannot be reinstated.

PLEASE NOTE: Extended coverage rights that are provided by the Plan in addition to what is required under federal law, are not guaranteed or contractual rights, and do not vest upon the happening of any event including retirement, disability or death. The Trustees reserve the right, in their sole and exclusive discretion, to amend and terminate extended coverage rights at any time and for any persons, regardless of their status at the time of amendment or termination.

E. TERMINATION OF COVERAGE

1. Active Employees

Your coverage will terminate on the earliest of the following dates to occur, subject to the right under the Plan, if any, to continue coverage under COBRA or to extend coverage following retirement or disability:

(a) For Collectively Bargained Employees, the first day of the first Benefit Month for which you do not have enough credit remaining in your Dollar Bank account to satisfy the full Required Amount;

(b) For Non-Bargaining Unit Participating Employees, the first day of the first Benefit Month for which the Plan does not receive enough Employer contributions on your behalf to satisfy the continuing eligibility requirements;

(c) The date the Plan or Fund is terminated or amended to exclude your coverage, or the date there are not enough assets remaining in the Fund to pay benefits under the Plan;

(d) The last date for which coverage has been paid in full timely if coverage is being provided on a self-payment basis;

(e) The date on which you are no longer eligible for coverage (or, if applicable, the last day of the paid-up period of coverage in which your eligibility ends); and

(f) The date of your death.

2. Retired and Disabled Employees

Your extended coverage will terminate on the earliest of the following dates to occur:

(a) The date the Plan or Fund is terminated or amended to exclude your coverage, or the date there are not enough assets remaining in the Fund to pay benefits under the Plan;

(b) The last date for which coverage is paid in full timely if coverage is being provided on a self-payment basis;

(c) The date of your death;

(d) For a Disabled Employee, the date you are no longer disabled, the date you become eligible for Medicare benefits, or the date you become eligible for coverage under another group health plan, whichever occurs first; and

(e) The date you are no longer eligible for coverage under the Plan (or, if applicable, the last day of the paid-up period of coverage in which your eligibility ends).

3. Eligible Dependents

Your Dependent's coverage will terminate on the earliest of the following dates to occur subject to the right, if any, to continue coverage under COBRA or to extend coverage following your retirement, disability or death:

(a) The date the Employee's coverage terminates other than by reason of death;

(b) The last day of the month in which the Dependent ceases to qualify as a Dependent;

(c) The date specified in a Qualified Medical Child Support Order;

(d) The date the Plan or Fund is terminated or amended to exclude coverage for the Dependent, or the date there are not enough assets remaining in the Fund to pay benefits under the Plan;

(e) The last day of the month of the Employee's death; and

(f) The date of the Dependent's death.

F. FAMILY AND MEDICAL LEAVE OF ABSENCE

If you are eligible for a leave of absence under the federal Family and Medical Leave Act of 1993 as amended ("FMLA Leave"), your Employer must provide you with up to 12 weeks of unpaid leave in a 12- month period, and up to 26 work weeks of unpaid leave if the reason is to care for a covered service member with a serious injury or illness. If you are eligible and take a FMLA Leave, you may continue your pre-leave medical coverage on the same terms as if you had continued to work.

FMLA generally applies to employers who employ 50 or more employees in 20 or more work weeks in the current or prior calendar year.

In order to be eligible, you must work for a covered employer for a total of 12 months, for at least 1,250 hours over the 12 months prior to the start of the leave, and at a location where at least 50 employees are employed by the employer within a 75-mile radius.

The reasons for which a FMLA Leave may be available include the following:

(a) The birth and care of your newborn child;

(b) A child's placement with you for adoption or foster care;

(c) To care for a spouse, child or parent with a serious health condition;

(d) To take medical leave when you are unable to work because of a serious health condition;

(e) For "qualifying exigencies" arising out of the fact that your spouse, child or parent is on active duty or called to active duty status as a member of the National Guard or Reserve in support of a contingency operations; or

(f) If you are a spouse, child, parent or next of kin of a current member of the Armed Forces, National Guard or Reserves, to care for such service member when he or she has a serious injury or illness incurred in the line of duty on active duty and that may render him or her medically unfit to perform duties.

"Qualifying exigencies" may include attending certain military events and related activities, making appropriate financial and legal arrangements, certain childcare and related activities, attending counseling, certain post-deployment activities and issues arising from short notice deployment.

Your Employer must properly grant your leave and make any required notification and payment of contributions to the Fund Office. You also have certain responsibilities such as giving notice of the need and reason for the leave in advance when it is foreseeable or otherwise as soon as reasonably possible, and providing sufficient information to substantiate that it qualifies as a FMLA Leave. You do not have to use your Dollar Bank account to continue your health coverage under the Plan. If you are considering taking a FMLA Leave or have questions concerning your eligibility or obligations, please contact your Employer or the Fund Office.

G. QUALIFIED MILITARY SERVICE LEAVE OF ABSENCE

If you take a leave of absence for qualified military service that is protected under the federal law known as "USERRA" (the Uniformed Services Employment and Re-Employment Rights Act of 1994 and corresponding regulations, as amended), any service you have earned and any contributions credited to your benefit for initial or continuing eligibility (including amounts credited to your Dollar Bank account), will be kept on the Plan's records and protected during such absence. "Qualified military service" may include such service as active or inactive duty training or active duty in the United States Armed Forces or National Guard. For example, if you take a leave of absence for qualified military service, are honorably discharged and return to Covered Employment within a certain time period, your pre-leave credited service and Dollar Bank account, and coverage under the Plan (if you are covered when your leave began), will be reinstated upon your return without a waiting period or exclusions.

If you and your Dependents have coverage when your qualified military service leave begins, you may continue such coverage for up to 24 months while you are performing qualified military service. If your leave of absence is not longer than 30 days, this continued coverage will be provided on the same terms that were in effect before the leave began, which means there is no charge (unless you were required to self-pay before the leave began). If your leave is longer than 30 days, the right to continue coverage will be provided in the same way as COBRA Coverage. This means that you must make a timely election to continue coverage and make the required self-payments within the COBRA

time periods. The continued coverage that is provided in satisfaction of your rights under USERRA will also apply to satisfy your rights under COBRA (i.e., they will run at the same time). See the "Continuation Coverage Rights Under COBRA" Section for a full explanation of COBRA.

Medical coverage under this Plan will be coordinated with any medical coverage provided to military personnel and their dependents under TRICARE in a manner that complies with the law.

When you are discharged (honorably or with a protected status), you must return to Covered Employment in accordance with the following time periods in order to be protected under USERRA and have the rights described in this Section:

(a) Within 90 days from the date of discharge for military service of more than 180 days;

(b) Within 14 days from the date of discharge for military service of more than 30 days but less than 180 days; and

(c) By the beginning of the first full regularly scheduled work period beginning after military service ends (plus travel time and an additional eight hours) if military service is 30 days or less.

If you are hospitalized for or recovering from an illness or injury incurred in military service, these time periods will be extended for a recovery of up to two years.

If you have questions about taking military leave, please speak directly with your Employer. If you have questions about how a leave of absence will affect your coverage under the Plan, please contact the Fund Office. Your USERRA rights are subject to change as the law changes, and Plan coverage will be provided only as required by law. If you leave employment for military service, you should notify your Employer and the Fund Office as soon as possible to ensure protection of your USERRA rights.

H. RECIPROCITY

From time to time the Trustees may enter into reciprocal agreements ("Reciprocal Agreements") with the trustees of other welfare benefit trust funds. The purpose of a reciprocal agreement is to allow an Employee, who works in another jurisdiction that is covered by the reciprocal agreement with this Fund, to elect to have all contributions that are received by the other reciprocating fund transferred to this Fund, or to have all contributions that are received by this reciprocating Fund transferred to the other fund. If you work or have worked outside the jurisdiction of this Fund and want to know if there is a reciprocal agreement in effect that applies to that jurisdiction, you should contact the Fund Office. It can provide you with that information and tell you what your rights and obligations are under any such reciprocal agreement.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Life Insurance and Accidental Death and Dismemberment Benefits are described below. The Life Insurance coverage for an eligible surviving spouse, following an Employee's death, is self-insured by the Fund. All other Life Insurance and Accidental Death and Dismemberment Benefits are provided through a group insurance policy purchased by the Fund (the "Policy"). The terms of the Policy in effect at the time of death (for the Life Insurance benefit) or accident (for the Accidental Death and Dismemberment benefit), will govern the benefits payable under the Plan. The Policy is incorporated with and made a part of the Plan. The following is a summary of the Life Insurance and Accidental Death and Dismemberment Benefits.

A. LIFE INSURANCE

1. For Employees

You will become covered for Life Insurance, in the amount set forth in the Schedule of Benefits, when you become covered under the Plan. Your Life Insurance coverage will terminate upon the earliest of the following to occur:

(a) the date Life Insurance coverage is no longer provided under the Plan;

(b) the date you are no longer eligible for this benefit;

(c) the date you are no longer covered by the Plan (subject to the right, if any, to continue Life Insurance coverage on a self-payment basis);

(d) for non-payment of a required premium or self-payment, the last day of the last period for which coverage has been paid timely;

(e) the date you enter full-time active duty with the armed forces of any country (subject to your right, if any, to self-pay to continue coverage as provided in the Policy); or

(f) the date of your death.

If your Life Insurance coverage terminates because your Plan coverage terminates, it will be reinstated if and when your Plan coverage is reinstated. If your Plan coverage is not reinstated, your Life Insurance coverage will become effective when you satisfy the initial eligibility requirements and are covered by the Plan.

In the event of your death from any cause, on or off the job, while you are covered for Life Insurance, a Life Insurance Benefit in the amount shown in the Schedule of Benefits will be paid in one lump sum to your surviving Beneficiary; however, up to $500 of that benefit may instead be paid to an individual who has incurred expenses for your burial, rather than to your Beneficiary.

You may designate in writing, on a form acceptable to the Insurer (or Plan for a self-insured benefit), the person(s) you wish as your Beneficiary. You may change your Beneficiary designation in writing at any time without the consent of the previously named Beneficiary. If you name more than one Beneficiary, they will share equally unless you state otherwise. You should contact the Fund Office for a copy of the Beneficiary designation form and return the completed form to the Fund Office. A Beneficiary designation is effective as of the date it is received by the Fund Office, but it will be without prejudice to any payment made by the Insurer (or Plan for a self-insured benefit) before receipt of the Beneficiary designation form by the payer.

If there is no named Beneficiary or no named Beneficiary survives you, the Life Insurance Benefit will be paid to the first surviving class in the following order of preference:

(a) your surviving spouse; if none

(b) your surviving children in equal shares; if none

(c) your surviving parents in equal shares; if none

(d) your surviving siblings in equal shares; if none

(e) the executors or administrators of your estate.

In identifying the Beneficiary, the Insurer or Plan may rely on an affidavit made by any individual listed above. If payment is made in accordance with such affidavit and written notice of claim by another person has not been received by the payer at the time of payment, the Insurer and Plan will be discharged of their liability for payment under the Plan for the amount so paid. Please contact the Fund Office if you have any questions about naming or changing Beneficiaries or about their share of the benefit.

Whenever a Beneficiary is a minor or someone who is not able to give a valid release for payment, the Insurer (or Plan with respect to a self-insured benefit) will pay the Life Insurance Benefit to the person's legal guardian or, if there is no legal guardian, to the individual or institution that has, in the payer's opinion, custody and principal support of the Beneficiary. The Insurer and Plan will be fully discharged of their liability under the Plan for any amount of Life Insurance Benefit so paid in good faith.

