SUMMARY PLAN DESCRIPTION

AND

PLAN DOCUMENT

FOR

ELECTRICIANS HEALTH AND WELFARE PLAN, IBEW 995

Restated Effective January 1, 2024
(Unless Otherwise Stated)

ELECTRICIANS HEALTH AND WELFARE PLAN, IBEW 995

PLAN OFFICE

8111 Tom Drive
Baton Rouge, LA 70815
Telephone: (225) 927-6340

BOARD OF TRUSTEES

Union Trustees	**Employer Trustees**
Mr. Jason Dedon	Mr. Tim Alexander
Mr. Jordan Henderson	Mr. Glen Ledoux
Mr. Darryl McGaha	Mr. Josh Overhultz

ADMINISTRATIVE MANAGER

Ms. Kristine Guillot

CONSULTANT AND ACTUARY

The Segal Company
901 Mopac Expressway South
Building 1, Suite 300
Austin, TX 78746

LEGAL COUNSEL

Robein, Urann, Spencer, Picard & Cangemi (APLC)
2540 Severn Avenue, Suite 400
Metairie, LA 70002

ELECTRICIANS HEALTH AND WELFARE PLAN, IBEW 995
("PLAN")

To All Eligible Employees and Dependents

We are pleased to provide you with this document ("Plan"), which serves as both the written plan document and summary plan description required under ERISA. It is effective January 1, 2024, unless otherwise stated, and includes amendments made through the effective date. It replaces the current January 1, 2019, edition of the Plan document and SPD Booklet.

You MUST satisfy all eligibility requirements to qualify for benefits under the Plan. Possession of this document does not automatically entitle you to benefits. The Plan is not a contract of employment and does not give you a right to remain in employment or interfere with an Employer's right to discharge you. Those issues are covered by the Collective Bargaining Agreement.

It is important to read this entire document to have a complete understanding of the available benefits and your responsibilities under the Plan. Please share the Plan with your covered family members and keep it in a safe place for future reference. **REMEMBER TO KEEP THE PLAN OFFICE INFORMED OF YOUR CURRENT MAILING ADDRESS TO ENSURE THAT YOU RECEIVE ALL REQUIRED COMMUNICATIONS.**

As the Plan sponsor and named fiduciary responsible for administering the Plan, we have full and exclusive authority and discretion to decide all matters arising under the Plan. Any decision we adopt in good faith will be binding on all persons and entities. To be effective, all communications to you must be in writing and signed by us as Trustees of the Plan, or by a person or entity we have authorized to act on the Plan's behalf.

The Plan's benefits are provided on a self-insured basis and payable out of the Fund. They are not guaranteed by an insurance company with the following exception. The life insurance and accidental death and dismemberment benefits (other than the life insurance benefit for surviving spouses) are provided on an insured basis through an insurance policy purchased by the Fund. There is no liability of the Board or any Trustee, Employer, Union, or other entity to provide payment for benefits under the Plan above the Fund's assets or available insurance policy proceeds.

If you have questions about the Plan or its benefits, please contact the Plan Office for assistance.

Sincerely,

BOARD OF TRUSTEES

PLEASE REMEMBER T0 NOTIFY THE PLAN OFFICE IF:

- You have a change of address.
- You get married or acquire a new dependent (you must provide a copy of the marriage certificate, birth certificate or proof of adoption/placement for adoption).
- You get divorced or become legally separated (you must provide a copy of the divorce decree or court-approved legal separation papers).
- A covered family member dies (you must provide a copy of the death certificate).
- Your dependent child loses eligibility (e.g., because the child reaches age 26).
- You wish to change your Beneficiary (you must complete a new beneficiary card).
- You or a covered family member is injured in an accident for which benefits are or may be payable by worker's compensation, another party or insurer.
- You enter the Armed Forces of the United States.
- You become totally disabled.
- You or a covered family member becomes entitled to Medicare or other group health coverage.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
Effective January 1, 2024
(Unless Otherwise Stated)

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT (Subject to terms of Insurance Policy through which benefits are provided	
All Eligible Employees	
Life Insurance	$10,000.00
Accidental Death &Dismemberment (Active Employees only):	
Loss of life, both feet, one hand & one foot, and quadriplegia	$10,000.00 (Full Benefit)
Loss of one hand, entire sight of one eye, loss of hearing (both ears)	$5,000.00 (50% of Full Benefit)
Loss of thumb and index finger on same hand	$2,500.00 (25% of Full Benefit)
Seat Belt Benefit (payable with loss of life)	$1,000.00
Air Bag Benefit (payable with loss of life)	$500.00
Repatriation Benefit (payable with loss of life)	Actual costs up to $5,000.00 maximum
Education Benefit (payable with loss of life)	$300.00 (maximum of 4 years) and Special Child Education Benefit of $1,000.00
All Eligible Dependents	
Life Insurance:	
Dependent spouse during Employee's Lifetime	$5,000.00
Eligible surviving spouse following Employee's death (self-insured by Fund)	$500.00
Dependent Children: Age live birth to 14 days Age 15 days to less than 6 months Age 6 months to less than 26 years	 $0.0 $100.00 $1,000.00
COMPREHENSIVE MEDICAL BENEFITS	
All Eligible Employees and Dependents	
Calendar Year Deductible	$3,000.00 per Participant per calendar year
Out-of-Pocket Limit	$5,000.00 per Participant per calendar year and $10,000.00 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: Network Providers	After Participant satisfies Calendar Year Deductible, Plan pays 70% of Covered Charges and Participant pays 30% of Covered Charges; after Participant satisfies Calendar Year Deductible and Out-of-Pocket Limit, Plan pays 100% of Covered Charges
Out-of-Network Providers	After Participant satisfies Calendar Year Deductible, Plan pays 50%* of Covered Charges and Participant pays 50%* of Covered Charges;

	after Participant satisfies Calendar Year Deductible and Out-of-Pocket Limit, Plan pays 100% of Covered Charges *To the extent required by federal law, cost sharing for Emergency Services, Non-Emergency Services in Network Hospitals & Air Ambulance Services, and for up to 90 days of continued treatment for Continuing Care Patients who qualify, will be at the Network Provider levels.
Additional Accident Expense Benefit (non-occupational)	Plan pays 100% of the first $300.00 of Covered Charges; Calendar Year Deductible waived
Preventive and Wellness Services Benefit-Network Providers only	Plan pays 100% of Covered Charges; Calendar Year Deductible waived
Prescription Drugs: All specialty drugs require pre-authorization; for more information, contact Sav-Rx at 1-866-233-4239.	Coverage is provided for Network Pharmacies only. After Participant satisfies Calendar Year Deductible, Plan reimburses Participant for 75% of cost; after Participant satisfies Calendar Year Deductible and Out-of-Pocket Limit, Plan reimburses Participant for 100% of cost.
Chiropractic Care: Outpatient treatment only	20 visits per Participant 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 Participant was an inpatient prior to admission to Skilled Nursing Care Facility
Infertility Treatment: Lifetime Maximum	$500.00 per couple
Speech Therapy	20 visits per Participant per calendar year
Occupational Therapy	30 visits per Participant per calendar year
Physical Therapy	30 visits per Participant per calendar year
Bariatric Surgery for Treatment of Morbid Obesity when covered	$35,000.00 per covered surgical treatment limited to one every 10 years

Pre-Certification Required:
All non-emergency inpatient hospital admissions (except for childbirth for up to 48 hours after normal vaginal delivery & 96 hours after C-Section); skilled nursing care in skilled nursing facilities; inpatient rehabilitation; long-term acute care; specialty drugs managed through medical benefit; coordinated home care; non-emergent air ambulance; home infusion therapy; non-emergency inpatient mental health & substance use treatment; intensive outpatient programs; applied behavior analysis; outpatient electroconvulsive therapy; repetitive transcranial magnetic stimulation; psychological/neuropsychological testing in limited situations; lipid apheresis; outpatient surgical procedures; outpatient gastroenterology; outpatient wound care service (hyperbaric oxygen therapy); outpatient neurology services (sacral nerve, vagus nerve & deep brain stimulation); ear, nose & throat services (nasal & sinus surgery); surgical deactivation of headache trigger sites; orthopedic stem-cell therapy; and functional neuromuscular electrical stimulation. All emergency Hospital admissions must be certified within 48 hours of admission. To obtain pre-certification or certification, contact Blue Cross Blue Shield of Illinois (BCBSIL) at 1-800-433-3232.

WAYS TO CONTROL YOUR HEALTH CARE

You can help control your health care expenses and health by practicing the following:

Treat yourself right. Many illnesses are often connected with lifestyle such as smoking, excessive drinking of alcoholic beverages, improper diet, and stress. Try to eat right, get enough sleep, and exercise regularly. Remember to wear your seatbelt when driving and be careful around your home to avoid unnecessary household accidents.

Ask "dumb" questions. The only dumb questions are ones you don't ask. Ask about charges on a hospital bill that you don't understand. Be informed about what to expect during a hospital confinement. Ask about the cost of medications and if generic drugs are available. If you have doubts about a treatment or procedure your Physician has recommended, consider getting a second opinion.

Don't be in when you can be out. Ask your Physician about the use of outpatient services for tests, treatments, and minor surgery. Outpatient care is always less expensive than inpatient care and can often accomplish the same objective.

Use the emergency room for "emergencies." The Hospital's emergency room is an expensive place to treat minor aches and ailments.

Understand your coverage before you have to use it. Read the Plan to understand how the benefits work, what is and is not covered, and what items and services ***must*** be pre-certified.

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 save you money. Take advantage of the Preventive and Wellness Benefit provided by the Plan.

ARTICLE I

DEFINITIONS

You should read this Article to understand terms used in the Plan. When the following terms are capitalized in the Plan, they will have the meaning described unless a different meaning is clearly indicated by the context. When the term "including" (or its variation, such as "includes") is used, it is not intended to be restrictive and will mean "including but not limited to" for purposes of interpreting the Plan. When the term "you" is used, it means a Participant unless otherwise specifically noted or indicated by the context.

"**Administrator**" means the Trustees for purposes of ERISA Section 3(16)(A). The Trustees may delegate their authority to determine eligibility, process and pay claims, and perform other functions authorized by the Plan, Trust Agreement, and applicable law.

"Air Ambulance" means medical transport by a rotary wing air ambulance, as defined in 42 CFR §414.605, or fixed wing air ambulance, as defined in 42 CFR §414.605, for patients.

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

"Allowable Charge" means the amount the Plan allows as payment for Covered Charges (subject to any limitations and cost-sharing provisions in the Plan and Schedule of Benefits), except when the special payment rules under the No Surprises Act require that payment for certain Out-of-Network Provider charges be based on the "**Recognized Amount**" or "**Qualifying Payment Amount**".

The Allowable Charge is the lowest of (a) the actual billed charge; (b) for a Network Provider, the negotiated fee or rate in the Network agreement with the Plan; and (c) for an Out-of-Network Provider, the amount established by the Administrator or its designee based on Medicare's allowable amounts, or such other adjustment, methodology, or fee schedule that is adopted. The Allowable Charge for an Out-of-Network Provider is not intended to reflect a usual, customary, or reasonable fee and is anticipated to be lower than the Allowable Charge for a Network Provider. Any amount greater than the Allowable Charge does not count toward the Plan's Out-of-Pocket limits.

"**Ambulance"** means a vehicle, helicopter or airplane that is staffed by trained personnel and licensed or certified for Emergency transportation of the sick and injured by the jurisdiction in which it operates.

"Ambulatory Surgical Center" means a licensed facility, other than a Hospital, that is used primarily for performing outpatient surgical procedures, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

"Ancillary Service" means (a) items and services (i) related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a Physician or non-Physician practitioner), (ii) provided by assistant surgeons, hospitalists, and intensivists, or (iii) provided by an OON Provider if there is no Network Provider who can furnish them at the Health Care Facility (i.e., a Hospital including its outpatient department, or an Ambulatory Surgical Center); and (b) diagnostic services (including radiology and laboratory services).

"Balance Billed" or **"Balance Billing"** means a bill from an OON Provider to you for the difference between the Plan's Allowable Charge and its billed charge. This amount is not covered by the Plan.

"Bargaining Unit Employee" means an Employee who is subject to a Collective Bargaining Agreement between the Employer and Union.

"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 a written bargaining agreement between an Employer and Union that requires the Employer to contribute to the Fund on behalf of the Covered Employment of its Bargaining Unit Employees, as extended, renewed, or amended.

"**Continuing Care Patient**" means a Participant who, with respect to a provider or facility: (a) is undergoing a course of treatment for a Serious and Complex Condition; or (b) is undergoing a course of institutional or inpatient care; or (c) is scheduled to undergo nonelective surgery, which includes receipt of postoperative care; or (d) is pregnant and undergoing a course of treatment for the pregnancy; or (e) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness. "Serious and Complex Condition" means, (a) for an acute illness, a condition serious enough to require specialized medical treatment to avoid death or permanent harm, and (b) for a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period.

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

"Covered Charge" means a charge you incur while covered by the Plan, for a service or supply for which medical benefits are available under the Plan, to the extent that it (a) is Medically Necessary or covered under the Preventive and Wellness Services Benefit, (b) does not exceed the Allowable Charge (or if required by the No Surprises Act, the Recognized Amount or QPA), (c) is covered and not excluded by the Plan, and (d) does not exceed any maximum limits shown in Schedule of Benefits.

"Covered Employment" means employment of a type covered by a CBA or Participation Agreement for which the Employer is obligated to contribute to the Fund.

"Custodial Care" means care and services, regardless of who recommends them or where they are provided, that can be provided safely and reasonably by a person not medically skilled, or that are given mainly to help you with daily living activities or are not likely to substantially reduce disability or enable you to live outside of an institution providing care (includes helping you get in and out of bed, bathe, dress, eat, use the toilet, walk, or take medications that can be self-administered).

"Dependent" means:

(a) An Employee's lawfully married spouse;

(b) An Employee's natural 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 (regardless of whether it becomes final), who is disabled and incapable of self-support due to disability beginning before age 26 and has over one-half of his or her support provided by the Employee. Satisfactory proof of disability and dependency must be given to the Plan Office (i) within 31 days or as soon as reasonably possible after disability begins, (ii) when the child reaches age 26, and (iii) upon the Plan's request; and

(d) An Alternate Recipient.