If your Life Insurance coverage terminates, you may be able to convert all or a portion of it to an individual life insurance policy (but not term insurance or insurance which provides disability or supplementary benefits), without having to show evidence of insurability. In order to do so, the conversion must be allowed under the Policy, and you must send a written application with payment of the first premium to the Insurer within the conversion period. Generally, the Policy allows conversion if you lose Life Insurance coverage because of any of the following:

(a) you cease to be eligible or you become eligible for reduced coverage due to your employee classification or change in classification;

(b) your age or retirement; or

(c) policy termination or amendment to terminate coverage for a class of eligible persons under which you were insured (provided you have been continuously insured for at least five years).

Restrictions on the amount available for conversion and conversion policy features may apply. You will be responsible for paying all premiums.

Generally, you are entitled to notice of your conversion rights. You will have a "Conversion Period" of thirty-one (31) days after the date your Life Insurance ends, in which to apply and pay for conversion. If you do not receive notice of your conversion rights at least 15 days before the end of the Conversion Period, you are entitled to an additional 15 days after receiving notice to apply for conversion. Regardless of when notice is sent, you will not be able to apply for conversion if more than 91 days have passed since your Life Insurance terminated under the Policy. If you die during the 31-day Conversion Period before you apply for conversion or before actual conversion, a Death Benefit will be paid in the amount of the Life Insurance you are entitled to convert. Please contact the Fund Office if you have questions about your conversion rights.

The Policy permits payment of an Accelerated Life Insurance Benefit for active employees in the following situations:

(a) you become terminally ill;

(b) you suffer a medical condition that requires extraordinary medical intervention or continuous confinement in an eligible institution if you have been confined for at least six months and are expected to remain confined for the rest of your life; or

(c) you suffer a medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span.

Only one Accelerated Benefit is payable per person. Once it is paid, that person's Life Insurance Benefit will be reduced by the amount of the Accelerated Benefit payment. There are numerous restrictions and conditions that apply to the availability and payment of the Accelerated Benefit. Please contact the Fund Office for additional information.

2. For Dependents

Dependents will become covered for Life Insurance, in the amount set forth in the Schedule of Benefits, on the date the Employee becomes covered or, if later, the date the Dependent first becomes covered under the Plan. A Dependent's Life Insurance coverage will remain in effect until termination on the earliest of the following to occur:

(a) the date Dependent Life Insurance coverage is no longer provided under the Plan;

(b) the date the Employee's Life Insurance coverage terminates, subject to the right, if any, to self-pay to continue Life Insurance coverage;

(c) the date the Dependent is no longer covered under the Plan (subject to the right, if any, to self-pay to continue Life Insurance coverage concurrent with COBRA coverage);

(d) the date the Dependent enters full-time active duty with the armed forces of any country (subject to any right to self-pay to continue coverage as provided in the Policy); or

(e) in the event of non-payment of premium or a self-payment, the last day of the last period for which coverage has been paid timely.

If a Dependent dies while covered for the Life Insurance Benefit, a Life Insurance Benefit in the amount set forth in the Schedule of Benefits will be paid in one lump sum to the Employee if surviving, or otherwise to the Employee's estate.

If a Dependent's Life Insurance coverage terminates for any reason, the Dependent may be able to convert all or a portion of the terminated Life Insurance coverage to an individual life insurance policy on the same basis as the Employee. Please contact the Fund Office for additional information regarding a Dependent's conversion rights.

B. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Only active Employees who are covered by the Plan are covered for the Accidental Death and Dismemberment ("AD&D") Benefit. If you have an accident on or off the job while you are covered for the AD&D Benefit, and you suffer one of the following losses within 90 days after the accident as a direct result of the accident and independent of all other causes, the corresponding benefit, in the amount shown in the Schedule of Benefits, will be payable to you or, for accidental loss of life, to your surviving Beneficiary:

Accidental Loss Of:	**AD&D Benefit**
Life	Full Benefit
Two Hands	Full Benefit
Two Feet	Full Benefit
Sight of Two Eyes	Full Benefit
One Hand & One Foot	Full Benefit
One Hand & Sight of One Eye	Full Benefit
One Foot & Sight of One Eye	Full Benefit
One Hand	One-Half the Full Benefit
One Foot	One-Half the Full Benefit
Sight of One Eye	One-Half the Full Benefit

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of the sight of an eye means the irrevocable and complete loss of the sight in the eye. If you suffer more than one loss in any one accident, payment will be made only for the loss for which the largest amount is payable.

No AD&D benefit will be paid for a loss caused directly or indirectly, in whole or part, by any of the following:

(a) bodily or mental illness or disease of any kind;

(b) ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

(c) suicide or attempted suicide while sane or insane;

(d) intentional self-inflicted injury;

(e) participation in, or the result of participation in, the commission of an assault, felony, riot or civil commotion;

(f) war or act of war, declared or undeclared, or any act related to war or insurrection;

(g) medical or surgical treatment of an illness or disease;

(h) parachuting, skydiving, bungee cord jumping, flying, ballooning, hang-gliding, parasailing or any other aeronautic activities except as a fare paying passenger on a commercial aircraft;

(i) intake of any drug, medication or sedative unless prescribed by a Doctor, or the intake of any alcohol in combination with any drug, medication or sedative; or

(j) any poison or gas voluntarily taken, administered, absorbed or inhaled.

C. FACILITY OF PAYMENT

If any benefit is payable under the Life Insurance or AD&D Benefit to your estate or to a person who is a minor or lacks capacity to give a valid release for payment, up to $1,000 of such benefit may be paid to any relative by blood or connection by marriage to you, as determined by the payer. The Insurer and Plan will be fully discharged of their liability for any amount of benefit so paid in good faith.

REMEMBER: This Life Insurance Benefit and AD&D Benefit Section is only a summary of the Policy provisions currently in effect. The Policy and its terms may change from time to time. In the event of a conflict or inconsistency between this summary of benefits and the actual terms of the Policy through which the benefits are provided, the terms of the Policy will govern. You should contact the Fund Office if you have questions or want additional information concerning the Policy terms.

MAJOR MEDICAL EXPENSE BENEFIT

A. WHAT THE PLAN PAYS FOR

The Plan helps you and your Dependents pay for Covered Expenses incurred for medical care, services and supplies, as described in this Section. These benefits are self-insured by the Fund. An expense is incurred on the date the service or supply for which it is charged is furnished.

B. THE CALENDAR YEAR DEDUCTIBLE

The "Calendar Year Deductible" is the amount of Covered Expenses, as shown in the Schedule of Benefits, that each Participant must first incur and pay out-of-pocket during a calendar year, before Covered Expenses that are incurred during the remainder of the calendar year are payable under the Plan. A separate Calendar Year Deductible will apply to you and to each of your Dependents.

C. COPAYMENT PERCENTAGE, NETWORK AND OUT-OF-NETWORK PROVIDERS AND OUT-OF-POCKET LIMIT

Copayment: "Copayment" under this Plan means a sharing of Allowable Charges for Covered Services between the Plan and the Participant. The sharing is expressed in the Schedule of Benefits as the percentage of an Allowable Charge that is payable by the Plan, after any deductible amount is satisfied. There are different copayment percentages for different categories of charges. If the percentage is less than 100%, the remaining percentage of the Allowable Charge is the Participant's responsibility. For example, if the applicable copayment percentage is 85%, the benefits payable by the Plan will be based on 85% of the Allowable Charge (after any applicable deductible is satisfied). The remaining 15% of the Allowable Charge (and any deductible) is the Participant's responsibility. The benefits payable under the Plan will also be subject to any other exclusions or limitations that apply, as described in this Booklet.

Network Providers and Out-of-Network Providers: The Trustees have contracted (and may contract from time to time) with a Preferred Provider Organization ("PPO"), to offer you and your Dependents discounted rates if you use a participating Hospital, Physician or other medical provider, described as a "Network Provider". A list of the providers participating in the Network will be furnished to you automatically, without charge, separately from this Booklet. You may also locate a Network Provider by contacting the Fund Office at 1-225-927-6340.

The copayment percentage payable by the Plan is higher if you use a Network Provider. Any other provider is described as an "Out-of-Network Provider".

If you use an Out-of-Network Provider, it is possible for the Out-of-Network Provider to "balance bill" you for the difference between its charges and the amount covered by the Plan. The amount covered by the Plan is based on the "Allowable Charge", which is the amount of the provider's charge that the Plan recognizes as payable for what is covered. For Out-of-Network Providers, the Allowable Charge

is based on a methodology approved by the Trustees. It is anticipated to be lower (and often substantially lower) than the Out-of-Network Provider's charge.

If you use a Network Provider, the Network Provider may not "balance bill" you for the difference between its charges and the Allowable Charge. The Allowable Charge for a Network Provider is the contractually agreed upon discounted rate.

Of course, you will be responsible for any deductibles, co-payment percentage and amounts that exceed a Plan limit (such as a visit or dollar limit) that are payable by you under the Plan, regardless of whether you use a Network Provider or Out-of-Network Provider.

Out-of-Pocket Limit: The Plan has an "Out-of-Pocket Limit," as set forth in the Schedule of Benefits, which affects the copayment percentage that is payable. The "Out-of-Pocket Limit" is the maximum amount of out-of-pocket Covered Expenses that a Participant is responsible for paying during a calendar year (in addition to the Calendar Year Deductible), before the copayment percentage for that Participant increases to 100% for the remainder of the calendar year.

For example, if you satisfy your Calendar Year Deductible and Out-of-Pocket Limit for a calendar year, any Allowable Charges incurred by you for the remainder of that calendar year will be subject to a 100% copayment percentage payable by the Plan.

There is also a per family Out-of-Pocket Limit for a calendar year as listed in the Schedule of Benefits. Once you and your covered Dependents collectively satisfy the family Out-of-Pocket Limit for a calendar year, any Allowable Charges incurred by you or a covered Dependent during the remainder of the calendar year will be subject to a 100% copayment percentage payable by the Plan, provided that individual has satisfied the Calendar Year Deductible.

Expenses that are not covered by the Plan or that exceed the Allowable Charge will not be credited toward satisfaction of the Out-of-Pocket Limit. The types of expenses that may be used to satisfy the Calendar Year Deductible are the same types that may be used to satisfy the Out-of-Pocket Limit.

D. ADDITIONAL ACCIDENT EXPENSE BENEFIT

If you or your Dependent suffers a non-occupational accidental bodily injury while covered by the Plan, the Covered Expenses incurred in connection with the injury within the first three (3) months following the accident, are eligible for this benefit. The copayment percentage and maximum benefit per Participant per accident are payable without application of the Calendar Year Deductible, as described in the Schedule of Benefits. Once this benefit is exhausted, any additional Allowable Charges will be considered for payment under the Major Medical Expense Benefit (subject to the applicable benefit limitations such as the Calendar Year Deductible and Copayment).

The types of Covered Services that are considered eligible under this benefit include:

1. medical and surgical treatment and supplies;
2. hospital confinement and treatment;
3. x-ray and laboratory examinations; and
4. services of a registered nurse.

E. PRE-ADMISSION CERTIFICATION AND POST-ADMISSION REVIEW REQUIREMENTS

All non-emergency/non-maternity inpatient admissions, and the facilities and services listed in the Schedule of Benefits, must be pre-certified. All emergency admissions must be certified within 48 hours of the admission. All maternity inpatient admissions that are going to exceed 48 hours for a normal vaginal delivery or 96 hours for a Caesarian section must be certified by the end of the 48 or 96-hour period, as applicable.

All pre-certification and certification services will be performed by the Plan's utilization review company. The name and contact information for the utilization review company are listed in the Schedule of Benefits, and are also available upon request to the Fund Office. To obtain the required pre-certification or certification, the treating Physician (or the Participant or a family member) must contact the utilization review company for the Plan in a timely manner and provide the requested information.

F. MENTAL AND NERVOUS DISORDERS BENEFIT

Covered Expenses incurred for treatment of Mental and Nervous Disorders (except for any such disorders completely excluded from coverage) are covered in the same manner as any other Illness, subject to the copayment and limits described in the Schedule of Benefits. The term, "Mental and Nervous Disorders", means mental disorders, mental illnesses, functional nervous disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or non-organic or of biological, genetic, chemical or non-chemical origin and regardless of cause, basis or inducement).

G. ALCOHOL, DRUG OR SUBSTANCE ABUSE BENEFIT

Covered Expenses incurred for the treatment of Alcohol, Drug or Substance Abuse (except for any such disorders that are completely excluded from coverage) are covered in the same manner as any other Illness, subject to the copayment and limits described in the Schedule of Benefits.

This includes coverage for inpatient treatment of Alcohol, Drug or Substance Abuse in a Hospital or Chemical Dependency Unit ("CDU"). A CDU means a facility that is established, operated and licensed as a CDU in accordance with the applicable laws of the jurisdiction in which it is operated. The CDU must also (i) be primarily engaged in providing treatment on an inpatient basis for Alcohol, Drug or Substance Abuse, including counseling and 24-hour nursing service by registered graduate nurses who are specially trained and physically present and on duty; (ii) charge patients for such services; and (iii) be operated continuously with organized facilities and personnel for such services.

H. CHIROPRACTIC CARE BENEFIT

Covered Expenses incurred for chiropractic care performed by a Chiropractor, on an outpatient basis only, are covered subject to the limits described in the Schedule of Benefits. This includes services for the detection or correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from a distortion, misalignment or dislocation of the spinal column, and related chiropractic services.

Covered Expenses incurred for x-rays, casts, splints, braces, surgery and Hospital charges are considered for payment under the “Major Medical Charges” described in Section O, and not under the Chiropractic Care Benefit. Any expenses for chiropractic care that exceed the limits for this benefit are not payable under another benefit.

I. SKILLED NURSING CARE FACILITY BENEFIT

Covered Expenses incurred for services and supplies received by a Participant while confined to a Skilled Nursing Care Facility, are covered subject to the limits described in the Schedule of Benefits. Any expenses for confinement in a Skilled Nursing Care Facility that exceed the limits for this benefit are not payable under another benefit. A “Skilled Nursing Care Facility” means a facility that is licensed by the state in which is located; is primarily engaged in providing skilled nursing care and other therapeutic services; and is an eligible provider of Medicare and Medicaid nursing care services.

The following requirements must also be satisfied: (i) a Physician must prescribe a written treatment plan and supervise the Participant’s care and treatment; (ii) the facility must maintain the treatment plan and medical records for each patient; (iii) the Participant must be confined in a Hospital for at least three days, and then begin to receive services in the Skilled Nursing Care Facility within three days after release from the Hospital, for the same Illness or injury that caused the Hospital confinement; and (v) in the absence of the skilled nursing care, the Participant would be required to be confined in a Hospital.

Charges incurred for care or services related to Alcohol, Drug or Substance Abuse, chronic brain syndrome, mental retardation, senile deterioration or Mental and Nervous Disorders, are NOT payable under this Skilled Nursing Care Facility Benefit.

J. MATERNITY BENEFIT

Covered Expenses incurred for pregnancy, childbirth or related medical conditions are covered for female Employees and Dependent spouses only (and NOT for Dependent children), and are payable on the same basis as any other Illness or injury. As required by the Newborns’ and Mothers’ Health Protection Act of 1996 (“NMHPA”), the Plan does not restrict benefits or require pre-authorization for a Hospital stay in connection with childbirth, for the mother or newborn child, of up to 48 hours following a normal vaginal delivery or 96 hours following a caesarean section. Authorization is required only if a longer period of Hospital stay is needed.

K. PREVENTIVE AND WELLNESS BENEFIT

Covered Expenses incurred by a Participant for the following preventive and wellness care are covered subject to the limits described in the Schedule of Benefits.

In order to be covered under this benefit, the services and items for which charges are incurred must be identified by the Physician as preventive and wellness services using the appropriate diagnosis code. In addition, only the following tests, screenings and services are covered under this benefit:

1. cholesterol tests/lipid panels;
2. complete blood counts;
3. chest x-rays;
4. electrocardiograms;
5. fecal blood tests;
6. gynecological examinations;
7. immunizations;
8. diagnostic mammograms;
9. occult blood counts;
10. pap smears;
11. physical examinations;
12. prostate testing;
13. sigmoidoscopies;
14. stress testing, not maternity;
15. urinalysis;
16. smoking cessation programs;
17. glucose, quantitative, blood;
18. general health panel;
19. basic metabolic panel;
20. thyroid stimulating hormone (“TSH”); and
21. hearing and vision testing (as part of a child’s routine annual exam).

Routine nursery care of a newborn Dependent child is not covered under the Preventive and Wellness Benefit (it is covered to the extent described under Section O., “Major Medical Charges”, Item 13). Any preventive and wellness expenses that are not covered under this benefit or that exceed the applicable limits are payable in full by the Participant and may not be used to satisfy the Calendar Year Deductible or Out-of-Pocket Maximum.

L. MASTECTOMY COVERAGE

As required by the Women’s Health and Cancer Rights Act of 1998, Covered Expenses incurred for breast reconstructive surgery that is part of a mastectomy procedure are covered. This includes: (i) reconstruction of the breast on which the mastectomy is performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications for all stages of the mastectomy including lymphedemas, all in a manner determined in consultation with the consulting Physician and patient. These Covered Expenses will be considered for payment

under coverage for “Major Medical Charges”, which means they are subject to the Plan’s cost control limitations (e.g., the Calendar Year Deducible and Copayment percentage limitations).

M. PRESCRIPTION DRUGS

Covered Expenses incurred by a Participant for Prescription Drugs are covered subject to the limits described in the Schedule of Benefits, and the terms and conditions generally applicable to coverage of “Major Medical Charges”.

The Plan may contract with a discount Prescription Drug provider and offer Participants a network of participating pharmacies at which they can obtain Prescription Drugs at a cost savings. Information about the current network of participating pharmacies is listed in the Schedule of Benefits. A list of the participating pharmacies will automatically be provided to you, without charge, separately from this Booklet. You may also obtain a copy by contacting the Fund Office.

Penalty Applies If Prescription Drugs Purchased From Non-Participating Pharmacy: If and as long as a network of participating pharmacies is made available under the Plan, the benefits payable under the Plan will be reduced for Participants who choose to use a non-participating pharmacy. The amount of the reduction (i.e., the penalty) is described in the Schedule of Benefits. You should consult the list of participating pharmacies and consider purchasing your Prescription Drugs from a participating pharmacy in order to maximize the benefits payable under the Plan.

Medicare Eligibility: Medicare prescription drug coverage is available to everyone with Medicare. If you are Medicare eligible, you can get this coverage by joining a Medicare Prescription Drug Plan or Medicare Advantage Plan (like a HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

This Plan also offers prescription drug coverage to Participants who are Medicare eligible retirees. Each year, the actuary for the Plan will review and determine if the Plan’s retiree prescription drug coverage is, on average, at least as good as a standard level of Medicare prescription drug coverage and considered “creditable coverage” for the year. The Plan will then provide an annual notice to Participants who are Medicare eligible retirees informing them of the creditable coverage determination and their enrollment options. The Plan will have an annual enrollment period, at the end of each calendar year, to allow Participants who have enrolled in a Medicare Prescription Drug plan but are still covered under this Plan (except for Prescription Drug coverage) to drop their Medicare Prescription Drug coverage and re-enroll in Prescription Drug coverage under this Plan.

Participants who are eligible and choose to enroll in a Medicare Prescription Drug plan, will lose their Prescription Drug coverage under this Plan beginning with the first day of their enrollment. They may continue to have medical coverage (other than Prescription Drug coverage) under this Plan. Participants must promptly notify this Plan of their enrollment in a Medicare Prescription Drug plan. Any Prescription Drug charges they incur that are not covered under this Plan (because of their Medicare Prescription Drug plan coverage) will NOT count toward satisfaction of the Calendar Year Deductible or Out-of-Pocket Limit under this Plan.

You will receive a notice about your prescription drug coverage under the Plan and Medicare when you become eligible for Medicare or, if later, when you first join the Plan; each year thereafter; and whenever the prescription drug coverage under the Plan changes so that it is no longer considered creditable coverage. You may also request a copy or contact the Fund Office if you have questions.

N. MAJOR MEDICAL CHARGES

Covered Expenses incurred by a Participant for the following medical charges are covered under the Major Medical Expense Benefit, subject to the limits described in the Schedule of Benefits:

1. hospital charges for room and board not to exceed the rate shown in the Schedule of Benefits;

2. charges for Hospital services and supplies other than room and board, and hospital admission kits;

3. charges for medical care by a Physician, or Physician Assistant and Nurse Practitioner provided there are no Physician charges for the same services. A Physician's Assistant is a licensed professional who has received specialized training to perform certain tasks usually performed by a Physician, under the direction of a supervising Physician, and who is acting within the scope of his or her license;

4. charges by a surgeon and assistant surgeon for surgical procedures. Assistant surgeon charges are only covered if: (i) the assistant surgeon is needed for a covered surgical or obstetrical service; and (ii) the assistant surgeon's duties are not routinely available from a Hospital intern, resident, Physician's Assistant, or full-time salaried person;

5. charges for nursing care by a professional registered nurse (R.N.) other than a nurse who ordinarily resides in the patient's home or who is related to the patient;

6. charges by a radiologist or physiotherapist;

7. charges for laboratory procedures for diagnosis or treatment;

8. charges for anesthesia and its administration by a Physician or professional anesthetist, and charges for anesthesia and anesthesia related care by a Certified Registered Nurse Anesthetist;

9. charges for professional local ambulance service to the nearest Hospital that can furnish the necessary emergency care or treatment for the Participant's condition, or that is certified by a Physician as Medically Necessary based upon the Participant's condition;

10. charges by any person or institution for (i) supplying blood or blood plasma and its administration; (ii) artificial limbs and eyes; (iii) casts, splints, trusses, braces and

crutches; (iv) oxygen and the rental or purchase (depending upon availability) of equipment for its administration; (v) Prescription Drugs ordered in writing by a Physician and dispensed by a licensed pharmacist or Physician; and (vi) the purchase of Durable Medical Equipment (unless rental is available and the Plan determines that it will cover rental in lieu of purchase), including but not limited to wheelchairs, hospital-type beds and ventilators;

11. charges incurred in connection with home photo-therapy for newborns with jaundice;

12. charges by a board certified or licensed social worker;