The term "placed for adoption" means the Employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. The placement for adoption will end when the Employee's obligation for the child ends.

The Plan may require an Employee to provide satisfactory proof of a Dependent's eligible status from time to time (includes certified copy of birth certificate, marriage license, divorce decree, adoption decree, death certificate, physician statement confirming disability, QMCSO, and tax return confirming dependent status). Benefits payable for a Participant covered as both an Employee and Dependent spouse will be coordinated and will not exceed 100% of the Covered Charges. A Dependent child who qualifies for coverage as both an Employee and Dependent child will qualify for benefits only in a single Participant capacity.

"Durable Medical Equipment" means equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home (includes sleep apnea monitors, blood sugar monitors, hospital-type beds, wheelchairs, nebulizers, oximeters, oxygen, and ventilators).

"**Emergency Medical Condition**" or "**Emergency**" means a medical condition, mental health condition or substance use disorder (including severe pain), of recent onset and severity, that would lead a prudent layperson with an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in (a) serious impairment to bodily functions, (b) serious dysfunction of a bodily organ or part, or (c) placing your health or, if you are pregnant, your unborn child's health, in serious jeopardy.

"**Emergency Medical Services**" means the following when related to your Emergency Medical Condition, unless not required by applicable law:

(a) If it is within the capability of a Hospital or independent freestanding emergency department, (i) a medical screening examination including Ancillary Services routinely available to the Emergency department to evaluate an Emergency Medical Condition, and (ii) further medical examination and treatment as required to stabilize your medical condition, regardless of the Hospital department in which it is furnished; and

(b) For an Emergency Medical Condition (regardless of the Hospital department where furnished), additional services and items covered by the Plan and furnished by an OON Provider after you are stabilized, that are part of an outpatient observation or inpatient or outpatient stay with respect to the visit in which the initial Emergency Medical Services are furnished, unless the following conditions and any other applicable law requirements are satisfied: (i) you are able to travel using nonmedical or nonemergency medical transportation, to an available Network Provider within a reasonable travel distance, as determined by the treating emergency physician or health care professional; and (ii) you or your authorized representative gives the OON Provider informed written consent to give up cost sharing and balance billing protections that would otherwise protect you from

being billed for the difference between what the Plan covers and the OON Provider charges for the services.

"To stabilize", as used above, means to provide necessary medical treatment of the Emergency Medical Condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or during a transfer from the facility or, if you are pregnant and having contractions, cause delivery of the newborn child and placenta.

"Employee" means a person employed by an Employer that is required to contribute to the Fund with respect to such employment pursuant to a CBA or Participation Agreement.

"Employer" means an employer that (a) is required under a CBA or Participation Agreement to contribute to the Fund on behalf of the employment of its Employees for their participation in the Plan, and (b) signs the Trust Agreement or otherwise agrees to its terms as required by the Trustees.

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

"Experimental or Investigational" means services or treatments that are not widely used or accepted by most practitioners or lack creditable evidence to support positive short or long-term outcomes for the condition for which they are being rendered or dispensed; they are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatments which: (a) do not constitute accepted medical practice under the standards of care and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or (b) are rendered on a research basis as determined by the United States Food and Drug Administration ("FDA") or AMA's Council on Medical Specialty Societies. All phases of clinical trials are considered Experimental, except that expenses that would otherwise be covered by the Plan and are incurred by you participating in a clinical trial will be covered to the extent required by federal law. A drug, device, or medical treatment or procedure is Experimental if: (a) it cannot be lawfully marketed without FDA approval and such approval has not been given at the time it is furnished; or (b) if reliable evidence shows that it is the subject of ongoing Phase I, II, or III clinical trials or is under study to determine the maximum tolerated dose, toxicity, safety, efficacy, and efficacy as compared with the standard means of treatment or diagnosis; or (c) if reliable evidence shows that the consensus among experts is that further studies or clinical trials are necessary to determine its efficacy as compared with the standard means of treatment or diagnosis. The Administrator retains maximum legal authority and discretion to determine what is Experimental or Investigational.

"**Family and Medical Leave**" or "**FMLA Leave**" means a family or medical leave of absence, intermittent leave or leave on a reduced schedule, taken under the federal law known as the Family and Medical Leave Act of 1993 and corresponding regulations, as amended ("FMLA"), as certified by the Employer in accordance with the Plan's administrative policies and procedures then in effect.

"**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, and defraying reasonable administrative expenses under the Plan.

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

"Hospital" means an institution that is primarily engaged in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets the following tests: (a) it is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association Health Care Facilities Accreditation Program; (b) it is approved by Medicare as a Hospital; (c) it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; (d) it continuously provides on the premises twenty-four (24) hour a day nursing services by or under the supervision of registered nurses (R.N.s); and (e) it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" includes the following: (a) a facility operating legally as a psychiatric Hospital or residential treatment facility for Mental Health and licensed as such by the jurisdiction in which it operates; and (b) a facility operating primarily for the treatment of a Substance Use Disorder if it meets the following tests: (i) it maintains permanent and full-time facilities for bed care and full-time confinement of at least fifteen (15) resident patients; (ii) it operates under the supervision of a Physician; (iii) it continuously provides twenty-four (24) hour a day nursing service by a registered nurse (R.N.); and (iv) it is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

"Illness" means a bodily disorder or mental infirmity diagnosed by a Physician, including a congenital abnormality and pregnancy of a covered Employee or covered Employee's Dependent spouse.

"Injury" means an accidental bodily injury that requires treatment by a Physician and results in loss independently of Illness and other causes.

"Insurer" means, for any insured benefit provided by the Plan, the insurance company that issues the insurance policy purchased by the Fund for the purpose of providing the benefit.

"Medically Necessary" or "Medical Necessity" means the services or supplies provided for the diagnosis, care, or treatment of an Illness or Injury meet the following criteria: (a) they are recommended or approved by a Physician; (b) they are required to identify or treat an Illness or Injury which a Physician has diagnosed or reasonably suspects; (c) they are in accordance with accepted standards of good medical practice and required for reasons other than convenience; (d) they are the most appropriate level of services that can be safely provided to the patient; and (e) they are not more costly than alternative care or treatment that is as likely to produce equivalent therapeutic or diagnostic results for diagnosis or treatment of the Illness or Injury.

The Administrator retains maximum legal authority and discretion to determine what is Medically Necessary. The fact that something is prescribed by a Physician does not necessarily mean that it is Medically Necessary for Plan purposes.

"**Mental Disorder**" means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or that is listed in the current edition

of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

"Network Provider" means a Hospital, Physician, or other health care provider that, by contractual agreement with the Plan or its Preferred Provider Organization, has agreed to charge reduced or discounted rates for health care services or supplies provided to you.

"**Non-Bargaining Unit Employee**" means an Employee whose work in Covered Employment is not governed by a Collective Bargaining Agreement.

"**No Surprises Act**" means the federal law enacted as part of the Consolidated Appropriations Act, 2021 (CAA, 2021), Pub. L. No. 116-260, Div. BB (2020) and corresponding regulations, that establishes patient rights and protections from surprise billing and limits cost sharing under many of the circumstances in which surprise billing occurs most frequently and applies to the Plan.

"**Nurse Practitioner**" means a person legally licensed as a nurse practitioner, acting under a Physician's supervision when required by law and performing services within the scope of the license.

"**Out-of-Network Provider**" or "**OON Provider**" means a Hospital, Physician, or other health care provider that is not a Network Provider.

"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 obligates the Employer to make contributions to the Fund for its Non-Bargaining Unit Employees who are covered by the agreement and specifies the terms by which they will participate.

"Physician" means any of the following practitioners who is licensed by the appropriate state agency to perform services covered by the Plan and is acting within the scope of the license at the time the covered services are performed: a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.), Doctor of Podiatry, Doctor of Optometry, Audiologist, Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and where required by law, any other licensed practitioner who is acting within the scope of that license and performing services that would be payable under the Plan if performed by an M.D..

"**Physician Assistant**" or "**PA**" means a person legally licensed as a physician assistant, who is acting under the supervision of a Physician when required by law, and performing services within the scope of the license.

"Plan" means the Electricians Health and Welfare Plan, IBEW 995, Rules and Regulations, initially adopted effective January 1, 1964, to provide rules and regulations for the welfare benefits payable from the Fund, as amended and most recently restated and combined with the summary plan description as set forth in this document, and as may be subsequently amended or restated.

"**Plan Year**" means the twelve (12) month period that begins on January 1 and ends on the following December 31, and is the fiscal year of the Plan.

"Plan Office" means the office of the Administrative Manager for the Plan and Fund as designated by the Board of Trustees.

"Prescription Drug" means the following when Medically Necessary in the treatment of an Illness or Injury: a drug purchasable only with a written prescription by a Physician (except for injectable insulin). It does not include (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, or (i) infertility medication once infertility is diagnosed.

"Qualified Medical Child Support Order" or **"QMCSO"** means a medical child support order or National Medical Support Notice that qualifies as a QMCSO under ERISA Section 609(a), as determined by the Trustees. A QMCSO creates or recognizes an Alternate Payee's right to enroll in the Plan. In order to qualify as a QMCSO, the medical child support order must clearly specify: (a) the name and last known mailing address of the Employee and each Alternate Recipient covered by the order; (b) the type of coverage to be provided by the Plan or how it is to be determined; (c) the period of coverage to which it applies; and (d) the name of the Plan. In addition, the medical child support order cannot require the Plan to provide any type or form of benefit, or option, that it does not otherwise provide, except to the extent necessary to satisfy state law relating to medical child support orders for Medicaid eligible children under Social Security Act Section 1908.

"**Qualifying Payment Amount**" or "**QPA**" means the amount calculated in accordance with 29 CFR § 2590.716-6(c), using the methodology adopted by the Trustees.

"**Recognized Amount**" means, for Air Ambulance services furnished by an OON Provider and covered by the Plan, the lesser of the billed amount and Qualifying Payment Amount. If an OON Provider furnishes Emergency Medical Services for an Emergency Medical Condition, or non-Emergency Medical Services at a Network Hospital or other covered Network facility (unless you give informed voluntary written consent as the No Surprises Act permits), and the services would be covered if provided by a Network Provider, the Recognized Amount means (a) the amount determined under the All-Payer Model Agreement, Social Security Act Section 1115A; or if none (b) the amount determined by a specified State law applicable to the Plan; or if none (c) the lesser of the billed amount and QPA.

"**Schedule of Benefits**" means, for a Covered Charge or loss for which Plan benefits are payable, the Schedule of Benefits in effect when (a) the charge is incurred, or (b) the loss giving rise to the benefits occurs (e.g., an accident giving rise to a claim for accidental death or dismemberment benefits). It is incorporated with and made part of the Plan, effective as of the date described, and remains in effect unless and until replaced by a Schedule of Benefits with a later effective date.

"**Substance Use Disorder**" means an Illness that is defined within the substance use disorders section of the current edition of the International Classification of Diseases manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

"Trustees" or **"Board of Trustees"** means, collectively, the individuals who are appointed pursuant to the Trust Agreement to serve in a trustee capacity for the Fund and are serving in that capacity. The Trustees are the named fiduciary for the Plan, within the meaning of ERISA Section 402(a)(2).

"**Trust Agreement**" means the Agreement and Declaration of Trust adopted by the Union, Association, and certain Employers to establish a welfare benefit trust, initially effective April 1, 1964, and as subsequently amended and restated (most recently restated effective August 14, 2014).

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

"**USERRA**" means the federal law known as the Uniformed Services Employment and Re-Employment Rights Act of 1994 and corresponding regulations, as amended.

ARTICLE II

ELIGIBILITY, COVERAGE, AND TERMINATION OF COVERAGE

A. ELIGIBILITY RULES FOR BARGAINING UNIT EMPLOYEES

Employers are required to contribute to the Fund, on behalf of their Bargaining Unit Employees, the contribution rate multiplied by their hours of Covered Employment as required under the Collective Bargaining Agreement. The following rules govern the eligibility of Bargaining Unit Employees.

1. **Dollar Bank** – The Plan maintains, for record-keeping purposes only, a "Dollar Bank" account for Bargaining Unit Employees to keep track of Employer contributions received by the Fund on their behalf. The amount is credited upon receipt and then becomes available to satisfy the initial and continuing eligibility requirements described below.

   There is a lag in time between the month Covered Employment is worked (the "Work Month"), and the month the Dollar Bank account is credited with Employer contributions received for the work (the "Benefit Month"), as shown in the Table below. Dollar Bank accounts are subject to a maximum credit for the cost of six (6) months of coverage, after deducting the cost of the current month's coverage. Contributions credited to a Dollar Bank account for more than twelve (12) months are forfeited.

Work 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

2. **Initial Eligibility Requirements** – The "Required Amount" (also called the "Monthly Cost"), as used in this Article II, means the cost for one month of Plan coverage for Bargaining Unit Employees. The amount is determined by the Trustees and may change. Once an Employee has a minimum Dollar Bank credit of $1,000.00, the Employee satisfies the initial eligibility requirements, and the Monthly Cost is automatically deducted to provide coverage for the following month. The $1,000.00 minimum Dollar Bank credit that is required must be accumulated over 12 months or less since Employer contributions credited for more than 12 months are forfeited.

3. **Continued Eligibility Requirements** – Once an Employee satisfies the initial eligibility requirements and is covered, coverage will continue month-to-month if the Employee's Dollar Bank credit is enough to satisfy the Monthly Cost. The Monthly Cost is deducted each month from the longest credited amounts to provide coverage for the next Benefit Month. If the Dollar Bank credit is not enough to satisfy the Monthly Cost, Plan coverage will terminate at the end of the last Benefit Month for which timely payment was made. The Employee may then be eligible to continue health coverage under the Plan, on a self-payment basis, under COBRA. If COBRA Coverage is available and timely elected, any remaining Dollar Bank credit will offset the amount of the first required self-payment.

B. ELIGIBILITY RULES FOR NON-BARGAINING UNIT EMPLOYEES

Non-Bargaining Unit Employees are eligible to participate in accordance with the Participation Agreement between their Employer and the Trustees. The following rules govern their eligibility.