13. charges for routine nursery or well-baby care in a Hospital, incurred on behalf of a covered newborn during the mother's confinement in the Hospital (notwithstanding that it is for wellness care), with the facility portion of the charges being included in the mother's benefits for the admission for pregnancy care and childbirth and subject to the mother's Calendar Year Deductible, and all other such charges being included in the newborn's benefits and subject to the newborn's Calendar Year Deductible. Charges for care and services for the newborn before discharge from the Hospital for an Illness contracted after birth or for an abnormal congenital condition caused by a premature birth will also be covered and will be included in the newborn's benefits, subject to the newborn's Calendar Year Deductible;

14. charges for the services of an oral surgeon for the removal of impacted wisdom teeth, and charges for dental treatment by a licensed dentist or dental surgeon for injuries to natural teeth resulting from an accident, including the replacement of such teeth and setting a fractured or dislocated jaw, but only to the extent such dental treatment begins within 90 days of the accident (unless a delay is Medically Necessary) and is completed within one (1) year following the accident;

15. Cosmetic Surgery but only in the following circumstances: (i) Cosmetic Surgery required as a result of injuries sustained in an accident and performed within twelve (12) months following the accident; (ii) Cosmetic Surgery required for the treatment of a congenital anomaly; and (iii) breast reconstructive surgery in connection with a mastectomy to the extent required by the Women's Health and Cancer Rights Act of 1998;

16. charges for the treatment of infertility subject to the Infertility Treatment limit set forth in the Schedule of Benefits;

17. charges for Occupational Therapy subject to the Occupational Therapy limits set forth in the Schedule of Benefits;

18. charges for Physical Therapy subject to the Physical Therapy limits set forth in the Schedule of Benefits (charges for massage therapy are not covered and do not count toward satisfaction of the Calendar Year Deductible or Out-of-Pocket Limit);

19. charges for speech therapy subject to the Speech Therapy limits described in the Schedule of Benefits;

20. charges for a routine wellness colonoscopy subject to the limits described in the Schedule of Benefits;

21. charges for or related to gastric bypass surgery or vertical sleeve gastrectomy procedure subject to the limits set forth in the Schedule of Benefits, provided the Participant obtains prior approval of coverage and satisfies all of the following conditions as evidenced by satisfactory documentation submitted to the Plan:

    (i) must be more than 100 pounds over his or her ideal body weight as defined by standardized tables generally accepted by the medical profession; and

    (ii) the duration of obesity must be more than three (3) years; and

    (iii) must satisfy at least one of the following conditions: (A) must have at least three (3) years of documented failure of medical weight loss regimes including but not limited to diet in a supervised weight loss program, exercise and behavioral techniques; (B) must have a body mass index over 50; or (C) must have a body mass index over 40 and a diagnosis of life-threatening sleep apnea, diabetes or cardiomyopathy; and

    (iv) must be free from alcohol and substance abuse for the one year period immediately preceding the proposed surgery or procedure; and

    (v) must have a pre-operative, pre-procedural evaluation by a primary care physician, and the physician must attest that he or she is medically stable and able to withstand the proposed surgery or procedure; and

    (vi) must have a pre-procedural psychological evaluation with an attestation that he or she is an appropriate candidate and likely to benefit from the procedure, and it must include a discussion and explanation of past diet habits and future commitment to diet structure which must be life-long.

    If requested by the Plan, the Participant must submit to examination by physicians and/or medical service providers of the Plan's choosing and at the Plan's expense, and the Plan may give controlling weight to their medical opinions. The Plan reserves the right to deny authorization of coverage because of existing medical conditions including but not limited to pregnancy, lactation, active substance abuse, severe or uncontrolled psychiatric disorders (such as schizophrenia, borderline personality disorder, uncontrolled depression or bi-polar disorder), or high grade malignancy within the last five years;

22. charges for medical services and supplies directly related to a non-Experimental or Investigational human organ or tissue transplant, when the Participant is the recipient

of the transplant. Covered charges will include Physician and Hospital charges, as well as charges for Prescription Drugs (including immunosuppressant drugs), coordinated home care, the purchase or rental (depending on availability) of medical appliances, oxygen and equipment directly related to the transplant, and organ or tissue acquisition costs (including surgical, storage and transportation costs), directly related to the covered transplant, except to the extent that donor benefits are available for such costs through other group coverage;

23. charges for outpatient services and supplies that are Medically Necessary and provided at a Qualified Ambulatory Surgical Facility;

24. charges for home health care incurred for the continued medical care and treatment of a Participant following hospitalization, provided the Participant is under a Physician's care, continued hospitalization would otherwise have been required if home care was not provided, and the charges qualify as Allowable Charges. Covered Charges will include charges incurred for part-time or intermittent home nursing care services performed by a licensed nurse, and medical supplies, drugs and medicines prescribed by a Physician, to the extent they would have been covered if the Participant had remained in the Hospital; and

25. if a Participant is an inpatient in a Hospital at the time Plan coverage terminates, the Plan will continue to provide benefits for Covered Expenses incurred by the Participant for services which are provided and regularly charged for by the Hospital or other facility provider in connection with such hospitalization, until the earlier of discharge or termination of the Plan.

O. CHARGES NOT COVERED

Notwithstanding any provision to the contrary, the following charges are not covered by the Plan and will not count toward satisfaction of any Calendar Year Deductible or Out-of-Pocket Limit:

1. charges that do not qualify as a Covered Expense, are not specifically covered, or are specifically excluded by the Plan;

2. charges for routine medical examinations or laboratory tests for check-up purposes that are not necessary for treatment of a specific Illness or injury, except as specifically covered (i) under the Preventive and Wellness Benefit or (ii) for routine nursery care of a covered newborn before discharge from the Hospital;

3. charges for the diagnosis and treatment of refractive errors, including but not limited to examinations to determine the need for (or changes of) eyeglasses or lenses of any type; the purchase, fitting or repair of eyeglasses or lenses of any type (except for one pair of glasses following cataract surgery); vision therapy and supplies except following an accident or Illness rehabilitation; and surgical correction of refractive errors and eye surgery that is intended to help the Participant see better without

eyeglasses or other vision correction, including but not limited to Radial Keratotomy (RK), Automated Keratoplasty (ALK), Laser In-Situ Keratomileusis (LASIK), and implantable contact lenses (ICL);

4. charges for Cosmetic Surgery of any kind and medical complications resulting from Cosmetic Surgery, unless specifically covered;

5. charges for medical care incurred as a result of an Illness or injury arising out of or in the course of the Participant's employment or entitling the Participant to benefits under any type of worker's compensation law;

6. charges for care and services relating to an injury, Illness or condition resulting from war or an act of war, declared or undeclared;

7. charge for dental procedures of any kind unless specifically covered;

8. charges incurred while the Participant is in a Hospital owned or operated by the U.S. Government, or for care and services in a Hospital for which an individual is not normally required to pay, or for care and services furnished by or payable under any plan or law of any government, Federal or State or a political subdivision thereof, unless and to the extent such exclusion is prohibited by applicable law;

9. charges for care and services for an injury, Illness or condition resulting from the commission of or attempt to commit an assault, battery, felony or act of aggression, insurrection, rebellion or riot (this exclusion does *not* include an injury, Illness or condition that results from an act of domestic violence and is required to be covered under HIPAA);

10. charges for medical or dental treatment of temporomandibular joint dysfunction or syndrome ("TMJ") which includes a variety of symptoms such as, but not limited to, masticatory muscle disorders producing severe aching pain in and about the temporomandibular or craniomandibular joint that connects the temporal bone with the mandible (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears), and hearing impairment, the cause of which may not be clearly established;

11. except as specifically covered, charges for the diagnosis and treatment of infertility and services, procedures, Prescription Drugs and devices to achieve fertility and induce pregnancy, including but not limited to charges incurred for in vitro and in vivo fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg/sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures, and reversal of sterilization procedures;

12. charges for hearing aids, cochlear implants, detachable portable monitors or stimulators, and examinations for the necessity, fitting or adjustment of the same;

13. charges for a weekend admission to a Hospital unless required by a medical emergency, or for a Hospital admission more than 24 hours before surgery unless it is Medically Necessary;

14. charges for medical services or supplies rendered or provided outside of the United States, except (i) for emergency medical care or treatment, or (ii) when provided to a Participant while on temporary work assignment at a location outside of the United States (unless otherwise specifically excluded under the Plan);

15. charges for the treatment of being overweight or obese, including but not limited to charges related to diets, prescriptions or treatment by a Physician, unless and except as specifically covered;

16. charges incurred by a Participant while enrolled in a Medicare Advantage HMO, which are considered ineligible by the HMO because the Participant received medical services from a Out-of-Network provider;

17. charges that are not Medically Necessary (including but not limited to charges for Prescription Drugs where the quantity or frequency is not Medically Necessary); charges for Custodial Care; and charges for services, supplies, drugs or devices that are determined to be Experimental or Investigational;

18. charges for the treatment of learning disabilities, except that Covered Expenses incurred for Attention Deficit Disorder ("ADD") and Attention Deficit Disorder with Hyperactivity ("ADHD”), to the extent classified as Mental and Nervous Disorders pursuant to generally recognized independent standards of current medical practice, will be covered in the same manner as any other Illness subject to the limits described in the Schedule of Benefits;

19. charges for massage therapy, rolfing and related services;

20. charges for group therapy or mental health services related to any of the following: adoption counseling; court-ordered services; custody counseling; developmental disabilities; family planning counseling; marriage, couples or sex counseling; mental retardation; pregnancy counseling; and transsexual counseling;

21. charges for medical, surgical or Prescription Drug treatment for transsexual/gender reassignment (sex change) procedures, preparation for such procedures and complications arising from such procedures;

22. charges for elective reversal of gastric bypass surgery, biliopancreatic diversion with duodenal switch, laproscopic duodenal switch, mini-gastric bypass, or vertical sleeve gastrectomy procedure

23. charges incurred by a Participant for the medical care of an injury or Illness for which a third party is liable due to negligence or wrongful action, provided that pending a determination whether a third party is responsible for the payment of such charges due to the third party's negligence or wrongful action, the Plan may advance or make payment to or for the Participant in an amount equal to the benefits otherwise payable under the Plan in the absence of such third party liability, subject to the Plan's subrogation, reimbursement and recovery rights;

24. charges for "Hospice Care", which means any of the following types of services given to a patient with a life expectancy of six months or less ("terminally ill patient"), or to his or her family: (i) palliative care, which is care that is rendered to relieve the symptoms or effects of an Illness without curing the Illness; (ii) respite care, which is care that is furnished to a patient so that the family or caregivers may have relief from the stress of caring for such patient; (iii) counseling furnished to the terminally ill patient or his or her family to assist in coping with the dying process; and (iv) other supportive health care services providing physical, psychological, social or spiritual care for the terminally ill patient or his or her family, when medical treatment and cure-oriented services are no longer medically appropriate due to the terminal condition;

25. charges for air conditioners, filters, dehumidifiers, air purifiers, heating pads, home enema equipment, swimming pools, saunas, whirlpool baths, home pregnancy tests, foods and nutritional supplements (except when provided during hospitalization), and any other items not normally considered medical supplies;

26. charges for construction or modification of a home or vehicle required as a result of a Participant's injury, Illness or disability;

27. charges for hair transplantation and other procedures to replace lost hair or promote the growth of hair, for Prescription Drugs or medicines used to promote the growth of hair, and for hair replacement devices including but not limited to wigs, toupees and hairpieces;

28. charges for the services of private duty nurses;

30. charges for educational, job training or vocational rehabilitation;

31. charges for memberships in or visits to health clubs, exercise programs, gymnasiums and any other facility for physical fitness programs, exercise equipment or weight training services;

32. charges for genetic tests;

33. charges for non-Prescription Drugs (other than injectable insulin), and charges for prenatal vitamins and minerals regardless of whether they require a prescription;

34. charges for services provided by a Physician or other health care provider who is the parent, spouse, sibling (by birth or marriage) or child of the Participant;

35. charges for missed appointments, the preparation of forms, mailing, interest, late fees, mileage or provider administration; and

36. charges for non-human organ or tissue transplants, for organ or tissue transplants that are Experimental or Investigational, and for non-Experimental or Investigational human organ or tissue transplants except to the extent specifically covered by the Plan.

COORDINATION OF MEDICAL BENEFITS

The Plan has "coordination of benefit" rules that apply whenever you or your Dependent has "other plan" coverage in addition to coverage under this Plan. You and your Dependent must promptly notify the Fund Office of the other coverage so that the Plan can apply these rules in processing and paying claims for medical benefits.

The term "other plan" means any of the following types of coverage that provide benefits or services for hospital, medical, dental or vision care: (a) group or blanket insurance or arrangement of coverage for individuals in a group (whether insured or uninsured), including employer plans, Blue Cross and Blue Shield plans and HMO plans (but excluding blanket school accident coverage, Little League coverage or similar coverage); (b) prepayment coverage provided on a group basis; (c) coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, employee benefits organization plan or any other benefit arrangement for individuals of a group; and (d) coverage under governmental programs and or required by statute, other than Medicaid and as otherwise prohibited by law. "Other plan" will not include any individually purchased health or hospitalization insurance.

Coordination of benefits is a concept of anti-duplication. It provides that if an individual is covered by two or more group health plans, the amount of benefits payable under this Plan and the other plan(s) will be coordinated so that the total amount paid is not greater than 100% of the "Allowable Expense". An "Allowable Expense" is the necessary, reasonable and customary expense for medical services, treatment or supplies, which is covered at least in part under this Plan and under the other plan(s).

Under coordination of benefits, payment is made on a primary-secondary basis. The primary plan will calculate its benefits and pay first without regard to the other plan. The secondary plan will then reduce benefits as needed, taking into account the amount paid by the primary plan, so that the total benefits paid or provided by all plans do not exceed 100% of the Allowable Expense. If a plan has no limitation against payments made under any other plan, it will be considered the primary plan and pay first regardless of the primary-secondary ranking. No plan will pay more than it would have paid if no other plan was involved. If benefits are being coordinated and this Plan is the primary plan, the Out-of-Pocket Limit under this Plan will not apply to Allowable Expenses.

The coordination of benefits rules and the coordination rules that apply when Medicare is involved, are lengthy and detailed. If you have questions or would like specific information about the rules, please contact the Fund Office.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

A. ESTABLISHMENT OF HRA

The Plan includes what is known as a "Health Reimbursement Arrangement" or "HRA". It is funded by the Employer and allows covered Employees to be reimbursed for eligible Medical Expenses incurred by them or their Dependents on a non-taxable basis.

This is how the HRA works. Solely for record-keeping purposes, a HRA account is established and maintained for each covered Employee. It reflects the Employer contributions credited to the Employee's HRA account each year and the Medical Expense reimbursements subtracted from the Employee's HRA account as they are paid to the Employee. The Plan will NOT create a separate fund or segregate assets for the HRA. Employees have no vested interest in their HRA accounts, and the Trustees reserve the right to amend or terminate the HRA at any time and for any reason.

B. ELIGIBILITY TO PARTICIPATE IN HRA

All Employees who are covered by the Plan as a result of active employment with an Employer (other than self-employed individuals and owner-operators who are prohibited by federal law from participating), are eligible to participate in the HRA.

An Employee's participation in the HRA begins when he or she initially become covered by the Plan, and continues until the earliest of the following to occur: (i) the date the active Employee's coverage under the Plan ends (taking into account any Dollar Bank account but excluding extended coverage through COBRA or a self-payment provision); (ii) the date the HRA is terminated; or (iii) the effective date of the Employee's election to permanently opt out of and waive participation in the HRA. The right to permanently opt-out of and waive participation in the HRA is exercisable by written notice to the Administrative Manager at the Fund Office. If an Employee exercises this option, the Employee will forfeit any remaining balance credited to his or her HRA account without right of reinstatement, and Employer contributions will no longer be credited to it. This opt out and waiver option may be useful to Employees who terminate employment, want to buy individual health insurance through the Health Insurance Marketplace, and would otherwise qualify for a premium tax credit but for continued participation in the HRA.

C. SOURCE OF CONTRIBUTIONS AND CREDITING/DEBITING OF ACCOUNTS

Only Employer contributions may be credited to HRA accounts. Employee contributions are not allowed. Before each calendar year begins, the Trustees will determine the amount of Employer contributions (if any) to be credited to HRA accounts for the calendar year. Employees who are

Participants at the beginning of the calendar year will have their HRA accounts credited with their share of the amount determined for the calendar year. Employees who are not Participants at the beginning of the calendar year but become Participants during the calendar year, will have a HRA account established at that time and credited with their pro rata share of the amount determined for the calendar year.

Formula for determining a participating Employee's HRA account credit for Employer contributions for each calendar year:

Employer contribution credit amount for calendar year as determined by Trustees / 12	X	No. of months Employee participated in Plan for prior calendar year

Examples of how this formula works:

1. Assume an Employee is a Participant in the Plan on January 1, 2020 and was a Plan Participant for all of 2019. If the Trustees establish $1,000 as the Employer contribution HRA credit for the calendar year 2020, the Employee's HRA account will be credited with $1,000 as of January 1, 2020;

2. Assume an Employee's participation in the Plan begins on January 1, 2020, with no participation during 2019. In this case, the Employee's HRA account will be credited with "0" as of January 1, 2020; and

3. Finally, assume an Employee was a Plan Participant for six months during 2019 but was not a Plan Participant on January 1, 2020. The Employee then works enough hours to have his or her Plan coverage reinstated on June 1, 2020. At that time, the Employee's HRA account will be credited with $500 (i.e., $1,000 (the maximum Employer contribution HRA credit for 2020) X 6 /12 (the number of months of Plan participation in 2019 over a total of 12 months)).

All reimbursements payable under the HRA are payable from the general assets of the Fund. No amounts will be segregated for an individual's benefit. No one shall have a claim against, right to, or security interest in, any account or asset of the Fund. The HRA reimbursement right may not be assigned or alienated.

The amount credited to an Employee's HRA account will be reduced if and as reimbursements are made for eligible Medical Expenses incurred by the Employee or the Employee's Dependents and submitted to the Plan for reimbursement. The amount available for reimbursement at any time is the remaining balance credited to the Employee's HRA account (i.e., the cumulative Employer contributions credited to the HRA account minus the cumulative reimbursements debited from the HRA account). If there is any balance remaining in the HRA account at the end of a calendar year, it will be

carried over to the following calendar year and remain available for reimbursements, provided the Employee's participation in the HRA continues.

See Section G, "Reimbursements After Termination", for a discussion of what happens when participation terminates.

D. ELIGIBLE MEDICAL EXPENSES

An Employee may use his or her HRA account solely to obtain reimbursement for eligible Medical Expenses incurred by the Employee or the Employee's Dependents while covered under the HRA. It may not be cashed out or used to provide any other taxable or nontaxable benefit.

"Medical Expenses" are expenses incurred by the Employee or the Employee's Dependents for medical care within the meaning of Code Section 213. This includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body, as well as self-payments for COBRA or other extended self-payment coverage under the Plan.

A Medical Expense is reimbursable from the HRA account ONLY to the extent that the Employee or Dependent has not already been reimbursed for it, and ONLY to the extent that it is not reimbursable through the Plan, other insurance, or another accident or health plan arrangement. If only a portion of the Medical Expense has been reimbursed or is reimbursable elsewhere, the unreimbursed (and unreimbursable) portion may be reimbursed under the HRA account.

A Medical Expense is "incurred" at the time the medical care or service giving rise to the expense is furnished, and not when the person is formally billed or pays for it. Medical Expenses that are incurred before the date the Employee or Dependent becomes eligible to participate in the HRA are not eligible for reimbursement.

The following expenses are NOT eligible for reimbursement under the HRA, even if they meet the definition of "medical care" under Code Section 213 and would otherwise be reimbursable under IRS guidance pertaining to HRAs: (a) amounts paid for any employee or group insurance coverage other than COBRA and extended coverage self-payment amounts under the Plan; (b) expenses for long-term care services; (c) expenses for drugs and medicines that are available without a prescription (e.g., antacids, pain relievers, allergy medications and cold medicines); and (d) expenses for any item that does not meet the definition of "medical care" as defined under Code Section 213 and related IRS regulations and bulletins.

E. REIMBURSEMENT PROCEDURE

In order to obtain reimbursement from the HRA account, the Employee must submit a written claim to the Fund Office, no later than March 31 after the end of the calendar year in which the Medical Expense is incurred. The claim must be submitted on the Plan's HRA reimbursement request form (these are available without charge upon request to the Fund Office). It must include the following information: (a) the name of the person on whose behalf the Medical Expense is incurred; (b) the nature of the

Medical Expense and date it was incurred; (c) the reimbursement amount requested; and (d) a statement that the Medical Expense has not otherwise been reimbursed and is not reimbursable through any other source.

Employees must also submit bills, invoices or other statements from an independent third party (such as an Explanation of Benefits from the insurance company), showing the amount of the Medical Expense incurred, and any other documentation requested by the Plan to substantiate the claim. Except for the final reimbursement claim for a calendar year or when participation has terminated, reimbursement claims may not be submitted more often than once every three months, or for reimbursement amounts of less than $100. At the end of each calendar year, all remaining reimbursement claims may be submitted regardless of the amount or date the last claim was filed.

F. REIMBURSEMENT BY THE PLAN

Within 30 days after the Plan receives a reimbursement claim, it will provide the claimant with reimbursement if the claim is approved, or written notice explaining why the claim has not been approved. This 30-day response period may be extended for up to 15 days for matters beyond the Plan's control, provided the claimant is notified in writing of the extension and why it is needed before this 30-day period ends. If the claim is incomplete, the claimant will be given 45 days to submit what is needed.

If a reimbursement claim is denied in whole or part, the claimant may appeal the denial and receive a full and fair review in accordance with the Plan's Claims Review Procedure. It will be treated as a Post-Service Claim.

G. REIMBURSEMENTS AFTER TERMINATION

If an Employee's participation in the HRA ends because of (i) failure to satisfy the eligibility requirements for active Employees or (ii) termination of the HRA, the Employee may receive reimbursement from any remaining HRA account balance, for eligible Medical Expenses incurred by the Employee or the Employee's Dependents during the period of participation or within 12 months after it ends. If participation in the HRA ends because of the Employee's death, or if the Employee dies within 12 months after his or her participation ends under (i) or (ii) above, the Employee's Dependents or estate may claim reimbursement from any remaining balance for eligible Medical Expenses incurred before death, or incurred by the Dependents within 12 months after the Employee's participation ends.