1. **Initial Eligibility Requirements and Enrollment** – Non-Bargaining Unit Employees who satisfy the following initial eligibility requirements may enroll in the Plan: (a) be hired to work a minimum of 40 hours per week if salaried, or 35 hours per week if paid hourly; (b) have an Employer that agrees to make the required amount of contributions to the Fund, on their behalf, as established by the Trustees; and (c) satisfy any additional requirements set forth in the Participation Agreement. Employer contributions are currently required based on 160 hours per month, regardless of hours worked, for four (4) months beginning with the initial month of employment. These Employees are *not* eligible for a Dollar Bank.

"Fund Employees" are a special category of Non-Bargaining Unit Employees. They are employed by the Fund to work in the Plan Office and are eligible to participate in the Plan based on rules established by the Trustees. They will be notified of these rules at the time of hire. Additional information is available upon request to the Administrative Manager.

Employees who satisfy the initial eligibility requirements may enroll in Plan coverage as follows: (a) within sixty (60) days after date of hire (or rehire) effective for the remainder of the Plan Year; (b) during the Plan's Annual Enrollment Period effective for the next Plan Year; and (c) whenever they qualify for special enrollment under HIPAA (described below), effective for the remainder of the Plan Year.

Enrollment is accomplished by providing written notice to the Plan Office, on a form provided by or acceptable to the Plan, with any required documents, before the end of the enrollment period. The Plan's enrollment form is available without charge upon request to the Plan Office.

2. **Continuing Eligibility Requirements** – Once an Employee satisfies the initial eligibility requirements, enrolls, and is covered, coverage will continue month-to-month, after the initial four (4) months of coverage, provided the eligibility requirements are satisfied and the Fund receives the required Employer contribution. If the continuing eligibility requirements are not satisfied, the Employee's coverage will terminate at the end of the last month for which they were satisfied. The Employee may then be eligible to continue health coverage under the Plan, on a self-payment basis, under COBRA.

3. **Special Enrollment Rights Under HIPAA** – HIPAA provides special enrollment rights in certain instances. If an Employee does not initially enroll because of COBRA or other group health coverage, the Employee will qualify for a Special Enrollment Period when: (a) COBRA coverage is exhausted; or (b) the other group health coverage terminates due to loss of eligibility or termination of employer contributions. Special enrollment rights will NOT apply for a loss of eligibility due to cause or other non-payment.

   An Employee who qualifies for special enrollment and wants to enroll must send a written enrollment request, with any required documents, to the Plan Office within 60 days after the exhaustion or termination of coverage, and Plan coverage will be effective retroactive to such date. An Employee who fails to enroll during a 60-day special enrollment period must wait for the next Annual Enrollment Period to enroll.

C. ELIGIBILITY RULES FOR DEPENDENTS

1. General Eligibility Requirements and Enrollment - An Employee's Dependents will be eligible for Plan coverage, without cost to the Employee, on the latest of the following dates to occur:

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

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

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

An eligible Dependent will be covered only if the Plan's enrollment form is completed and submitted with any required documents to the Plan Office (or as otherwise indicated on the form), within sixty (60) days after the Dependent is first eligible. Upon timely enrollment, coverage will be effective retroactive to the date the Dependent was first eligible. Enrollment forms are available without charge upon request to the Plan Office.

An eligible Dependent who is not timely enrolled must wait until the next Annual Enrollment Period or, if applicable, a Special Enrollment Period, to enroll. The Plan will not verify coverage or pay benefits until receipt of a timely completed enrollment form and any required documents.

Employers who receive a medical child support order or National Medical Support Notice should promptly forward it to the Plan Office for handling. Upon receipt, the Plan will notify the affected Employee and child's representative of its administrative procedures for determining if it qualifies as a "QMCSO", as well as its determination when made. Participants may receive a copy of the Plan's QMCSO administrative procedures, without charge, upon written request to the Plan Office.

Benefits payable for a Participant covered as both an Employee and Dependent spouse will be coordinated and will not exceed 100% of the Covered Charges. A Dependent child who qualifies for coverage as both an Employee and Dependent child will qualify for benefits only in a single Participant capacity.

2. **Annual Enrollment Period –** An Annual Enrollment Period will be held each year, normally during November and December, to enroll for the next Plan Year. Enrollment forms will be provided or made available to Employees. These completed forms and any required documents must be returned to the Plan Office (or as directed on the form), on or before the last day of the Annual Enrollment Period. Employees who do not return a completed enrollment form by the due date will be deemed to have continued their current enrollment election for their Dependents for the next Plan Year.

3. **HIPAA Special Enrollment Period –** The Plan will provide a Special Enrollment Period for Employees and Dependents to the extent required by law. Individuals will be enrolled as of the earliest date for which they qualify.

(a) **Acquisition of Dependent**: If a covered Employee acquires a Dependent because of birth, adoption, placement for adoption or marriage, the Employee may enroll the newly acquired Dependent and a Dependent spouse who is not already enrolled. Enrollment is accomplished by completing the Plan's enrollment form and sending it, with any required documents (e.g., a marriage license and birth certificate), to the Plan Office (or as directed on the form), within sixty (60) days after the birth, adoption, placement for adoption or marriage. Upon timely enrollment, coverage will be effective (i) retroactive to the date of birth, adoption, or placement for adoption, or (ii) for marriage, as of

the first day of the calendar month after enrollment. A Dependent who is not timely enrolled must wait until the next Annual Enrollment Period to enroll.

(b) **Other Group Health or COBRA Coverage:** If a covered Employee does not enroll a Dependent spouse or child when the Dependent is first eligible because of COBRA or other group health coverage, the Dependent will qualify for a Special Enrollment Period when: (i) COBRA coverage is exhausted; or (ii) the other group health coverage terminates due to loss of eligibility or termination of employer contributions. Special enrollment rights will NOT apply for a loss of eligibility due to cause or other non-payment.

An Employee may enroll a Dependent who qualifies for special enrollment, effective as of the date the other coverage terminates. Enrollment is made by completing the Plan's enrollment form and sending it, with any required documents, to the Plan Office (or as otherwise indicated on the form). They are due within sixty (60) days after the date the other coverage terminates.

(c) **Medicaid or CHIP Coverage**: If an Employee or Dependent who is eligible but not covered under the Plan (i) has coverage through Medicaid or a State Children's Health Insurance Program ("CHIP") and loses eligibility for such coverage, or (ii) becomes eligible for a premium assistance program through Medicaid or CHIP, the following special enrollment period will apply. The Employee will have sixty (60) days after (i) the loss of Medicaid or CHIP coverage, or (ii) a determination of eligibility for the premium assistance program, to enroll the Employee and Dependents in the Plan. Enrollment is made by completing the Plan's enrollment form and sending it, with any required documents, to the Plan Office (or as otherwise indicated on the form). If timely enrolled, Plan coverage will be effective as of the first day of the month after the Plan receives the enrollment form and documents. If there is no timely enrollment, the Plan's general eligibility and enrollment rules will apply.

D. PARTICIPANT NOTIFICATION REQUIREMENTS

You must notify the Plan Office in writing within thirty (30) days after a change in address or change in Dependent status that affects Plan coverage. For example, notice of a divorce or a child reaching age 26 is required. If the Plan pays benefits in error because of your failure to notify the Plan as required, the Plan may recover the overpayment from you to the fullest extent allowed by law. Recovery of improper payments may be made by notice and demand to you, by legal action, or by withholding payment of other benefits due to or for you for related or unrelated claims as an offset against the amount owed.

E. REINSTATEMENT OF COVERAGE

1. **Bargaining Unit Employees** – If Plan coverage terminates because your Dollar Bank credit falls below the amount needed to satisfy the Monthly Cost, but within twelve (12) months after coverage terminates the amount credited is again sufficient to do so, the Monthly Cost will be deducted, and your coverage will be reinstated as of the first

day of the following month. Coverage will then continue as provided by the continuing eligibility requirements. If your Dollar Bank credit does not become sufficient to satisfy the Monthly Cost within 12 months after coverage terminates, you must again satisfy the initial eligibility requirements to qualify for coverage.

2. **Non-Bargaining Unit Employees** – If your Plan coverage terminates because of insufficient Employer contributions, you must again satisfy the initial eligibility requirements to qualify for coverage. Coverage will then continue as provided by the continuing eligibility requirements.

3. **Dependents** – An Employee's covered Dependents, who lose coverage when the Employee loses coverage, will have their coverage reinstated when the Employee's coverage is reinstated, provided they continue to qualify for Dependent coverage.

F. DISABILITY SERVICE CREDIT

If you are an Employee who becomes disabled and unable to work in employment for more than seven (7) continuous days while covered by the Plan, you will qualify for a "Disability Service Credit". It will be available, retroactive to the date your disability began, solely to enable you to maintain eligibility for Plan coveragefor up to a maximum of twelve (12) weeks per disability.

To qualify for this credit, you must (1) provide written notice and satisfactory proof of disability to the Plan Office initially and on a continuing basis as required by the Plan, and (2) remain under a Physician's care. If you qualify for this credit while receiving COBRA Coverage, you will be credited with the hours needed to offset the required self-payment for COBRA Coverage during disability up to the 12-week maximum per disability.

The Disability Service Credit may NOT be used for any of the following purposes: (1) to give you more COBRA Coverage than you are entitled to receive; (2) to reinstate your active Employee coverage; (3) to continue your coverage if you are a retired employee receiving extended coverage on a self-payment basis; or (4) to give service credit for more than a total of twelve (12) weeks for the same disability.

G. COBRA CONTINUATION COVERAGE RIGHTS

COBRA gives you the right to continue your health coverage under the Plan, on a self-payment basis for a limited time, when it would otherwise end because of a "qualifying event" ("COBRA Coverage"). The Plan will be interpreted and administered in a manner consistent with its intent to comply with COBRA.

1. Qualifying Events Providing COBRA Coverage Eligibility

(a) **Employee** – A covered Employee who would otherwise lose health coverage under the Plan due to one of the following qualifying events may elect COBRA Coverage:

- Failure to work or be credited with enough hours of Covered Employment to maintain coverage under the Plan; or
- Termination of employment for any reason other than gross misconduct.

(b) **Dependents** – A covered Dependent who would otherwise lose health coverage under the Plan due to one of the following qualifying events may elect COBRA Coverage:

- The Employee fails to work or be credited with enough hours of Covered Employment to maintain coverage under the Plan;
- The Employee terminates employment for any reason other than gross misconduct;
- The Employee dies, divorces, or becomes legally separated; or
- A Dependent child ceases to qualify as an eligible Dependent under the Plan.

2. Qualified Beneficiaries - If a qualifying event occurs, COBRA Coverage is available to each person who is a "qualified beneficiary". A "qualified beneficiary" is an Employee or Dependent who, on the day before the qualifying event, has health coverage under the Plan and will otherwise lose it due to the qualifying event. In addition, any Dependent child who is born to or placed for adoption with a covered Employee during a period of COBRA Coverage is a qualified beneficiary. This child's COBRA Coverage will begin at enrollment and be available for the remaining period of COBRA Coverage available to the Employee's Dependents.

If a qualified beneficiary with COBRA Coverage acquires a family member who could be enrolled in the Plan as a Dependent if the qualified beneficiary was an active Employee, the qualified beneficiary may add the family member to his or her COBRA Coverage for the remainder of the COBRA Coverage period; however, the family member is not a qualified beneficiary with independent COBRA rights.

If a qualified beneficiary with COBRA Coverage (a) has a Dependent who was eligible but did not enroll for COBRA Coverage when the qualified beneficiary enrolled because the Dependent had other COBRA or health plan coverage, and (b) the Dependent exhausts the other COBRA coverage or loses the other health plan coverage due to loss of eligibility or termination of employer contributions (but not for failure to pay or for cause), the qualified beneficiary may enroll the Dependent in his or her COBRA Coverage for the remaining coverage period. Enrollment is accomplished by giving written notice to the Plan Office within 30 days after exhaustion or termination of the other coverage. Failure to do so will result in forfeiture of the right to enroll. COBRA Coverage that ends for a qualified beneficiary will end for any enrolled family members who are not themselves qualified beneficiaries.

3. Notice of COBRA Rights and Qualifying Events and How to Elect COBRA Coverage

(a) **Required Notice from Plan** – The Plan will notify all Employees and Dependent spouses of their COBRA rights when they first become covered by the Plan. The Plan will also notify you, at your last known address, of your COBRA Coverage rights and how to elect it, within 30 days after your coverage would otherwise end due to a qualifying event that is the Employee's death, termination of employment, or insufficient hours.

(b) **Required Notice from Employees and Dependents** – You must notify the Plan Office in writing of the following events to protect your COBRA rights: (i) an Employee's divorce, legal separation, or death after termination of employment; (ii) a Dependent child ceasing to qualify as a Dependent under the Plan; (iii) a Social Security Administration ("SSA") determination that an individual, entitled to 18 months of COBRA Coverage, is disabled; and (iv) a SSA determination that a disabled individual with COBRA Coverage is no longer disabled.

The notice must include the names of the Employee and each qualified beneficiary; type of event for which notice is being given and date it occurred; and a copy of the divorce, legal separation decree, or SSA disability determination (as applicable).

Notice must be given to the Plan Office (postmarked or delivered) within 60 days after the date of the qualifying event or, if later, the date the qualified beneficiary loses (or would lose) coverage under the Plan due to the qualifying event, except as follows.

Notice of a SSA determination that an individual is disabled must be provided to the Plan Office (i) within 60 days after the latest of (A) the SSA determination, (B) the qualifying event, or (C) the date the individual loses or would lose Plan coverage due to the qualifying event, and (ii) within the first 18 month of COBRA Coverage.

Notice of a SSA determination that a disabled individual is no longer disabled must be given to the Plan Office within 30 days after the date of the final SSA determination.

Failure to provide the required notice to the Plan Office in a timely manner may result in forfeiture of the right to elect COBRA Coverage. Notice may be provided by the Employee, a Dependent, or a representative acting on their behalf. Notice from one individual will satisfy the notice requirements for all individuals affected by the same qualifying event.

If the required notice of a qualifying event is timely provided, the Plan will notify all qualified beneficiaries, within 30 days after receiving the notice, of their COBRA Coverage rights and how to elect it. Any notice given to an Employee or Dependent spouse is treated as notice to all affected Dependent children living with that person. If notice is given to the Plan but there are no COBRA Coverage rights, the Plan will provide written notice explaining why COBRA Coverage is not available.