All persons submitting claims for reimbursement must follow the claims filing requirements described in Section E, "Reimbursement Procedure". Claims must be filed by March 31 after the end of the calendar year in which the eligible Medical Expense was incurred. **Failure to submit a claim timely will result in forfeiture of the right to obtain reimbursement.**

If an Employee's participation in the HRA ends and is not reinstated within 12 months, any remaining HRA account balance (at the end of such 12-month period) will be forfeited and cannot be reinstated. If participation is reinstated within 12 months after it ends, any remaining HRA account balance will remain as if participation had never ended.

However, if participation in the HRA ends because of the Employee's election to permanently opt out of and waive participation in the HRA, any remaining HRA account balance will be forfeited without right of reinstatement.

H. COORDINATION OF BENEFITS

HRA accounts are available only for reimbursement of eligible Medical Expenses that have not previously been reimbursed and are not reimbursable elsewhere. If an otherwise eligible Medical Expense is payable or reimbursable from another source, the other source must make the payment or reimbursement first before the Medical Expense is eligible for reimbursement from the HRA.

I. TAX CONSEQUENCES AND CORRECTION OF MISTAKES

The Plan makes no guarantee that any amount reimbursed under the HRA account is excludable from gross income for federal, state or local income tax purposes. It is the claimant's obligation to determine if reimbursement payments received through the HRA account are excludable from gross income, and to notify the Fund Office immediately if the claimant has any reason to believe that a reimbursement payment is not excludable.

If a reimbursement claim is submitted and paid through the HRA account and the payment does not qualify for tax-free treatment under the Code, the claimant will be required to indemnify and reimburse the Fund for any liability it incurs for failure to withhold taxes.

If there is a mistake regarding an Employee's HRA participation, HRA account allocations or HRA account reimbursements, the Plan reserves the right to make any adjustments it deems proper to correct the mistake, to the extent administratively possible and legally permissible.

J. NONDISCRIMINATION

Reimbursements to "highly compensated individuals", within the meaning of Code Section 105(h), may be limited or treated as taxable compensation to comply therewith, as determined by the Trustees. It is not anticipated that the nondiscrimination requirements under Code Section 105(h) will affect any Participants.

CLAIMS PROCEDURE AND CLAIMS REVIEW PROCEDURE

A. CLAIMS RELATED DEFINITIONS

The following terms will have the meaning indicated for purposes of the Plan's Claims Procedure and Claims Review Procedure.

1. "**Concurrent Care Claim**" means a claim for an ongoing course of treatment over a period of time or number of treatments that is being reconsidered after the original pre-authorization and before the end of the initial course of treatment.

2. “**Death/AD&D Claim**” means a claim for Life Insurance or Accidental Death and Dismemberment Benefits.

3. “**Denial”** means any denial, reduction, termination, or failure to provide or make payment, in whole or part, of a claimed benefit under the Plan. It also includes a retroactive cancellation of coverage other than for failure to pay a required self-payment.

4. “**Disability Claim**” means a claim for benefits that is conditioned on a determination of disability made by the Plan, and not by a party other than the Plan for non-Plan purposes. If the Plan is relying on a determination of disability made by a party other than the Plan for non-Plan purposes, the claim will instead be treated as a Death/AD&D Claim for purposes of the response time periods.

5. “**Post-Service Claim**” means any claim for medical benefits that is not a Pre-Service Claim.

6. “**Pre-Service Claim**” means a claim for medical benefits for which the Plan conditions coverage, in whole or in part, on approval before receipt of the services or treatment.

7. “**Urgent Care Claim**” means a claim for medical care or treatment where application of the normal time periods for pre-service authorization could seriously jeopardize the claimant’s life, health or ability to regain maximum function, or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The opinion of the treating Physician that a claim qualifies under either condition described will be accepted by the Plan.

B. WHEN AND WHERE TO FILE CLAIMS AND PROOF OF LOSS

In order to receive benefits under the Plan, Participants and Beneficiaries, or an authorized representative on their behalf, must file a written notice of claim and proof of loss, in a form that is acceptable to the Plan, to the Fund Office (unless otherwise directed in writing by the Trustees), within the following time periods.

1. **Claims for Life Insurance and Accidental Death and Dismemberment Benefits:** Claims must be filed within 90 days after the death or occurrence or commencement of loss, or if it is not reasonably possible to do so, as soon as reasonably possible; and

2. **Claims for Medical Benefits:** Claims must be filed within 90 days after the date the expense to which the claim relates was incurred, or if it is not reasonably possible to do so, as soon as reasonably possible but in no event later than 12 months after the date the expense was incurred.

C. HOW TO FILE CLAIMS

Claims must be filed in the following manner.

1. **Claims for Life Insurance and Accidental Death and Dismemberment Benefits:** The completed claim form and proof of loss must include all information necessary to determine the nature, extent and date of the loss (including a certified copy of the death certificate and the decedent's Social Security Number in case of death), and any additional information required by the Plan (for example, an authorization to obtain medical and nonmedical information).

2. **Claims for Medical Benefits:** At the start of each calendar year, the Fund Office will send each Participant an initial claim form for the calendar year. This form must be completed by the Participant for each covered family member and returned to the Fund Office (or as otherwise directed on the claim form) before the Plan will pay any medical benefits for the calendar year.

   After the initial claim form is submitted, a Participant will only need to submit additional medical benefit claim forms when an accident-related expense is incurred or when disability coverage or benefits are claimed. All non-accident related medical benefits claims that are made during the year do not require the submission of a new claim form. The health care provider must submit sufficient information for the claim to be processed, and it will be paid by the Plan if covered. If the claimant or provider communicates with a person in the Fund Office who customarily handles medical benefit matters about a potential Pre-Service Claim and identifies a specific claimant, medical condition or symptom, and a specific treatment or service for which approval is requested but does not fully comply with the Claims Procedure, the claimant or provider will be notified of the failure and of what is needed within five (5) days, or within 24 hours for an Urgent Care Claim. Notification may be oral unless otherwise requested.

3. **Services Requiring Pre-Certification**: Please remember that certain non-emergency and non-maternity inpatient procedures and other services and care, as described in the Schedule of Benefits, require pre-certification by the Plan's utilization review company. All emergency Hospital admissions require certification by the Plan's utilization review company within 48 hours of admission. These requirements apply regardless of whether a claim form has been or must be submitted.

Claim forms may be obtained from the Fund Office, without charge, by writing or telephoning:

Electricians Health and Welfare Plan, IBEW 995
8111 Tom Drive
Baton Rouge, Louisiana 70815
(225) 927-6340

Anyone with questions about the coverage and medical benefits available under the Plan should contact the Fund Office for additional information.

D. CLAIMS PROCEDURE

Each claim that is filed as provided above will be processed for a determination as to the amount (if any) that is covered under the Plan, without regard to whether all necessary information accompanies the filing. For Disability Claims under review at the initial review level or appeals level, Plan decisions about hiring, compensation, termination, promotion or similar matters with respect to a medical or vocational expert or other person in connection with the review will not be based on the likelihood that he or she will support a Denial of such claim.

The claimant will be notified of the determination in accordance with the following provisions.

1. **For Death/AD&D Claims:** Notice will be given within 90 days after the claim is filed. This response period may be extended for up to 90 days if necessary due to matters beyond the reviewer's control, provided the claimant is notified, before the initial period ends, of the extension, why it is needed and when a decision will be made. The Trustees may delegate their discretionary authority to determine claims involving insured benefits to the Insurer or to any other person or entity.

2. **For Urgent Care Claims:** Notice will be given as soon as possible taking into account the medical exigencies, but no later than 72 hours after the claim is filed (claims that are intended to qualify as Urgent Care Claims should be identified as such when filed). If additional information is needed to make a determination, notice describing the specific information needed will be given, as soon as possible and within 24 hours after receipt of the claim, with a response deadline of at least 48 hours. Notification of the determination will then be given as soon as possible and within 48 hours after receipt of the requested information or, if earlier, the response deadline.

3. **Concurrent Care Claims:** Notice of any proposed reduction or termination of a pre-approved course of treatment will be given sufficiently in advance to allow an appeal before the treatment is reduced or terminated. If the appeal qualifies as an Urgent Care Claim, it will be decided as soon as possible taking into account the medical exigencies.

4. **Pre-Service Claims:** Notice will be given within 15 days after the claim is filed. This response period may be extended for up to 15 days if necessary due to matters beyond the Plan's control, provided the claimant is notified, before the initial period ends, of the extension, why it is needed and when a decision will be made. If applicable, the notice will describe any additional information that is needed and allow the claimant at least 45 days to respond.

5. **Post-Service Claims:** Notice will be given within 30 days after the claim is filed. This response period may be extended for up to 15 days if necessary due to matters beyond the Plan's control, provided the claimant is notified, before the end of the initial 30-day period, of the extension, why it is needed and when a decision will be made. If applicable, the notice will describe any additional information that is needed and allow the claimant at least 45 days to respond.

6. **Disability Claims:** Notice will be given within 45 days after the claim is filed. This response period may be extended initially for up to 30 days, and again for another 30 days, but only if necessary and the claimant is notified before the end of the 45-day period or first 30-day extension (as applicable) of the extension and the following information: (i) why it is needed; (ii) when a decision will be made; (iii) the standards on which entitlement to the benefit will be based; and (iv) the unresolved issues and additional information needed to resolve those issues, with at least 45 days to provide the information.

Whenever an extension of time is needed to decide a Pre-Service Claim, Post-Service Claim or Disability Claim because additional information is needed from the claimant, the Plan's response period will be suspended (or tolled) from the date notice is given to the claimant until the claimant responds or, if earlier, the claimant's response deadline. Voluntary extensions of time may be agreed to by the parties.

If a claim is Denied, written notice of the following information will be given to the claimant, and for Disability Claims the notice will be provided in a culturally and linguistically appropriate manner calculated to be understood by the claimant:

(a) the specific reason(s) for the Denial;

(b) a reference to the specific Plan provision(s) on which the Denial is based;

(c) a description of any additional material or information necessary to perfect the claim and the reasons why it is needed;

(d) a copy of the Claims Review Procedure;

(e) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) if benefits are Denied after review;

(f) for all claims other than Death/AD&D Claims, the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Denial or, alternatively, a statement that such rules, guidelines, protocols, standards or similar criteria do not exist;

(g) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

(h) for all claims other than Death/AD&D Claims, if the determination is based on medical necessity or experimental treatment or a similar exclusion or limit, notice that it was relied upon and that a copy is available free of charge upon request;

(i) if the determination concerns an Urgent Care Claim, a description of the expedited review process. Notice may be given orally within the prescribed time period, provided written notice is furnished to the claimant within three days after oral notification;

(j) Information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable) and a description of the availability, upon request, of the diagnosis and treatment codes and their meaning;

(k) For Disability Claims where proof of disability has not been established: (1) a discussion of the decision including an explanation of the basis for disagreeing with or not following the views of the claimant's treating health care professionals and evaluating vocational professionals, the views of medical or vocational experts whose advice was obtained on the Plan's behalf regardless of whether it was relied upon, and the Social Security Administration's disability determination if presented to the Plan; and (2) the Plan's specific internal rules, guidelines, protocols, standards or similar criteria relied upon in making the determination or a statement that they do not exist.

E. CLAIMS REVIEW PROCEDURE (APPEALS)

If a claim is Denied on the initial filing, the claimant may appeal the determination and receive a full and fair review in accordance with the Plan's Claims Review Procedure, which is described below.

In order to appeal a Denial, the claimant must file a written request for review with the Fund Office (or as otherwise instructed in the notice of Denial) within the following time periods (for Urgent Care Claims, Pre-Service Claims, and Concurrent Care Claims that qualify as such, the request for review may also be made by calling the Fund Office or other appropriate party): (i) for Death/AD&D Claims, within 60 days after receipt of the Denial, and the appeal will be forwarded to the reviewer for a determination; and (ii) for all other claims, within 180 days (or a reasonable period of time for a Concurrent Care Claim) after receipt of the Denial, and the appeal will be determined by the Trustees (or other appointed reviewer). *If a request for review is not filed timely as required, the initial decision on the claim will be final.*

If the request for review is filed timely, the claimant may submit written comments, documents, records and other information, and obtain, upon request and free of charge, reasonable access to and copies of all documents, records and information relevant to the claim. The claimant may also obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. The reviewer on appeal will take into account all comments, documents, records and information submitted by the claimant and relating to the claim, without regard to whether it was submitted or considered in the initial determination.

For appeals of claims other than Death/AD&D Claims, the claimant may obtain the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the initial determination, without regard to whether it was relied upon.

The review on appeal will comply with the following requirements:

1. for all claims other than Death/AD&D Claims, no deference will be given to the initial determination;

2. for benefits that are insured and provided through an insurance policy, the review will be conducted by the Insurer unless otherwise provided by the policy. For all other claims, the review will be conducted by the Trustees or the person(s) or entity designated by the Trustees as the appropriate named fiduciary to consider and decide the appeal, provided that the reviewer on appeal is not the same person(s) or entity that made the initial determination or a subordinate thereof;

3. for claims other than Death/AD&D, if the initial determination is based in whole or part on medical judgment (for example, it involves issues of Medical Necessity or whether a treatment or drug is Experimental or Investigational), the reviewer will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment, who was not consulted and is not a subordinate of a health care professional who was consulted, in connection with the initial determination;

4. provide for the identification of medical or vocational experts whose advice was obtained on the Plan's behalf without regard to whether it was relied upon in making the benefit determination;

5. for Urgent Care Claims or Concurrent Care Claims that qualify as such, all necessary information and the review process may be transmitted and handled by telephone, facsimile or other expeditious method; and

6. Before Denying a Disability Claim on review because of a failure to establish disability, the claimant will be provided with the following information free of charge:

   (i) any new or additional evidence considered, relied upon, or generated by the Plan, or by the Insurer or other person making the disability determination for the Plan. The evidence will be provided as soon as possible and sufficiently in advance of the date on which notice of Denial on review is required to be provided to give the claimant reasonable opportunity to respond before that date; and

   (ii) before the Plan can issue a Denial on review based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which notice of Denial on review is required to be provided to give the claimant reasonable opportunity to respond before that date.

A decision will be made within a reasonable period of time after receipt of a timely filed appeal, without regard to whether all necessary information accompanies the filing, and in accordance with the following time periods. Concurrent Care Claims will be determined within the time period applicable to the nature of the claim.

1. **Death/AD&D Claims**: Notice of the decision on appeal will be given within a reasonable period of time and within 60 days after receipt of the appeal. This response period may be extended for up to 60 days if needed due to special circumstances, provided the claimant is notified in writing, before the initial period ends, of the extension, why it is needed and when a decision will be made.

2. **Urgent Care Claims**: Notice of the decision on appeal will be given as soon as possible taking into account the medical exigencies, and within 72 hours after receipt of the appeal.

3. **Pre-Service Claims**: Notice of the decision on appeal will be given within 30 days after receipt of the appeal.

4. **Post-Service Claims and Disability Claims**: The appeal will be considered and decided no later than the first regularly scheduled meeting of the Board of Trustees that immediately follows receipt of the appeal. If it is received within 30 days before such meeting, the Board of Trustees will have until the next Board meeting in which to consider and decide the appeal. If more time is needed due to special circumstances, a further extension until the following Board meeting may be taken provided the claimant is notified, in writing, of the extension before it begins and also of the special circumstances and when a decision will be made. Notice of the decision on appeal will be given to the claimant as soon as possible and within five (5) days after it is made. If an extension is taken because additional information is needed from the claimant, the time period for deciding the appeal will be suspended (or tolled) from the date notice is given to the claimant until the claimant responds, or if earlier until the claimant's deadline to respond. Voluntary extensions of time may be agreed to by the parties.

The reviewer on appeal will provide the claimant with written notification of the benefit on review. If the claim is Denied on appeal, the notification will include the following information in a manner calculated to be understood by the claimant:

(a) the specific reasons for the Denial;

(b) a reference to the specific Plan provisions on which the determination is based;

(c) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim and a statement of the claimant's right to bring an action under ERISA Section 502(a);

(d) for all claims other than Death/AD&D Claims, any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Denial or a statement that it was relied upon and that a copy will be provided free of charge upon request;

(e) for all claims other than Death/AD&D Claims, if the Denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request; and

(f) a statement describing any voluntary alternative dispute resolution options (such as mediation) that are available, and that the claimant may contact the local Department of Labor office or the state insurance regulatory agency to determine what options might be available; and

(g) for Disability Claims Denied because the claimant failed to establish satisfactory proof of disability:

(i) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (1) the views presented to the Plan of the claimant's treating health care professionals and evaluating vocational professionals; (2) the views of medical or vocational experts whose advice was obtained on the Plan's behalf in connection with the Denial without regard to whether it was relied upon in making the determination; and (3) any Social Security Administration disability determination presented to the Plan;

(ii) any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(iii) a description of any contractual limitations period that applies to the claimant's right to bring legal action, including the calendar date on which the limitations period ends for the claim.

A decision on review of any claim made under the Plan in accordance with the Claims Review Procedure will be final and binding on all persons.

F. TIME LIMIT ON LEGAL ACTION

Before legal action, such as filing a lawsuit, may be brought by or on behalf of an Employee, Dependent or Beneficiary to receive benefits under the Plan, all of the requirements of the Claims Procedure and Claims Review Procedure under the Plan must first be followed and timely exhausted. Once these administrative procedures under the Plan are timely exhausted and there is a final decision on the claim, there is a one year time limit for bringing legal action with respect to such claim. If the claim involves a benefit that is insured and payable by an Insurer under an insurance policy purchased by the Fund, the time limit for bringing legal action with respect to such insured benefit will be the time limit set forth in the insurance policy if it is different from the Plan's one year period.

PLAN AMENDMENT AND TERMINATION

The Trustees reserve the right to amend and terminate the Plan, and to merge with any other fund established for similar purposes (subject to compliance with any legal limits that apply). This right is exercisable by the Trustees, in whole or part and at any time, in their sole discretion. It includes, for example but not limitation, the right to reduce or terminate eligibility, benefits or coverage, or to alter or postpone the method of paying benefits.

Any changes that are authorized by the Trustees will take effect on the date specified. The changes will apply to all affected Participants without regard to status, illness or injury in effect before the date of change, and without regard to future medical care or services required because of an illness, injury or condition occurring before the date of change. Eligibility and benefits under the Plan are not guaranteed and are subject to change at any time.

In the event of a Plan termination, the Board of Trustees will, within the limits of the remaining Fund assets, adopt a plan to discharge all outstanding obligations and provide that all remaining assets be used in a manner which best carries out the basic purpose for which the Plan was established, or are otherwise disposed of in a manner that is consistent with applicable law.

PLAN'S SUBROGATION, REIMBURSEMENT AND RECOVERY RIGHTS

The Plan will have subrogation, reimbursement and recovery rights for medical benefits that it advances or pays for a Participant, for an Illness or injury that results or is alleged to result from a third party's negligence or wrongful action, or for which worker's compensation benefits are payable or allegedly payable. In order to recover any such benefits that are paid, the Plan will have all claims, demands, actions and rights of recovery that the Participant has against a responsible third party or its insurer (or against the Participant's own insurer, such as pursuant to uninsured motorist or homeowner's coverage), because of the alleged negligence or wrongful action or for worker's compensation benefits that are payable. The Plan may condition payment of benefits upon execution of its subrogation, assignment and reimbursement agreement, certifying that: (a) no other payments have been made in satisfaction of the claim(s); (b) the claim(s) are disputed; (c) the responsible third party is withholding payment pending resolution of the dispute; and/or (d) any additional provisions required by the Plan. The Plan may require a Participant to sign such agreement before receiving benefits or at any time thereafter pending recovery of benefits.

In addition, any benefits paid by the Plan for which there may be third party liability or worker's compensation benefits payable will be made on the condition and with the understanding that the Plan will be reimbursed from any recovery with respect thereto, and that the Participant is obligated to comply with the following requirements:

1. to reimburse the Plan out of the first proceeds of any recovery or settlement payable by the responsible third party, the responsible third party's insurer, or the Participant's insurer with respect to such third party liability, or pursuant to worker's compensation law, whether by way of litigation, settlement or otherwise and regardless of how the

proceeds are characterized (e.g., as payment for pain and suffering, lost income, medical benefits or other specified damages). The Plan's right of recovery will be a prior lien against such proceeds and will not be defeated or reduced by the application of any make-whole or other doctrine that allocates the proceeds to non-medical expense damages;

2. to reimburse the Plan from any gross amount recovered before payment of attorneys' fees and costs;

3. to cooperate fully with the Plan, to execute and provide all requested documents and information requested by it to protect, enforce and facilitate its subrogation, reimbursement and recovery rights, and not to take any action that would interfere with its rights;

4. to recognize that the Plan has no obligation to pay any amounts spent by the Participant or the Participant's attorneys in attorneys' fees and costs of litigation in pursuing claims against others;

5. to reimburse the Plan and make it whole for all attorneys' fees and costs spent by the Plan in pursuing litigation or other actions, in whatever forum, to enforce the terms of the Plan and the Plan's subrogation, reimbursement and recovery rights;

6. to notify the Plan before starting legal action or filing a lawsuit against a third party that is allegedly liable or an insurer with respect thereto, and to make no settlement and grant no release without the prior written consent of the Plan;

7. to acknowledge the Plan's rights and allow the Plan to intervene in any claim or action taken against an allegedly liable third party or insurer; and

8. to protect the Plan's subrogation, reimbursement and recovery rights and do nothing that would in any way prejudice such rights.

If a Participant refuses or fails to comply with these obligations, to cooperate as required or to reimburse the Plan after receiving payment of sums due to the Plan, the Plan may take legal action to recover the benefits paid, and it may also withhold payment of other benefits due under the Plan for related or unrelated claims as an offset against the amounts owed.

The Plan's subrogation, reimbursement and recovery rights described in this Section will apply equally to any benefits paid by the Plan in error for any reason, including but not limited to false or erroneous representations made by the Participant, a provider or other third party, as well as a Participant's failure to notify the Plan as required (for example, failure to notify the Plan of a change in address or Dependent status, or of any other change that affects coverage). If the Plan makes an improper payment for any of these reasons and does not recover the payment after notice and demand to the recipient, the Participant will be obligated to reimburse the Plan for the improper payment, and

the Plan may take legal action to recover the benefits paid and/or withhold payment of other benefits payable under the Plan for the Employee or the Employee's Dependents for related or unrelated claims, as an offset against the amounts owed.

MISCELLANEOUS

A. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A "QMCSO" is a medical child support order or National Medical Support Notice that qualifies as a QMCSO, within the meaning of ERISA Section 609(a). The purpose of a QMCSO is to give a participating Employee's child, who is not otherwise covered, the right to enroll in the Plan.