If the required notice of a qualifying event is not given and the Plan pays a claim in error after coverage should have terminated, the Participant for whom it was paid must reimburse the Plan for the overpayment, or the Plan may recover the overpayment to the fullest extent allowed by law.

(c) **How to Elect COBRA Coverage –** After a qualifying event occurs and any required notice is given to the Plan Office, the Plan will furnish each qualified beneficiary with specific information about when and how to elect COBRA Coverage, including the amount of the required self-payment.

Qualified beneficiaries will have 60 days after their coverage would otherwise end due to the qualifying event, or if later, after they are notified of their COBRA rights, to elect COBRA Coverage (the "60-day election period"). Election is accomplished by returning a completed and signed election form to the Plan Office (must be postmarked or received) within the 60-day election period and timely paying the required self-payment. Failure to do so will result in loss of the right to elect COBRA Coverage.

Each qualified beneficiary has an independent right to elect COBRA Coverage. It may be elected by some but not all qualified beneficiaries. An Employee may elect COBRA Coverage on behalf of the Dependent spouse, and a parent may elect COBRA Coverage on behalf of Dependent children living with that parent. If elected, COBRA Coverage will be effective retroactive to the date coverage terminated. A qualified beneficiary who waives COBRA Coverage during the 60-day election period may revoke the waiver and elect it during such period. The Plan may then choose to provide it from the date of revocation or retroactive to the date coverage terminated. Unless otherwise specified, an election by an Employee or Dependent spouse will be treated as an election for all other Dependents who are qualified beneficiaries.

4. Type of COBRA Coverage - The health coverage available under the Plan during the COBRA Coverage period will be the same health coverage that is being provided to similarly situated individuals with respect to whom a qualifying event has not occurred (including any changes).

The Trustees may provide an additional option to qualified beneficiaries to continue their life insurance coverage under the Plan, on a self-payment basis, *in addition to* COBRA Coverage. This option and the required self-payment amount will be described in the COBRA notice and election form. Qualified beneficiaries may *not* elect to continue life insurance coverage *only*. The same election time periods and payment due dates will apply. The life insurance coverage that will be made available during the COBRA Coverage period will be the same as the life insurance coverage being provided by the Plan to similarly situated Participants with respect to whom a qualifying event has not occurred. If this option is elected, the qualified beneficiary's 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 or under this self-payment continuation option is terminated by the Trustees.

5. COBRA Coverage Self-Payments and Due Dates - Qualified beneficiaries who elect COBRA Coverage must pay the required monthly self-payment. The amount is established by the Trustees, subject to periodic review and change, and generally must remain constant for a 12-month period. It is limited to 102% (150% for a disability related extension from 18 to 29 months) of the applicable premium. Qualified beneficiaries will be notified of the monthly cost in the COBRA election notice and of any subsequent changes that affect them.

All self-payments are due at the Plan Office by the due date. The first self-payment is due within 45 days after COBRA Coverage is elected. It must cover the cost of COBRA Coverage for all months ending before the first self-payment. For example, if COBRA Coverage is elected on November 15 for coverage retroactive to October 1, the first self-payment is due by December 30. If it is made on December 10, it must cover the self-payments due for October and November.

Qualified beneficiaries are responsible for ensuring that the self-payment amounts are correct and should contact the Plan Office if assistance is needed. If the first self-payment is not paid by the due date, COBRA Coverage will not take effect and will be forfeited.

All self-payments, after the initial payment, are payable monthly and due on the first day of the month, with a 30-day grace period. For example, the self-payment for April's coverage is due on April 1. The 30-day grace period ends on April 30. If the self-payment is paid by April 30, COBRA Coverage will be provided for April. If it is *not* paid by April 30, COBRA Coverage will end as of March 31 (assuming timely payment for March) and cannot be reinstated. Self-payments that are received at the Plan Office late will not be accepted. No waivers will be granted. A check that is submitted for payment but returned for insufficient funds or other reasons will be treated as non-payment.

Claims for reimbursement will not be processed and paid until there is a timely election and payment. If the required monthly self-payment is made *on or before the first day of the month*, Plan coverage will continue for that month without a break. If it is made *within the 30-day grace period but after the 1st day of the month*, Plan coverage for the month may be suspended as of the first day of the month and then retroactively reinstated when payment is received. Bills or notices of self-payments due for coverage will *not* be sent. Qualified beneficiaries are responsible for paying the required amounts in a timely manner.

6. Length of COBRA Coverage -COBRA Coverage is available to a qualified beneficiary until the first of the following to occur:

(a) For a covered Employee's insufficient hours or termination of employment qualifying event ("QE"), 18 months of COBRA Coverage or, for a Bargaining Unit Employee who exhausts the initial 18 months, up to an additional 18 months if he or she remains available for work in Covered Employment;

(b) For a QE that is a (i) covered Employee's death, divorce, or legal separation, or (ii) covered Dependent's loss of status as an eligible Dependent under the Plan, or (iii) when there are multiple QEs, 36 months of COBRA Coverage after the loss of Plan coverage due to the initial QE (required written notice of a second or additional QE must be given to the Plan Office within 60 days after it occurs);

(c) If, during the initial 18 months of COBRA Coverage for a QE that is an Employee's insufficient hours or termination of employment, a qualified beneficiary with COBRA Coverage is determined by SSA to be totally disabled before or during the first 60 days of COBRA Coverage and provides the required notice to the Plan Office, 29 months of COBRA Coverage will be available to the entire family receiving COBRA Coverage unless the disability ends before that time. If it does, the extended period for disability (from 18 to 29 months) will end at the end of the month that includes the 30th day after a SSA determination that the disability has ended;

(d) If the QE is a covered Employee's insufficient hours or termination of employment that occurs after the Employee first becomes entitled to Medicare while covered by the Plan, the 18 months of COBRA Coverage that would otherwise be available to qualified

beneficiaries who are Dependents will extend, if longer, to the end of the 36-month period measured from the date the Employee first becomes entitled to Medicare;

(e) The last day of the last month for which the required self-payment is made timely (taking into account any applicable grace period);

(f) The date, after COBRA Coverage is elected, on which the individual first becomes covered under another group health plan (does not include Medicare) that does not have a limitation or exclusion for a pre-existing condition affecting the individual (or if it does, the first day on which it no longer affects the individual). Qualified beneficiaries who become covered under another group health plan must notify the Plan Office within 30 days after initially becoming covered;

(g) The date the Plan no longer provides group health care coverage to Employees; and

(h) The date the individual takes action that would result in a termination of coverage for cause for a similarly situated active Employee or Dependent.

No individual affected by multiple events will be entitled to a continuous COBRA Coverage period of more than 36 months from the initial loss of Plan coverage. If COBRA Coverage will terminate earlier than the 18, 29, or 36-month period that would normally apply based on the type of QE, the Plan will notify the affected individuals in writing as soon as practicable explaining why and when coverage will terminate and any available alternative coverage.

7. The Marketplace and Other Coverage Options - Instead of enrolling in COBRA Coverage, there may be other more affordable coverage options through the Health Insurance Marketplace ("Marketplace") or other group health plan coverage options (e.g., through a spouse's employer) with a special enrollment period. Some of these options may cost less than COBRA Coverage. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, an individual may be eligible for a tax credit that lowers monthly premiums and cost-sharing reductions right away. Through the Marketplace, individuals can also learn if they qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program ("CHIP").

Individuals who lose their job-based coverage have a special enrollment period of 60 days from such loss to enroll in the Marketplace. After this 60-day special enrollment period, they may not be able to enroll until an open enrollment period. Individuals who enroll in Marketplace coverage instead of COBRA Coverage cannot then change to COBRA Coverage. For more information, visit www.HealthCare.gov, or contact the Plan Office.

H. OTHER EXTENDED COVERAGE OPTIONS

1. Extended Coverage Option for Retired Employees and their Dependents - The following retired Employees ("Retirees") may extend health and life insurance coverage under the Plan, for themselves and their covered Dependents, on a self-payment basis as described below:

(a) Retirees who are receiving a pension benefit from the Electricians Pension Plan, IBEW 995 ("Pension Plan") or the National Electricians Benefit Fund; and

(b) Retirees under age 65 who have terminated employment, are eligible for Medicare, and are also eligible to receive a pension benefit from the Pension Plan.

The amount of the required self-payment is determined by the Trustees (the "Retiree Rates"). This extended coverage option is available in lieu of, and not in addition to, COBRA Coverage. It must be elected during the election period for COBRA Coverage or, if COBRA Coverage is initially elected, at any time through the date it ends. To make the election, the Retiree must pay the required self-payment and waive all remaining rights to COBRA Coverage in the form required by the Plan.

If a Retiree dies while the Retiree and Dependent spouse have this extended coverage, the surviving Dependent spouse may elect to continue (a) health coverage for the spouse and any Dependent children covered at the Retiree's death, and (b) the Surviving Spouse Life Insurance coverage in the amount described in the Schedule of Benefits, on a self-payment basis at the Retiree Rates. If elected, coverage will continue until the first of the following to occur: (a) failure to pay a required self-payment timely; (b) the surviving spouse's remarriage or death, (c) the surviving spouse's eligibility for other group health plan coverage (does not include Medicare), or (d) for a Dependent child, the date the child ceases to qualify as a Dependent under the Plan. The Surviving Spouse Life Insurance coverage is self-insured by the Fund.

The required self-payments must be made monthly and received at the Plan Office by the first day of the month to be timely. For purposes of determining the self-payment rate, a Retiree will be treated as an active Employee for any period for which coverage is paid through Employer contributions or exhaustion of a Dollar Bank account. A Retiree with a Dependent child will be charged the highest self-payment rate established by the Trustees. If self-payment is not made timely as required, extended coverage will terminate at the end of the last month for which timely payment was made and cannot be reinstated.

2. Extended Coverage Option for Disabled Employees and Their Dependents – Employees who become "totally disabled" while covered by the Plan and satisfy the following requirements, may extend health and life insurance coverage under the Plan, for themselves and their covered Dependents, on a self-payment basis, when their active Employee coverage ends (after exhausting any available Dollar Bank account balance):

(a) They must present satisfactory proof of "total disability" to the Plan, which means the Employee is totally disabled from gainful employment within the meaning of the Social Security Act; and

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

The required self-payment amount is determined by the Trustees. This extended coverage option is available 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 initially elected, at any time through the date it ends. Election is made by paying the required self-payment and waiving all remaining rights to COBRA Coverage in the form required by Plan.

If the disabled Employee dies while having this extended coverage, any surviving Dependents covered at the Employee's death may elect to continue health coverage, and for a surviving Dependent spouse the Surviving Spouse Life Insurance coverage in the amount described in the Schedule of Benefits, on a self-payment basis at rates established by the Trustees. If elected, 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 plan coverage (does not include Medicare), or (c) the end of the 36-month period that begins with the first calendar month after the disabled Employee's death. The Surviving Spouse Life Insurance coverage is self-insured by the Fund.

All required self-payments are payable monthly and must be received at the Plan Office by the first day of the month to be timely. In determining the self-payment rate, the disabled Employee will be treated as an active Employee for any period for which coverage is paid through Employer contributions or exhaustion of a Dollar Bank account. A disabled Employee with a Dependent child will be charged the highest self-payment rate established by the Trustees. If self-payment is not made timely as required, extended coverage will terminate at the end of the last month for which timely payment was made and cannot be reinstated.

3. **Extended Coverage Option for Surviving Spouses** - If an active or retired Employee dies while the Employee and his/her Dependent spouse are covered by the Plan, health coverage for the Employee's Dependents (spouse and children) and life insurance coverage for the Dependent spouse, will continue without charge, before COBRA Coverage or another extended coverage option becomes available, until the Employee's coverage would have ended using any remaining Dollar Bank credit, or if longer, for 90 days after the end of the month in which death occurs. The covered Dependents (spouse and children) may then elect COBRA Coverage to the extent available under the Plan.

   If the surviving spouse is receiving a surviving spouse's pension benefit from the Pension Plan and is not eligible for the extended coverage option described in Section 1. above, the surviving spouse will also have the option to extend health and life insurance coverage under the Plan, on a self-payment basis at Retiree Rates, until (a) remarriage or death; (b) eligibility for other group health plan coverage (does not include Medicare); or (c) failure to make a required self-payment timely.

   This extended coverage option is available in lieu of, and not in addition to, COBRA Coverage. It may be elected at any time during the COBRA Coverage election period or, if COBRA Coverage is elected, at any time through the date it ends. The election is made by paying the required self-payment and waiving all remaining rights to COBRA Coverage in the form required by the Plan.

   All required self-payments are payable monthly and must be received at the Plan Office by the first day of the month 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 is self-insured by the Fund. If self-payment is not made timely as required, the extended coverage will terminate at the end of the last period for which timely payment was made and cannot be reinstated.

PLEASE NOTE: Extended coverage rights provided by the Plan that are 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, total 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 anyone, regardless of status at the time of the amendment or termination.

I. TERMINATION OF COVERAGE

1. Active Employees – An active Employee's coverage under the Plan will terminate on the first of the following dates to occur, subject to any right to continue coverage under COBRA or another extended coverage option under the Plan:

(a) For Bargaining Unit Employees, the end of the last Benefit Month for which timely payment is made from the available Dollar Bank credit;

(b) For Non-Bargaining Unit Employees, the end of the last month for which the Employer contribution required for coverage is received by the Fund;

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

(d) The last day for which coverage has been timely paid if the Employee is required to self-pay to continue coverage;

(e) The date on which the Employee is no longer eligible for coverage (or, if applicable, the end of the last paid-up period of coverage in which such eligibility ends); and

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

2. Retirees and Disabled Employees - The extended coverage for a Retiree or Disabled Employee will terminate on the first of the following dates to occur:

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

(b) The last day for which coverage has been timely paid if coverage is being provided on a self-payment basis;

(c) The date of the Employee's death;

(d) For a Disabled Employee, the date the Employee is no longer totally disabled or the date the Employee first becomes eligible for other group health plan coverage (does not include Medicare), whichever occurs first; and

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

3. Eligible Dependents – A Dependent's coverage under the Plan will terminate on the first of the following dates to occur subject to the right, if any, to continue coverage under COBRA or another extended coverage option under the Plan:

(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 in which the Employee's death occurs; and

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

J. FAMILY AND MEDICAL LEAVE OF ABSENCE

If you are an Employee who is eligible for FMLA Leave, you may take unpaid leave for up to 12 weeks during a 12-month period or 26 weeks if the reason is to care for a covered service member with a serious injury or illness and continue your pre-leave medical coverage.