A "medical child support order" is generally a judgment, decree, or order that is issued by a court of competent jurisdiction, and provides for child support or health benefit coverage for an Employee's child. It must describe the name and last known mailing address of the participating Employee and child who is covered by the order; the type of coverage that is to be provided by the Plan to the child (or manner in which it is to be determined); the period for which coverage is to be provided; and the name of this Plan. The order cannot require the Plan to provide any type or form of benefit or option that it does not otherwise provide. National Medical Support Notices, which are notices issued by an appropriate agency of a state or local government, may also qualify as a QMCSO. National Medical Support Notices are generally sent by the agency to the Employer. The Employer should promptly forward any such notices it receives to the Fund Office for handling.

Upon receipt of a medical child support order or National Medical Support Notice, the Plan will promptly notify the affected Employee and child and, if applicable, the issuing state or local agency, of its receipt and the Plan's administrative procedures for determining if it qualifies as a QMCSO. They will also be notified of the Plan's determination as soon as it is made.

Participants may obtain a copy of the Plan's QMCSO procedures, free of charge, upon request to the Fund Office. These procedures explain in greater detail the requirements for a QMCSO, the actions to be taken by the Plan, and how a determination will be made.

B. ASSIGNMENT OF MEDICAL BENEFITS

A Participant may assign medical benefits payable under the Plan only to a Physician, Hospital or other medical provider, if it is done in writing on a form acceptable to the Plan. The assignment must be received by the Plan before the "assigned" benefits are paid. An assignment will be without legal effect with respect to medical benefits that have been paid before the Plan's receipt and acceptance of the assignment.

C. MEDICAL EXAMINATION

Medical examinations are not required as a prerequisite for enrollment in the Plan. The Plan may require, at its expense and in connection with a pending claim, that the person, who is the subject of the pending claim, submit to a medical examination by a Physician of the Plan's choosing. The Plan may

also require, in connection with a claim involving death, that an autopsy be performed at the Plan's expense provided it is not forbidden by law.

D. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan may release and obtain, to and from any insurance company, provider or other person or entity, information which it deems necessary to administer and implement the terms of the Plan, without consent or notice to anyone.

E. APPLICABLE LAW

The laws of the State of Louisiana will govern this Plan, except as to matters governed by federal law.

IMPORTANT INFORMATION ABOUT THE PLAN

The following information concerning the Plan is being provided to you in accordance with the federal law known as ERISA.

1. Plan Name

The name of the Plan is the Electricians Health and Welfare Plan, IBEW 995, Rules and Regulations.

2. Type of Plan

The Plan is a group health plan that provides comprehensive medical benefits and prescription drug benefits, as well as life insurance and accidental death and dismemberment benefits.

3. Name, Address and Telephone Number of Plan Sponsor and Plan Administrator

The Plan is sponsored and administered by a joint labor-management Board of Trustees consisting of an equal number of Union and Employer representatives. The address and telephone number that may be used to contact the Board of Trustees is:

The Board of Trustees
Electricians Health and Welfare Plan, IBEW 995, Rules and Regulations
8111 Tom Drive
Baton Rouge, LA 70815
Telephone: (225) 927-6340

A complete list of the employers and/or employee organizations sponsoring or participating in the Plan is available for inspection without charge at the Fund Office, and a copy may be obtained by employees, dependents, retirees and beneficiaries upon written request to the Plan Administrator for a minimal copying fee.

4. Type of Administration

The Plan is administered by a joint labor-management Board of Trustees consisting of an equal number of Union representatives and Employer representatives. The Board of Trustees is the named fiduciary charged with the responsibility to administer the Plan in accordance with the Plan documents and applicable law. The Board of Trustees may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services.

5. Names and Business Addresses of the Trustees

Union Trustees

Mr. Jason Dedon
IBEW Local Union No. 995
8111 Tom Drive
Baton Rouge, LA 70815

Mr. Darryl McGaha*
IBEW Local Union No. 995
8111 Tom Drive
Baton Rouge, LA 70815

Mr. James C. Carter
Ledoux's Control Systems Inc.
2860 Needham Drive
Baton Rouge, LA 70814

Employer Trustees

Mr. Tim Alexander
Buffalo Electric
3207 Jefferson Street
Baker, LA 70714

Mr. Glen Ledoux
Ledoux's Control Systems Inc.
2860 Needham Drive
Baton Rouge, LA 70814

Mr. Josh Overhultz
Buffalo Electric
3207 Jefferson Street
Baker, LA 70714

*Replaced Mr. Tim G. Overmier effective July 3, 2019.

6. Agent for Service of Legal Process

The Administrative Manager has been designated as agent for service of legal process on behalf of the Plan. Legal process may also be served on the Board of Trustees or any member of the Board of Trustees, as well as the Administrative Manager, at the following address:

Electricians Health and Welfare Plan, IBEW 995
8111 Tom Drive
Baton Rouge, LA 70815

7. Employer Identification Number (EIN) and Plan Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 72-6029075. The Plan Number assigned to the Plan by the Board of Trustees is 501.

8. Plan Year

The Plan Year is the calendar year beginning January 1 and ending on the following December 31.

9. Identity of Funding Medium Used for Accumulation of Assets

All assets of the Plan are accumulated in a trust fund ("Fund") established and administered by the Board of Trustees for the purpose of providing benefits to the participants and beneficiaries and paying the administrative costs of the Plan. The Fund is governed by the Trust Agreement by which it was established and is maintained. The Fund assets are held in the custody of a national bank, which is currently U.S. Bank National Association. The Board of Trustees has appointed, and may appoint from time to time, certain qualified investment advisors to assist with the investment of Plan assets. The Board of Trustees may, from time to time, contract with an insurance company to underwrite benefits under the Plan. Currently, the Life Insurance and Accidental Death and Dismemberment Benefits (other than the Life Insurance benefit for an eligible surviving spouse following the Employee's death, which is self-insured by the Fund), are fully insured by the Union Labor Life Insurance Company, Executive Office located at 111 Massachusetts Ave., N.W., Washington D.C. 20001, (202) 682-0900 or 1-800-431-5425. All other Plan benefits are payable solely out of the assets of the Fund. There is no obligation or liability of any Employer or Trustee or the Union to provide the benefits established under the Plan if the Fund does not have enough assets to make such payments.

10. Contribution Source

All contributions to the Plan are made by Employers in accordance with the Collective Bargaining Agreement between the Employers and Local Union Number 995, and any Participation Agreements between the Employers and Trustees. The Collective Bargaining Agreement and Participation Agreements require contributions to the Plan at a fixed rate per hour of Covered Employment.

Upon request, the Plan Administrator will provide you with information as to whether a particular Employer is contributing to the Plan on behalf of participants working under a Collective Bargaining Agreement or Participation Agreement.

11. Collective Bargaining and Participation Agreements, Plan Documents and Reports

The Plan is maintained pursuant to one or more Collective Bargaining Agreements and Participation Agreements requiring the signatory Employers to make contributions to the Fund on behalf of their Employees, at fixed rates for each hour in Covered Employment.

You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

- (a) Trust Agreement;
- (b) Collective Bargaining and Participation Agreements;
- (c) Plan documents and all amendments;

(d) Form 5500 and full Annual Report filed with the Internal Revenue Service and Department of Labor; and
(e) list of contributing Employers.

You may also obtain copies of these documents by making a written request to the Fund Office and paying the copying fee. You should ask what the charge will be before requesting copies. If you prefer, you can arrange to examine these documents, during normal business hours, at your Local Union Office. To make such arrangements, call or write the Fund Office. A summary of the Annual Report which gives details of the financial information about the Plan's operation is furnished free of charge to all participants.

STATEMENT OF ERISA RIGHTS

As a participant in the Electricians Health and Welfare Plan, IBEW 995, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended from time to time ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements and Participation Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements and Participation Agreements, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your Dependent spouse and children if there is a loss of coverage under the Plan as a result of a qualifying event. You and your Dependents will have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan, by following the Plan's Claims Procedure and Claims Review Procedure described in this booklet, before you may file a lawsuit in any court. You will then have one year, from the date a final decision on appeal is reached under the Plan, in which to start a lawsuit (or, for fully insured benefits provided through a life insurance policy, the time period permitted under the life insurance policy if different). In no event may legal action be brought in court, by you or on your behalf, later than this one-year period.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Fund Office or the nearest office of the Employee Benefits Security Administration ("EBSA"), U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, EBSA, U. S. Department of

Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

You can telephone the EBSA's toll-free Employee & Employer Hotline at 1-866-444-EBSA (3272), or write to the EBSA's Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

NOTICE OF GRANDFATHERED STATUS

The Board of Trustees, as Plan sponsor, believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that our Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans such as, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act such as, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Manager at the Fund Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PRIVACY AND SECURITY RULE

The law known as "HIPAA" resulted in federal privacy and security rules that require health plans, such as this Plan, to protect the confidentiality of Participants' protected health information, sometimes called "PHI". PHI is defined under HIPAA and generally includes health information, including demographic information, that is collected from a Participant or created or received by the Plan in any form (oral, written or electronic), from which it is possible to individually identify a Participant. In addition, the information must relate to a Participant's past, present or future health or condition (physical or mental), to providing health care to a Participant, or to paying for a Participant's health care. A complete description of Participants' privacy rights can be found in the Plan's Privacy Notice, which is distributed to Participants upon enrollment. A copy of the Privacy Notice may also be obtained upon request to the Fund Office.

The Plan will not use or disclose a Participant's PHI except as is necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law, or as otherwise authorized by the Participant. The Plan requires all of its business associates, such as its consultants, that may create or receive PHI on the Plan's behalf to observe the privacy and security rules with respect to such PHI.

The Plan will not, without the Participant's authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefits or employee benefit plans. If someone other than the Participant, even a friend or relative, contacts the Plan and wants to discuss a claim or matter involving the Participant's PHI, the Participant's authorization will first be required unless the discussion is otherwise permitted under HIPAA. **Written explanations of benefits (EOBs) for Dependent spouses and children age 18 or older will be mailed to the spouse or child unless he or she provides other written instructions to the Plan.**

Participants have certain rights under the privacy rules with respect to their PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information, and to amend the information in certain circumstances. Participants also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if they believe their rights under HIPAA have been violated. Participants' rights are explained in greater detail in the Privacy Notice.

For questions about the privacy or security of a Participant's health information or filing a complaint under HIPAA, please contact the Administrative Manager at the Fund Office. The Administrative Manager also serves as the Plan's Privacy and Security Officer.

All information concerning the Plan and the Fund must come from the Fund Office.

NOTHING IN THIS BOOKLET IS MEANT TO INTERPRET OR CHANGE IN ANY WAY THE PROVISIONS EXPRESSED IN THE ELECTRICIANS HEALTH AND WELFARE PLAN, IBEW 995. THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE THE PLAN, IN WHOLE OR PART, AT ANY TIME AND IN THEIR SOLE DISCRETION.

IMPORTANT INFORMATION

It is important that Participants notify the Fund Office whenever:

1. **Their home address changes.**
2. **They want to change their Beneficiary.**
3. **They are receiving Worker's Compensation.**
4. **They get married or divorced.**
5. **They have a new Dependent, or there is a change in status of a Dependent.**
6. **They become totally and permanently disabled.**
7. **They recover from a disability and return to work.**
8. **They are retired and return to work.**