FMLA applies to employers who employ at least 50 employees in 20 or more work weeks in the current or prior calendar year. To be eligible, you must work for a covered Employer for at least 12 months and 1,250 hours over the 12 months before leave begins, at a location where the Employer employs 50 or more employees within a 75-mile radius.

FMLA Leave may be available for the following reasons:

1. Birth and care of a newborn child;

2. Placement of a child with you for adoption or foster care;

3. Caring for a spouse, child, or parent with a serious health condition;

4. Medical leave if you are unable to work due to a serious health condition;

5. "Qualifying exigencies" due to a spouse, child, or parent being on active duty or being called to active-duty status as a member of the National Guard or Reserve in support of contingency operations; or

6. Caring for a spouse, child, parent, or next of kin who is a member of the Armed Forces, National Guard or Reserves, and has a serious injury or illness incurred in the line of active duty rendering him or her medically unfit to perform duties.

The Employer must (a) properly grant the FMLA Leave, (b) notify the Plan Office, and (c) pay contributions to the Fund on your behalf. You must give advance notice of the need and reason for the leave when it is foreseeable or otherwise as soon as reasonably possible and provide information to substantiate that it qualifies as FMLA Leave. The Dollar Bank credit does not have to be used to continue health coverage. If you have questions or are considering taking FMLA Leave, contact your Employer or the Plan Office.

K. QUALIFIED MILITARY SERVICE LEAVE OF ABSENCE

If you are an Employee who (a) takes a leave of absence for qualified military service that is protected under USERRA, (b) is discharged honorably or with a protected status, and (c) returns to Covered Employment within the protected period, you will *not* lose credit for your earned service, your credited contributions for eligibility purposes, or your Dollar Bank credit, and will have any pre-leave coverage reinstated upon return. "Qualified military service" may include active or inactive duty training or active duty in the United States Armed Forces or National Guard.

Employees and Dependents with Plan coverage when qualified military service leave begins, may continue coverage during the leave for up to 24 months. If the leave is 30 days or less, coverage will be provided on the same terms (i.e., there is no charge unless self-pay is required when leave begins). If it is longer than 30 days, coverage will be provided in the same manner as COBRA Coverage, which means there must be a timely election to continue coverage and payment of the required self-payments within the COBRA time periods. Any continued coverage provided to satisfy USERRA will also apply to satisfy COBRA rights (i.e., they will run at the same time). See the "COBRA Continuation Coverage Rights" Section for a full explanation of COBRA.

Medical coverage under the 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.

To qualify for USERRA protections, you must return to Covered Employment within the following period following discharge:

1. Within 90 days for military service that is more than 180 days;

2. Within 14 days for military service that is more than 30, but less than 180, days; and

3. By the beginning of the first regularly scheduled work period (plus travel time and an additional eight hours) for military service of 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 recovery of up to two years.

If you have questions about military leave, you should speak directly with your Employer or, for questions about Plan coverage, the Plan Office. If you must leave employment for military service,

you should notify your Employer and the Plan Office as soon as possible to ensure protection of your USERRA rights. USERRA rights and Plan coverage will be provided only as required by law.

L. RECIPROCITY

The Trustees may enter into reciprocal agreements ("Reciprocal Agreements") with trustees of other welfare benefit trust funds. Their purpose is to allow an employee, who works outside of the home jurisdiction and in another jurisdiction that is covered by a Reciprocal Agreement, to have employer contributions received by the work jurisdiction welfare fund transferred to the home jurisdiction welfare fund. Employee registration and consent to the transfer are generally required. Please contact the Plan Office for questions about Reciprocal Agreements and your related rights and obligations.

ARTICLE III

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

A. INSURED BENEFITS

The Life Insurance and Accidental Death and Dismemberment ("**AD&D**") Benefits are fully insured and provided through an insurance policy purchased by the Fund, unless otherwise noted. "**Policy**" means the insurance policy, related certificate of insurance, and benefit booklet, issued by the Insurer. The Policy is incorporated with and forms a part of the Plan.

The Life Insurance and AD&D Benefits provided by the Plan, and your related obligations and rights, will be governed by the Policy in effect at the date of death, or date of an accident resulting in accidental death or dismemberment. The Policy will override any conflicting Plan provisions with respect to the Life Insurance and AD&D Benefits that are payable. The following is a summary of those benefits. Benefit booklets issued by the Insurer are available without charge upon request to the Plan Office.

B. LIFE INSURANCE BENEFIT

1. For Covered Employees - If you are an Employee who dies while covered by the Plan and the Life Insurance Benefit, the amount shown in the Schedule of Benefits will be paid to your surviving Beneficiary. Payment will be made in one lump-sum, or any settlement option offered under the Policy, upon submission of satisfactory proof of death to the Plan Office.

Your "**Beneficiary**" will be the surviving person(s) or entity designated by you in writing on a form acceptable to and filed with the Plan. If there is none, your Beneficiary will be the surviving member or members of the first surviving class determined in the following order (to be shared equally): (a) your surviving lawfully married spouse; (b) your surviving children; (c) your surviving parents; (d) your surviving siblings; or (e) your estate. For a fully insured benefit, the Trustees may delegate to the Insurer the authority to make a Beneficiary determination for payment purposes.

You may change your Beneficiary designation in writing at any time without notice to or consent of your previously named Beneficiary. If you name two or more Beneficiaries, they will share equally unless you specify otherwise. Beneficiary designation forms are available without charge upon request to the Plan Office. Completed Beneficiary designation forms should be returned to the Plan Office. A

Beneficiary designation is effective as of the date recorded by the Plan and is without prejudice to any payment made before recordation. If the Beneficiary is the estate, a portion of the Life Insurance Benefit may be paid to a person who incurred funeral or other expenses incident to your death.

2. For Dependents - If you are an Employee's Dependent who dies while covered by the Life Insurance Benefit, the amount shown in the Schedule of Benefits will be paid in one lump-sum, upon submission of satisfactory proof of death to the Plan Office: (a) to the Employee if surviving; or (b) if not surviving, to the surviving member or members of the first surviving class in the following order listed (to be shared equally): (i) the Employee's lawfully married spouse; (ii) the Employee's children; (iii) the Employee's parents; (iv) the Employee's siblings; or (v) the Employee's estate.

C. CONVERSION RIGHTS

The Policy provides conversion rights if you lose your Life Insurance coverage in certain instances. Generally, you must be covered under the Policy for at least five (5) years to qualify for converting a specified amount to a whole life insurance policy with no evidence of insurability. Written application and payment of the first premium are required within 31 days after Life Insurance coverage ends. Certain restrictions and conditions apply. Failure to act promptly may result in the forfeiture of these rights. For additional information, please refer to the Policy, or contact the Insurer or Plan Office.

D. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS (EMPLOYEES ONLY)

If you are an active Employee and die or suffer a covered loss due to an injury sustained in an accident that occurs while covered, the amount shown in the Schedule of Benefits will be paid as follows.

For a covered loss of life, the benefit will be paid to your Beneficiary determined in the same manner described above for a covered Employee's Life Insurance Benefit.

For any other covered loss, the benefit will be paid to you. When the benefit for a covered loss is based on a percentage of the Full Benefit, the maximum benefit payable for all covered losses arising from the same accident is the Full Benefit (e.g., if there is loss of a hand and death due to the same accident, the maximum benefit payable is the Full Benefit, not 50% plus 100% of the Full Benefit).

There are additional benefits described which list a specific dollar amount that is payable with loss of life (i.e., the Seat Belt, Air Bag, Repatriation, and Education Benefits). If any of these benefits are payable, they will be paid in addition to the Full Benefit that is payable for loss of life.

To be covered, the loss must be a direct result of the accident and occur within 365 days. *There are exclusions under the Policy*. For example, a loss caused or contributed to by any of the following is currently excluded: (a) disease, infirmity of mind or body, or medical or surgical treatment thereof; (b) infection; (c) suicide or attempted suicide; (d) intentionally self-inflicted injury; (e) war, declared or undeclared; (f) travel or flight in an aircraft while a crew member, engaged in operation, or giving/receiving training or instruction; (g) commission (attempted or successful) or participation in an assault or felony; (h) being under the influence of drugs, gas, fumes, poisons, or other controlled substances (unless being used in a manner prescribed by a licensed physician); (i) intoxication; and (j) participation in a riot, public violence, disorder, or disturbance of the peace. Please refer to the Policy for the actual terms and conditions.

REMEMBER: The above descriptions of the Life Insurance and AD&D Benefits are only summaries of the Policy which may change from time to time. The actual terms of the Policy will govern. For questions or additional information, please contact the Plan Office.

ARTICLE IV

COMPREHENSIVE MEDICAL BENEFITS

A. WHAT THE PLAN PAYS FOR

The Plan helps you pay for Covered Charges incurred for covered medical care, services, supplies and treatment as described in this Article (generally referred to as "**Covered Services**"). These benefits are self-insured by the Fund. A charge is incurred on the date the Covered Service is furnished.

B. THE CALENDAR YEAR DEDUCTIBLE

The "Calendar Year Deductible" is the annual aggregate dollar amount of your Covered Charges incurred during a calendar year, as shown in the Schedule of Benefits, for which you are financially responsible before the Plan has a financial responsibility for Covered Charges you incur during the calendar year. A separate Calendar Year Deductible applies to each Participant. All Covered Services are subject to the Calendar Year Deductible except for (1) Preventive and Wellness Services, and (2) Covered Services that are subject to the Additional Accident Expense Benefit. Balance Billed charges, excluded services and items, and Prescription Drugs which are not covered because you do not submit a reimbursement claim to the Plan Office, do *not* count toward the Calendar Year Deductible.

C. NETWORK AND OUT-OF-NETWORK (OON) PROVIDERS

The Trustees have contracted with a Preferred Provider Organization ("**PPO**") to provide a network of Physicians, Hospitals, and other health care providers ("**Network Providers**") that agree to charge you discounted rates for Covered Services. The Allowable Charge for a Network Provider is the contractually agreed upon discounted rate.

You may obtain Covered Services from providers that do not participate in the PPO and are not Network Providers (called "**Out-of-Network Providers**" or "**OON Providers**"); however, their charges will *not* be discounted and the benefits payable under the Plan will be lower (and often substantially lower) than the benefits payable for Network Providers.

The Trustees have also contracted with a Pharmacy Benefit Manager to provide a network of pharmacies ("**Network Pharmacies**") that agree to charge you discounted rates for Prescription Drugs. Prescription Drugs are covered only when purchased from Network Pharmacies.

A directory of the Network Providers and Network Pharmacies will be provided to you without charge. For a list of Network Providers, see www.bcbsil.com. For a list of Network Pharmacies, see www.savrx.com. You may also use the contact information on your Plan ID card or call the Plan Office to obtain this information.

If you use an OON Provider, you may be Balance Billed for the difference between its charges and the amount covered by the Plan which is based on the Allowable Charge, except under the special rules described below. If you use a Network Provider, the Network Provider may not Balance Bill you for more than the amount covered by the Plan.

Special Rules Under No Surprises Act: The rules described above are the general rules that normally apply. However, you have certain patient protections under the No Surprises Act when you receive the following services from an OON Provider that would be covered by the Plan if received from a Network Provider: (1) Emergency Medical Services for an Emergency Medical Condition; (2) non-Emergency Medical Services from an OON Provider at a Network Hospital or other covered Network facility (unless you give informed voluntary written consent, when permitted, to waive those protections); and (3) Air Ambulance services.

When these special rules apply: (1) the Plan's payment for an OON Provider's charges will be based on the "Recognized Amount", *no*t the Allowable Charge, and the Co-Payment Percentage will be the amount that applies for a Network Provider; (2) you *cannot be* Balance Billed by the OON Provider for amounts not covered by the Plan; and (3) your out-of-pocket costs will count toward your annual Out-of-Pocket Limit as if the Recognized Amount is for services and items received from a Network Provider. These special rules will be interpreted and applied in a manner that complies with the No Surprises Act and will override any conflicting general rules that would normally apply.

D. CO-PAYMENT PERCENTAGES AND OUT-OF-POCKET LIMIT

Co-Payment Percentages: The Co-Payment Percentages are the percentages of Covered Charges payable under the Plan and payable by you, as shown in the Schedule of Benefits, after your Calendar Year Deductible is satisfied and subject to any maximum Plan limits. The Plan's Co-Payment Percentage for a Network Provider is higher than its Co-Payment Percentage for an OON Provider. Conversely, your Co-Payment Percentage for a Network Provider is lower than your Co-Payment Percentage for an OON Provider.

Special Rule for Continuing Care Patients: This special rule applies if you qualify as a Continuing Care Patient with a Network Provider and, during treatment: (1) the provider's Network Provider status terminates (other than for fraud or failure to meet quality standards); or (2) the Plan benefits change for the provider due to a change in its participation in the Plan. If this occurs, the Plan will notify you of your right to continue to receive treatment or care with that provider, if needed and on the same coverage terms as if its Network Provider status had not terminated, for up to 90 days or, if earlier, until you no longer qualify as a Continuing Care Patient.

Out-of-Pocket Limit: The Plan also has an Out-of-Pocket Limit. It is the annual aggregate dollar amount of your Covered Charges incurred during a calendar year, as shown in the Schedule of Benefits, for which you are financially responsible. After your Out-of-Pocket Limit is met, the Plan's Co-Payment Percentage increases to 100% for your Covered Charges incurred during that calendar year.

There is also a family Out-of-Pocket Limit. It is the annual aggregate dollar amount of Covered Charges incurred by a covered Employee and Dependents (the "Family") during a calendar year, as shown in the Schedule of Benefits, for which the Family is financially responsible. After the Family Out-of-Pocket Limit is met, the Plan's Co-Payment Percentage increases to 100% for Covered Charges

incurred by any Family member during that calendar year, provided the Family member has also satisfied the Calendar Year Deductible.

The following do *not* apply towards satisfaction of an Out-of-Pocket limit: (1) charges incurred for medical services, items, or prescription drugs *not* covered by the Plan for any reason; (2) charges exceeding the Allowable Charge; (3) Balance Billed charges; and (4) any penalties paid for failure to comply with Plan requirements.

E. ADDITIONAL ACCIDENT EXPENSE BENEFIT

If you suffer a non-occupational Injury while covered by the Plan, any Covered Charges you incur for the Injury, within the first three (3) months after the accident, are eligible for this benefit. The Calendar Year Deductible will be waived, and the Plan's Co-Payment Percentage will increase to 100%, subject to the maximum benefit amount shown in the Schedule of Benefits. The maximum benefit amount applies per Participant per accident. Once the maximum benefit is paid, any additional expenses incurred will be subject to the Plan's normal limits and rules.

F. UTILIZATION REVIEW PROGRAM

The Plan has a Utilization Review Program to determine Medical Necessity, appropriateness, location, and cost-effectiveness of health services. It may include pre-certification, continued stay review, discharge planning, retrospective review, case management, and physician fee negotiation.

All Hospital inpatient admissions (except for Emergency and maternity admissions) and the admissions and services listed in the Schedule of Benefits must be reviewed, approved, and certified by the Plan as being Medically Necessary and covered ***before*** admission or receipt of services. The list may change from time to time. The Schedule of Benefits will be updated as needed to reflect changes.

To obtain the required pre-certification, you or your provider must contact the Plan's Utilization Review ("**UR**") Coordinator, before the proposed admission or rendering of services, and provide all required information. The UR Coordinator will determine if it is Medically Necessary and covered and notify you or your provider of its determination. The UR's name and contact information are listed in the Schedule of Benefits. It is an independent utilization management company, staffed with licensed health care professionals, who use nationally recognized health care screening criteria and their medical judgment to make these determinations.

If required pre-certification is not requested and obtained, the Plan will determine if the admission or services are Medically Necessary and covered. If they are not, you will have to pay all charges incurred.

Once you are admitted for inpatient care, the UR Coordinator will monitor your inpatient stay for continued Medical Necessity and appropriateness. If additional days of inpatient care are needed beyond the number certified, you or your provider must notify the UR Coordinator and provide the necessary information as soon as possible and before the end of the certified stay. The UR Coordinator will evaluate if additional inpatient care is Medically Necessary and the most appropriate setting for additional care. If approved, it will pre-certify an additional number of days of continued inpatient care.

The UR Coordinator may change the number of days pre-certified at any time if it determines that fewer days of inpatient care are needed, and care can be safely and effectively provided in another setting.

Notice of any change will be provided to you or your provider before its effective date. If you receive inpatient care beyond the number of days pre-certified, no benefits will be payable.

G. CHIROPRACTIC SERVICES BENEFIT

Chiropractic Services are services for the diagnosis and treatment, by manual or mechanical means, of conditions associated with the functional integrity of the spinal column, and interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column, and related X-rays and rehabilitative measures. Covered Charges incurred for Chiropractic Services performed by a Physician who is a Doctor of Chiropractic, are covered by the Plan on an outpatient basis only, subject to the limits described in the Schedule of Benefits. Covered Expenses incurred for x-rays, casts, splints, braces, surgery and Hospital charges will be considered for payment under Other Medical Benefits described in Section L, not under the Chiropractic Services Benefit.

H. SKILLED NURSING CARE FACILITY 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.

If you (1) are treated for an Illness or Injury on an inpatient basis in a Hospital for three or more days, and (2) can receive continued treatment, that is needed and would otherwise be provided in the Hospital, in a Skilled Nursing Care Facility, and (3) are admitted to the Skilled Nursing Care Facility immediately after release from the Hospital, your Covered Charges incurred for continued treatment in the Skilled Nursing Care Facility will be covered by the Plan subject to the limits described in the Schedule of Benefits. As a condition of coverage, your treating Physician must prescribe a written treatment plan and supervise your continued care and treatment in the Skilled Nursing Care Facility. Any expenses incurred for confinement in the Skilled Nursing Care Facility that exceed the limits for this benefit will not be payable by the Plan under another benefit.

I. PREGNANCY BENEFIT

Covered Charges incurred for pregnancy, childbirth or related medical conditions are covered only for Participants who are Employees and Dependent spouses, and not for Dependent children. Under federal law, benefits (a) may not be restricted for a Hospital length of stay in connection with childbirth, for the mother or newborn child, to less than 48 hours after a normal vaginal delivery, or 96 hours after a caesarean section, or (b) require a health care provider to obtain Plan authorization for this length of stay. Plan authorization may be required for a longer length of stay. You and your provider may voluntarily agree to a shorter period.

J. PREVENTIVE AND WELLNESS SERVICES BENEFIT (NETWORK ONLY)

Preventive and Wellness Services Covered: The Plan covers the Preventive and Wellness Services required to be covered by the Patient Protection and Affordable Care Act ("ACA"). Coverage is provided for Network Providers only, at 100% with no Calendar Year Deductible or other cost-sharing. The list of services required by the ACA is reviewed and updated each year as needed to reflect current recommendations. If a recommendation is issued to add or update a service, the Plan

will cover the recommended change starting with the Plan Year that begins at least one year after the recommendation is issued. If a recommendation is issued to discontinue a service, it will no longer be covered after the end of the Plan Year in which the recommendation is issued.

The required Preventive and Wellness Services fall within the following categories:

1. Services with an "A" or "B" rating recommended by the U.S. Preventive Services Task Force or "USPSTF", (includes screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, and child and adult obesity);

2. Immunizations for routine use in children, adolescents or adults recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents listed in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) including the American Academy of Pediatrics Bright Futures guidelines;

4. Preventive care and screenings for women listed in comprehensive guidelines supported by HRSA (includes FDA-approved contraceptive methods and counseling and gestational diabetes screening);

5. Preventive care services for smoking cessation and tobacco cessation for Participants age 18 or older as recommended by the USPSTF including counseling and nicotine replacement therapy products prescribed by a Physician; and

6. Over the counter items identified as an A or B recommendation by USPSTF when prescribed by a Physician.

Certain age, gender, and quantity limitations apply. To check the current list of recommended services, visit the website for the U.S. Department of Health and Human Services at http://www.healthcare.gov/preventive-care-benefits/. You may also call the number on your Plan ID card or the Plan Office for assistance.

If federal guidelines are unclear about which preventive and wellness services must be covered under the ACA, the Plan will determine if a particular service is covered under this benefit.

Office Visit Coverage: There may be limited situations when a Network Provider office visit is payable under the Preventive and Wellness Services Benefit. If a preventive and wellness item or service is billed separately from an office visit, or if it is not billed separately but the primary purpose of the office visit is *not* the delivery of such item or service, the Plan will impose cost sharing for the office visit. However, if it is not billed separately from the office visit and the primary purpose of the office visit is the delivery of such preventive and wellness service or item, the Plan will cover 100% of the office visit.

Preventive and Wellness Services Limitations and Exclusions:

1. Preventive and wellness services are covered in full under this benefit only when performed for preventive screening reasons and billed under the appropriate preventive services codes, not when they are performed for diagnostic reasons.

2. The Plan may use reasonable medical management techniques to control costs of this benefit by covering only the most cost-effective test methodology that is medically appropriate for you, and by establishing treatment, setting, frequency, and medical management standards for specific preventive services.

3. Travel immunizations that are not otherwise covered under this benefit are not covered.

4. Examinations, screenings, tests, items, and services are not covered when they are not otherwise covered under this benefit and are provided for the following purposes: (i) when required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes; (ii) when related to judicial or administrative proceedings; (iii) when required to maintain employment or a license; and (iv) when related to medical research or trials unless specifically required by law.

K. PRESCRIPTION DRUG BENEFIT

The Plan has contracted with a Pharmacy Benefit Manager, as shown in the Schedule of Benefits, to offer you a network of participating pharmacies ("**Network Pharmacies**") at which you can obtain Prescription Drugs at a cost savings. Information about the current Network Pharmacies is listed in the Schedule of Benefits. A directory of the Network Pharmacies will be provided to you without charge. For a list of Network Pharmacies, see www.savrx.com. You may also use the contact information on their Plan ID card or call the Plan Office.

The Plan only covers Prescription Drugs purchased from a Network Pharmacy and does not cover Prescription Drugs purchased from an out-of-network pharmacy. To obtain benefits under the Plan for Prescription Drugs, you must go to a Network Pharmacy and present your Sav-RX Identification ("ID") card and Physician's prescription. The pharmacist will handle any required pre-authorization and confirm coverage. You must pay 100% of the discounted cost upfront and then submit an acceptable printout or receipt with all required information to the Plan Office for reimbursement. Upon approval, the reimbursable amount, which is the Co-Payment Percentage applied to the discounted cost paid, (i) will first be applied to satisfy your Calendar Year Deductible as needed, and (ii) then will be payable to you.

For long-term medications, you may be able to use a Sav-RX Mail Order Pharmacy, which is cost effective and allows convenient home delivery. For additional information, contact Sav-RX using the contact information on your ID card or call the Plan Office.

Coverage for Prescription Drugs that are prescribed and administered in a Hospital, Ambulatory Surgical Center, or Skilled Nursing Care Facility, will be determined under the medical benefit.

Medicare Eligibility: Medicare prescription drug coverage is available to everyone with Medicare. 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. You may choose to get your prescription drug coverage by enrolling in a Medicare Prescription Drug Plan or Medicare Advantage Plan that offers such coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may offer more coverage for a higher premium.

The Plan also offers prescription drug coverage to Participants who are Medicare eligible retirees. Each year, the Plan's actuary 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". An annual notice will be provided to you, if you are a Medicare eligible retiree, informing you of this determination and your enrollment options. You may then choose, during the Plan's annual enrollment period, to enroll in a Medicare drug plan. If you do so, you must promptly notify the Plan Office of your enrollment. You will continue to have medical coverage under the Plan; however, you will lose Prescription Drug coverage under the Plan effective upon such enrollment.

L. OTHER MEDICAL BENEFITS

Medical benefits are payable under the Plan for Covered Charges you incur for the following medical care, services, supplies and treatment, subject to the Calendar Year Deductible, Co-Payment Percentages, and benefit limitations and exclusions described below as well as in the Schedule of Benefits, and Limitations and Exclusions for Medical Benefits:

1. Hospital room and board facility fees with general nursing services, laboratory, x-ray, diagnostic, and related ancillary services, supplies, and medicines while an inpatient.

2. Hospital specialty care unit facility fees (such as intensive care unit, cardiac care unit, and neonatal care unit), including laboratory, x-ray, diagnostic, and related ancillary services and supplies.

3. Services and supplies for treatment of an Injury or Illness on an outpatient basis at a Hospital or Ambulatory Surgical Center.

4. Use of a Hospital emergency room ("ER") and Ancillary Services performed during the ER visit for treatment of an Emergency Medical Condition.

5. Services for medical care or treatment of Injuries, Illnesses, Mental Disorders, and Substance Use Disorders, provided by a Physician, or by a Physician Assistant or Nurse Practitioner when there are no Physician charges for the same services, at an in-person visit. Coverage will also be provided when these services are provided at a telehealth visit, but only for Physicians, Physician Assistants, and Nurse Practitioner, who are Network Providers. A "telehealth visit" means a real-time interaction between the patient and provider, through use of electronic information and communication technologies as the mode for the provider to deliver these services for consultation with, and/or diagnosis, treatment, and care of, the patient.

6. Services by a Physician who is a surgeon or assistant surgeon for surgical procedures. Coverage for an assistant surgeon is provided only if the use of an assistant surgeon is required with reference to nationally established guidelines. The Allowable Charge for an assistant surgeon is based on a percentage of the primary surgeon's fee. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan will determine which surgical procedures are considered separate procedures and which are considered a single procedure for the purpose of determining the Plan's benefits.

7. Services for nursing care by a Registered Nurse (R.N.).

8. Outpatient laboratory and radiology (X-ray) services and examinations, including technical and professional fees associated with diagnostic and curative laboratory and X-ray services.

9. Anesthesia, and its administration and related care by a Physician.

10. Professional Ambulance services for local transportation to the nearest Hospital that can furnish the necessary care or treatment for your Emergency Medical Condition, or that is certified by a Physician as Medically Necessary for your condition. For Emergency transportation by air or other non-ground Ambulance to be covered, you must be in a location that cannot be reached by ground Ambulance, or it must be specifically requested by police or medical authorities present at the site because of your condition. If you have an Emergency Medical Condition that arises while you are traveling outside of the United States and require special and unique covered medical services that are not locally available, coverage will be provided for transportation to the United States by ground Ambulance or on a regularly scheduled flight on a commercial airline.

11. Blood and blood derivatives that are not donated and administration of these items.

12. Artificial limbs and eyes.

13. Surgical dressings, casts, splints, trusses, braces, crutches, and other devices used in the reduction of fractures and dislocations.

14. Oxygen and the rental or purchase (depending upon availability) of equipment for its administration.

15. Prescription Drugs ordered in writing and dispensed by a Physician. Prescription Drugs approved for self-administration (includes oral and self-injectable drugs) must be obtained through the Prescription Drug Benefit.

16. Durable Medical Equipment when prescribed by a Physician. At the Plan's option, benefits will be provided for the rental or purchase of the Durable Medical Equipment.

Reasonable quantity limits will be determined by the Plan. There is no coverage for repair or replacement of equipment damaged due to neglect or misuse.

17. Home phototherapy to treat jaundice when prescribed by a Physician.

18. Routine nursery or well-baby care of a covered newborn in the Hospital 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 covered mother's benefits for the admission for pregnancy care and childbirth, subject to the mother's Calendar Year Deductible; all other charges for the covered newborn's care will be included in the newborn's benefits, subject to the newborn's Calendar Year Deductible. Medical services for care and treatment of a covered newborn before discharge from the Hospital for an Illness contracted after birth, or an abnormal congenital condition caused by a premature birth, are covered and will be included in the newborn's benefits, subject to the newborn's Calendar Year Deductible.

19. Services by a Physician to remove impacted wisdom teeth and to treat injuries to natural teeth resulting from an accident, including replacement of the injured teeth, setting a fractured or dislocated jaw, and necessary dental X-rays, but only to the extent treatment begins within 90 days after the accident (except as delayed due to Medical Necessity), and is completed within one (1) year after the accident.

20. Mastectomy resulting from breast cancer and related breast reconstruction surgery including: (i) all stages of reconstruction of the breast on which the mastectomy is performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; (iii) prostheses; and (iv) treatment of physical complications of mastectomy including lymphedemas. Benefits for reconstructive breast surgery will be provided as required by the Women's Health and Cancer Rights Act of 1998, and in a manner determined in consultation with the attending provider and patient.

21. Cosmetic Surgery required (i) due to injuries sustained in an accident and performed within 12 months following the accident, and (ii) for treatment of a congenital anomaly.

22. Charges incurred for the treatment of infertility subject to the infertility treatment limit set forth in the Schedule of Benefits.

23. Physical therapy, occupational therapy, and speech/language pathology therapy for rehabilitative and habilitative treatment or care for Injuries, Illnesses, Mental Disorders, and Substance Use Disorders, when rendered by a Physician and subject to the limits described in the Schedule of Benefits.

24. Bariatric surgery for the treatment of morbid obesity when it is Medically Necessary and meets all medical criteria established by the Plan's Utilization Review Coordinator.

25. Medical services and supplies directly related to your receipt of a human organ or tissue transplant, including patient screening, procurement and transportation of the

organ/tissue, transportation and surgery for patient and donor, follow-up care, and immunosuppressant drugs, except to the extent benefits for donor related services are available through other group health coverage. Organ/tissue transplant services must be performed at a transplant center program in a major medical center approved by the federal government or an appropriate state agency of the state where the center is located.

26. Surgical procedures, medical services and supplies that are Medically Necessary and performed on an outpatient basis at an Ambulatory Surgical Center.

27. Home health care services for your continued medical care and treatment following hospitalization, provided you are under a Physician's care and continued hospitalization would otherwise be required if home health care was not provided; this includes 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 you had remained in the Hospital.

28. Effective July 1, 2024, hospice care, which means care that (i) is furnished or arranged by a Hospice, and (ii) is provided as part of a coordinated plan of home and inpatient care designed to meet the special needs of a terminally ill Participant and family unit due to the terminal illness. The hospice care may include medical care, palliative care rendered to relieve the symptoms or effects of the illness without curing it, and bereavement counseling by a licensed or certified social worker to assist the patient or family unit in coping with the dying process.

    The hospice care covered by the Plan is limited to six (6) months every three (3) years for a Participant and excludes the following: (i) respite care; (ii) custodial care; (iii) private duty nursing; (iv) homemaker services; (v) travel or transportation expenses or escort services; and (vi) dietitian services, food or home-delivered meals.

    A "terminally ill Participant" is a Participant who is certified by a Physician as being terminally ill and expected to live six (6) months or less. The "family unit" is each member of the terminally ill Participant's family who is also a Participant. "Hospice" means an agency or organization that administers a program of palliative and supportive health care services for terminally ill persons, is approved by Medicare or licensed under the laws of the jurisdiction where it is located and operates under the direction of a Physician.

29. Effective July 1, 2024, for Participants who are Dependent children ages five (5) to eighteen (18), one (1) routine eye examination per Plan Year and one (1) pair of eyeglasses or contact lenses per Plan Year.

30. If you are receiving covered treatment on an inpatient basis in a Hospital or other covered facility when your coverage under the Plan terminates, your coverage under the Plan will continue solely for such inpatient covered treatment until the earlier of discharge or Plan termination.

31. Treatment of Mental Disorders and Substance Use Disorders are covered by the Plan in the same manner as any other Illness.

32. Routine patient costs for items or services otherwise covered by the Plan and furnished in connection with your participation in an Approved Clinical Trial ("Trial") for treatment of cancer or another life-threatening disease or condition, when you are eligible according to Trial protocol, and (i) your health care provider is a participating provider in the Plan and concludes that your participation would be medically appropriate, or (ii) when you provide medical and scientific information establishing that your participation would be medically appropriate. Routine patient costs do not include (i) an investigational item, device, or service; (ii) items and services provided solely to satisfy data collection and analysis needs and not used in your direct clinical management; and (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. The Trial must be a phase I, II, III, or IV clinical trial conducted for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, that is (i) funded or approved by the federal government, (ii) conducted under an investigational new drug application reviewed by the federal FDA, or (iii) a drug trial exempt from having such an investigational new drug application.

M. LIMITATIONS AND EXCLUSIONS FOR MEDICAL BENEFITS

No benefits will be payable under the Plan for charges incurred for the following, regardless of Medical Necessity and notwithstanding any Plan provision to the contrary, nor will such charges count toward satisfaction of your Calendar Year Deductible or Out-of-Pocket Limit:

1. Any treatment, service, or supply that is not specifically identified as covered, and complications of non-covered treatments.

2. Services, equipment, drugs, devices, items, or supplies that are: (i) not Medically Necessary, unless covered under the Preventive and Wellness Services Benefit or for routine nursery or well-baby care of a covered newborn in the Hospital; (ii) for Custodial Care; or (iii) determined by the Plan to be Experimental or Investigational.

3. Charges you are not obligated to pay, or that exceed the Allowable Charge or the amount that would be charged if you had no health coverage.

4. Charges you incur when you are not covered by the Plan (except as provided for continued coverage of inpatient treatment until discharge or Plan termination).

5. Services or items provided or furnished by or at the direction of a Physician or medical provider acting outside of the scope of his or her license.

6. Diagnosis and treatment of refractive errors (includes routine eye exams, eyeglasses, and contact lenses except for an initial pair and fitting after cataract surgery and as specifically covered for Dependent children); vision therapy (except following an accident or Illness rehabilitation); and surgical correction of refractive disorders

(includes radial keratotomy and other eye surgery), unless and except as required under the Preventive and Wellness Services Benefit.

7. Cosmetic surgery and related medical complications, and treatments, services, prescription drugs, equipment, and supplies given for cosmetic purposes, which means they are performed or given primarily to preserve, change or improve physical appearance and not physical function, except as specifically covered by the Plan.

8. Medical care or treatment for an Illness or Injury arising out of or in the course of your employment or entitling you to benefits under any type of worker's compensation law.

9. Medical care and services for an Illness, Injury or condition resulting from or incurred while taking part in: (i) war or an act of war, declared or undeclared (does not include being a victim of an act of terrorism); or (ii) the commission of or attempt to commit an assault, battery, or felony. This exclusion does not apply if the Injury results from being the victim of an act of domestic violence, or from a medical condition (includes both physical and mental health conditions).

10. Medical or dental treatment of temporomandibular joint dysfunction or syndrome ("TMJ"), and dental procedures of any kind, except as specifically covered by the Plan.

11. Medical care, treatment and supplies furnished by a Hospital, program, or agency owned, operated, or funded by the U.S. Government; however, this exclusion does not apply to Medicaid or when otherwise prohibited by law.

12. Except as specifically covered, the diagnosis and treatment of infertility and inducing pregnancy (includes fertility tests, surgical impregnation procedures, reversal of sterilization procedures, hormonal therapy, in vitro and in vivo fertilization, surrogate parenting, donor egg/semen, cryostorage of egg/sperm, and infertility donor expenses).

13. Hearing aids, cochlear implants, detachable portable monitors or stimulators, and examinations for the necessity, fitting or adjustment of the same.

14. Medical care, services, supplies, and prescription drugs for or in connection with the pregnancy of a covered Dependent child.

15. Medical care, treatment, and supplies furnished outside of the United States, except for emergency medical care or treatment or while you are on temporary work assignment outside of the United States, to the extent it would be covered under the Plan if provided in the United States. For the Plan to reimburse your Covered Charges for services and supplies provided outside the United States and as needed by the Plan, you must submit a claim and itemized bill in English or translated into English which includes (i) the CPT-4 procedure code and ICD-9 diagnosis code or a full description of the procedures, medical services and supplies furnished with the diagnosis for each date of service, and (ii) clearly identifies the provider's credentials and shows that the provider is a registered or certified health care practitioner, and (iii) the charges in U.S. currency and value of the currency at the time the claim was incurred. The Plan will

determine the Allowable Charge based on the general level of charges made by providers rendering comparable services in the geographical area of the Plan Office.

16. Care and treatment of obesity, weight loss programs, and dietary control (includes diets, prescription drugs, surgery, and skin reduction procedures) even if performed to treat a comorbid or underlying health condition, except as specifically covered by the Plan or required by federal law.

17. Medical services and items that you receive from an out-of-network provider while enrolled in a Medicare Advantage HMO, that are considered ineligible by the HMO.

18. Educational services and supplies; job and vocational training and retraining; and treatment of learning disabilities (except to the extent classified as Mental Disorders).

19. Massage therapy, rolfing, and related services.

20. Career counseling, marital or pre-marital counseling, divorce counseling, parental counseling (including as it relates to pregnancy, adoption, custody, and family planning), and employment counseling, unless required to be covered under the Preventive and Wellness Services Benefit or by applicable law.

21. Gender-affirming and reassignment (sex change) medical, surgical, and prescription drug (including hormone therapy) treatment and care.

22. 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 of third-party liability the Plan may advance or pay Plan benefits that are due in the absence of such third-party liability subject to the Plan's subrogation, reimbursement, and recovery rights.

23. Items for personal comfort, hygiene, fitness, and convenience which are not considered medical supplies (includes air conditioners, air-purification units, dehumidifiers, exercise and personal fitness equipment, health club and exercise program charges, home or vehicle alterations, foods, nutritional supplements, and formulas).

24. Care and treatment for hair loss, whether prescribed by a Physician or not (includes wigs, hair transplants, and any drug that promises hair growth).

25. Care, treatment, or services of a private duty nurse.

26. Genetic testing, unless the results are specifically required for a medical treatment decision, and gene therapy, whether provided as part of the medical or prescription drug benefit; gene therapy typically involves replacing a gene that causes a medical problem with one that does not, or adding a gene to help the body fight or treat disease, or inactivating a gene that cause medical problems (includes chimeric antigen receptor T-cell therapies such as Kymriah and Yescarta, and Luxturna and Zolgensma).

27. Cellular immunotherapy whether provided as part of the medical or prescription drug benefit, and also known as adoptive cell therapy or T-cell transfer therapy, which is a form of treatment that uses the cells of your own immune system to eliminate disease (includes tumor-infiltrating lymphocyte (TIL) therapy, engineered T-cell receptor (TCR) therapy, chimeric antigen receptor (CAR) T-cell therapy and natural killer (NK) cell therapy).

28. Non-Prescription Drugs (other than injectable insulin), and prenatal vitamins and minerals regardless of whether they require a prescription, unless required to be covered under the Preventive and Wellness Services Benefit.

29. Organ and tissue transplants except to the extent specifically covered by the Plan.

30. Charges for missed appointments, the preparation of forms, mailing, interest, late fees, mileage, or provider administration.

31. Treatment for sexual dysfunction.

32. Nursing home care and assisted living facility care, regardless of the level of care required or provided.

33. Telehealth services rendered by Out-of-Network Providers and telehealth services that are not suitable for the setting in which they are provided (even if rendered by a Network Provider).

ARTICLE V

COORDINATION OF BENEFITS

A. MEDICAL BENEFITS SUBJECT TO COORDINATION OF BENEFIT RULES

General Rule – The medical benefits provided by the Plan will be coordinated with medical benefits provided by any Other Plan. It is your obligation, as a Participant, to notify the Plan Office of the existence of any other medical coverage.

Failure to notify the Plan Office of coverage under Other Plans may result in overpayment by the Plan. If this happens, the Plan will have recovery rights against you for the overpayment.

The Coordination of Benefit ("**COB**") rules require that medical benefits payable under all plans be coordinated so that the total amount paid is not greater than 100% of the Allowable Expense incurred. Payment will be made on a primary-secondary plan basis. The primary plan will calculate its benefit for the Allowable Expense and pay first without regard to any Other Plan. Each secondary plan will then calculate and reduce its benefit, to credit payments by all plans that are primary to it, so that the total benefits paid by all plans do not exceed 100% of the Allowable Expense.

DEFINITIONS

The following terms, when used in this Article as capitalized terms, will have the meaning described.

"**Allowable Expense**" means a necessary and reasonable expense (including deductibles and coinsurance) for medical services, treatment, or supplies, which is covered in whole or part under any Other Plan. An expense that is not payable by the primary plan because of your failure to comply with cost containment requirements (such as, for example, pre-certification and pre-admission testing) will not be considered an Allowable Expense by the secondary plan. If a plan provides benefits in the form of services and not cash payments, the reasonable cash value of each service provided will be treated as an Allowable Expense and benefit paid.

"**Other Plan**" means any of the following plans or coverage which provide benefits or services for or by reason of medical care or treatment: (1) group, blanket or franchise coverage, whether on an insured or self-insured basis (except student accident insurance); (2) group Blue Cross and/or Blue Shield and other pre-payment coverage on a group basis, including Health Maintenance Organizations (HMOs); (3) coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit plan; (4) coverage under governmental programs or required or provided by statute, including Title XVIII of the Social Security Act, Medicare Part A, B, or C, but not a state plan for medical assistance provided under Title XIX of the Social Security Act (Medicaid) or as otherwise prohibited by law; and (5) other arrangements of insured or self-insured coverage. Other Plans also include, but are not limited to, coverage provided under employer-sponsored health coverage resulting from your spouse's employment, Medicare coverage resulting from your disability, and other work-related health care plans.

B. ORDER OF BENEFIT DETERMINATION AND EFFECT ON PLAN BENEFITS

When the Plan receives a claim involving an Allowable Expense, it will apply the COB rules described in this Article to determine the Plan benefits payable for the Allowable Expense. The order of benefit determination rules described below will determine which plan is the primary plan and which plan(s) are the secondary plan(s). The primary plan will pay its benefits without regard to the secondary plan(s). The secondary plan(s) will then adjust their benefits so that the total benefits from all plans do not exceed the Allowable Expense. No plan pays more benefits than it would have paid in the absence of an Other Plan and the COB rules.

Benefits payable under the Other Plan will include the benefits that would have been payable if a claim had been made to the Other Plan.

Order of Benefit Determination Rules:

A plan without a coordinating provision is always the primary plan. If two or more plans have a coordinating provision, the following rules apply to establish the order of benefit determination:

1. Non-Dependent/Dependent: A plan that covers a person as an employee or retiree is primary, and a plan that covers a person as a dependent is secondary.

2. Dependent Child Covered Under More Than One Plan: If there is a court order or Qualified Medical Child Support Order mandating a Dependent child's coverage, it will always govern. Otherwise, the following rules apply to determine the primary and secondary plans for the child.

If the parents are married or living together (regardless of whether they have ever married), the plan of the parent whose birthday (month and day only) occurs earlier in the calendar year is the primary plan, and the plan of the parent whose birthday (month and day only) occurs later in the calendar year is the secondary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan. If a plan with the "birthday" rule is coordinating with a plan that uses a rule based on the parent's sex, the rule based on the parent's sex will determine the order.

If the parents are divorced or legally separated, or are not living together (regardless of whether they have ever married), the following rules apply: (a) a plan covering the parent with custody of the child pays first; (b) a plan covering the spouse of the custodial parent pays next; (c) a plan covering the non-custodial parent pays next; and (d) a plan covering the spouse of the non-custodial parent pays next.

3. Active, Laid-Off or Retired Employee: A plan that covers a person as an active employee (not laid-off or retired) or as that person's dependent is primary. A plan that covers a person as a laid-off or retired employee or as that employee's dependent is secondary. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined under the Non-Dependent/Dependent rule.

4. Continuation of Coverage: If a person with coverage under a right of continuation under federal or state law or under an Other Plan's continuation of coverage rules is also covered under the Plan, the plan that covers the person as an employee, retiree, or dependent thereof, is primary, and the plan that covers the person through continuation coverage is secondary. If the Other Plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.

5. Longer/Shorter Length of Coverage: If the previous rules do not establish an order of benefit determination, a plan that has covered the person for a longer time is primary, and a plan that has covered the person for the shorter time is secondary.

6. Medicare and Medicaid: If a person is covered under the Plan as an active Employee or as a Dependent spouse of an active Employee and is also covered under Medicare, the Plan is primary while the active employment status continues, and Medicare is secondary. If a person is covered under the Plan as a retired Employee or as a Dependent of a retired Employee and is also covered under Medicare, Medicare is primary, and the Plan is secondary. If a person with end-stage renal disease is covered under the Plan and under Medicare: (a) for the first 30 months of the end-stage renal disease, the Plan is primary, and Medicare is secondary; (b) thereafter, Medicare is primary, and the Plan is secondary.

If a Medicare Advantage HMO is primary and the Plan is secondary, and the Plan receives an Explanation of Benefits ("EOB") from the HMO which shows the total Allowable Expenses, the Plan will consider the total Allowable Expenses, less the amount covered by the HMO, in determining the benefits payable by the Plan. If the Plan does not receive an EOB from the HMO, it will consider only the following in determining the benefits payable by the Plan: (i) out-of-pocket expenses (such as co-payments) charged by the HMO; and (ii) expenses not normally covered by Medicare.

If a person is covered by the Plan and under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid), the Plan is primary. The Plan will pay its benefits in accordance with Medicaid law, which may include payment by the Plan in accordance with an assignment of rights made by or for such person.

7. Default Rule: If none of the preceding rules determines the primary plan, the Allowable Expense will be shared equally by the plans, although in no event will a plan pay more than it would have paid had it been the primary plan.

8. Miscellaneous Rules: If a person is covered by the Plan as the primary plan, the Plan's Out-of-Pocket Limit will not apply to any Allowable Expenses except with respect to coverage of Prescription Drugs. If a person is covered by a HMO as the primary plan and voluntarily goes out of the HMO's network to receive medical services that are not covered by the HMO, all charges incurred for those services will *not* be eligible for reimbursement under the Plan. If, however, a person covered by a HMO as the primary plan, receives in-network services which are not covered by the HMO, all charges incurred for those services will be eligible for reimbursement under the Plan.

C. RIGHT TO RECEIVE AND RELEASE INFORMATION AND PAYMENT

The Plan may release to or obtain from another person or entity information necessary to administer and determine the applicability of the COB rules. When you claim benefits under the Plan, you must furnish the information required by the Plan to implement the COB rules. The Plan reserves the right to pay, to another person or entity, the amount it determines to be warranted to satisfy the intent of these rules, and any amount so paid will fully discharge the Plan and Fund, to the extent of such payment, from further liability under the Plan.

D. RIGHT OF RECOVERY

The Plan reserves the right to recover any overpayments that are made to the fullest extent allowed by law. In doing so, the Plan may calculate the payment it should have made based on its presumption that the level of health coverage provided by the Other Plan is equivalent to the Plan's level of coverage. Participants must cooperate fully with the Plan, and provide requested information and documents, to assist with and enable its recovery of the overpayment. If an overpayment is due to your failure to submit a claim for benefits to an Other Plan, the Plan may reduce payment of future benefits for claims incurred by you or your Dependents, as allowed by law, to recoup its overpayment.

ARTICLE VI

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

A. ESTABLISHMENT OF HRA

The Plan includes a "Health Reimbursement Arrangement" or "HRA". It is an Employer-funded health care reimbursement account that allows eligible Employees to obtain reimbursement of their Eligible HRA Expenses on a tax-free basis. The HRA is intended to qualify as a medical reimbursement plan

under Code Sections 105 and 106, and as a health reimbursement arrangement under IRS guidance. It will be interpreted and administered in a manner consistent with that intent.

B. ELIGIBILITY TO PARTICIPATE IN HRA AND TERMINATION OF ELIGIBILITY

Employees who are covered by the Plan due to active employment with an Employer are eligible to participate in the HRA. Self-employed individuals are *not* eligible to participate. "You", as used in this Article, means an eligible Employee.

Your HRA participation begins when you are initially covered by the Plan. It will terminate on the effective date of the first of the following events to occur, subject to any COBRA continuation coverage rights: (1) your Plan coverage as an active Employee terminates (taking into account any Dollar Bank credit but excluding other extended coverage); (2) the HRA is terminated; or (3) your election to permanently opt-out of and waive participation in the HRA.

Once your HRA participation terminates, no further contributions will be credited to your HRA account. If your HRA participation ends and is not reinstated within 12 months, any HRA account balance remaining at the end of the 12 months will be forfeited and cannot be reinstated. If your HRA participation is reinstated within 12 months, it will remain in effect.

The right to permanently opt-out of and waive participation in the HRA is exercisable by written notice to the Plan Office. If this option is exercised, any remaining HRA account balance will be forfeited without the right of reinstatement, and Employer contributions will no longer be credited to the HRA account. This opportunity to make a permanent opt-out election will be allowed at least annually.

Participants must be enrolled in a group health plan that provides "minimum value coverage" to obtain reimbursement of Eligible HRA Expenses. The Plan provides "minimum value coverage".

C. SOURCE OF CONTRIBUTIONS AND CREDITING OF HRA ACCOUNTS

Only Employer contributions may be credited to HRA accounts. You may not contribute to your HRA account. Before each Plan Year begins, the Trustees will determine, in their discretion, the amount (if any) of Employer contributions that will be credited to HRA accounts for the Plan Year. They reserve the right not to credit HRA accounts for one or more Plan Years and for any reason.

If the Trustees approve an "**HRA Credit**" for a Plan Year and you are a Participant on the first day of the Plan Year, your HRA account will qualify for a credit in the following amount. The amount credited will be the total HRA Credit approved for the Plan Year, multiplied by the following fraction: (1) the number of months you participated in the Plan in the prior Plan Year, divided by (2) 12.

If you are *not* a Participant on the first day of the Plan Year but become a Participant during the Plan Year for which an HRA Credit is approved, an HRA account will be established for you as of the date your participation begins. It will be credited with a pro rata share of the total HRA Credit approved for the Plan Year, based on the number of months you participated during the prior Plan Year.

Examples of how a HRA Credit of $1,000.00 approved for the 2025 Plan Year would be credited:

1. If you are a Participant on January 1, 2025, and participated for all 12 months of 2024, your HRA account will be credited with $1,000 as of January 1, 2025.

2. If you are a Participant on January 1, 2025, but did *not* participate for any month during 2024, your HRA account will *not* receive a credit on January 1, 2025.

3. If you are *not* a Participant on January 1, 2025, but become a Participant on June 1, 2025, and you participated for six (6) months of 2024, your HRA account will be credited with $500.00 as of June 1, 2025 ($1,000 approved for 2025 multiplied by 6/12 months of participation in 2024).

HRA accounts are established for record-keeping purposes only and will not be maintained as separate accounts or have segregated assets. All HRA reimbursements are payable from the Fund's general assets. No one has a claim, right, or security interest to or in any account or asset of the Fund. The HRA reimbursement right may not be assigned or alienated.

You may use your HRA account only to obtain reimbursement for Eligible HRA Expenses incurred by you or your covered Dependents. Reimbursement is available up to your HRA account balance. Your HRA account balance will be the cumulative Employer contributions credited to your account, minus the cumulative reimbursements debited from your account. If you have an HRA account balance remaining at the end of the Plan Year, it will be carried over to the following Plan Year provided your HRA participation continues.

There is a limit on the amount of an HRA account balance that may be carried over to the following Plan Year. Beginning December 31, 2024, the maximum HRA account balance that may be carried over to the following Plan Year (the "Carry-Over Year"), is the Out-of-Pocket Limit Per Family Per Calendar Year for the Plan (the "OOP Family Limit"), in effect as of January 1 of the Carry-Over Year. The OOP Family Limit is stated in the Schedule of Benefits for the Plan. There is one exception to this limit. If you have an existing HRA account balance as of December 31, 2024 ("Grandfathered Amount" or "GF Amount"), that is greater than the OOP Family Limit, you may carry over the greater GF Amount until it equals or falls below the OOP Family Limit.

Examples of how the HRA Carry-Over Limit Applies:

Example 1: You have an HRA account balance of $12,000.00 on December 31, 2024 (your "GF Amount"). The Plan's OOP Family Limit, as of January 1, 2025, is $10,000.00. You may carry over your higher GF Amount of $12,000.00 as your HRA account balance on January 1, 2025.

Assume the Plan's OOP Family Limit is the same as of January 1, 2026 ($10,000.00); however, you received HRA account reimbursements during 2025 and reduced your GF Amount to $9,000.00 as of December 31, 2025. You no longer have a higher GF Amount on December 31, 2025, so your maximum HRA carry-over limit for 2026 is now the Plan's OOP Family Limit as of January 1, 2026 ($10,000.00).

Example 2: On December 31, 2024, you do *not* have an existing HRA account balance that is greater than the Plan's OOP Family Limit as of January 1, 2025, so your maximum HRA carry-over limit for 2025 is the Plan's OOP Family Limit as of January 1, 2025.

D. ELIGIBLE HRA EXPENSES

"Eligible HRA Expenses" are medical care expenses, within the meaning of Code Section 213, incurred by you or your covered Dependents. These expenses include self-payments for COBRA or other extended self-payment coverage under the Plan. To be reimbursable, the Eligible HRA Expense must be incurred on or after the date the person first becomes eligible to participate in the HRA. Expenses incurred before eligibility are *not* reimbursable.

Eligible HRA Expenses may be reimbursed only to the extent that the person who incurs the expense has *not* been reimbursed for it, and only to the extent it is *not* reimbursable through the Plan or other accident or health insurance or coverage. If only a portion of the expense has been reimbursed or is reimbursable elsewhere, the unreimbursed and unreimbursable portion may be reimbursed from the HRA account. For example, if you incur a medical care expense that is not reimbursed by the Plan because it is applied to your Calendar Year Deductible or Co-Payment Percentage, it may be eligible for reimbursement through the HRA. HRA accounts may *not* be cashed out or used to provide any other taxable or nontaxable benefit.

The following expenses are NOT eligible for reimbursement under the HRA, even if they meet the definition of a "medical care expense" under Code Section 213 and would otherwise be reimbursable under IRS guidance pertaining to HRAs: (a) amounts paid for employee or group insurance coverage *other than* COBRA and extended coverage self-payment amounts under the Plan; and (b) expenses for long-term care services.

E. REIMBURSEMENT PROCEDURE

To obtain reimbursement for an expense, you must submit a written claim to the Plan Office, within 90 days after the expense is incurred, in a form acceptable to the Plan, unless it is not reasonably possible to do so, in which case it must be filed as soon as reasonably possible and within one (1) year after the expense is incurred. The Plan's HRA reimbursement request forms are available without charge upon request to the Plan Office. Your claim must include the following information: (i) the name of the person for whom the expense was incurred; (ii) the nature of the expense and date incurred; (iii) the reimbursement amount requested; and (iv) a statement that the expense has not been reimbursed and is not reimbursable through any other source. **Failure to submit a claim timely will result in forfeiture of the right to obtain reimbursement.**

You should also submit with your claim form a bill, invoice, or statement from an independent third party (such as the Plan's Explanation of Benefits), showing the amount incurred and paid, and any other information requested by the Plan to substantiate the claim. Except for the final reimbursement claim for a Plan Year or when participation terminates, claims may not be submitted for reimbursement amounts of less than $100.00.

F. REIMBURSEMENTS BY PLAN

Within 30 days after the Plan Office receives your reimbursement claim, you will be reimbursed if your claim is approved, or you will receive a written notice explaining why your claim is denied. This 30-day period may be extended for up to 15 days if necessary for matters beyond the Plan's control, including when a claim is incomplete. You must be notified in writing of an extension and why it is needed within the initial 30 days and be given 45 days to submit what is needed and complete the claim.

HRA reimbursement claims that are denied may be appealed by following the Plan's Appeal Procedure. They will be treated as Post-Service Claims.

If your HRA participation ends for a reason other than a permanent opt-out and waiver election, you may be reimbursed from any remaining HRA account balance, for Eligible HRA Expenses incurred by you or your Dependents during HRA participation or within 12 months after it ends. If HRA participation ends due to your death, or if you die within 12 months after HRA participation ends, your Dependents or estate may claim reimbursement from any remaining HRA account balance for Eligible HRA Expenses you incurred before death or within 12 months after your HRA participation ends.

All persons submitting HRA reimbursement claims must follow the Reimbursement Procedure described above. **Failure to do so will result in forfeiture of the right to obtain reimbursement.**

G. COORDINATION OF BENEFITS

HRA accounts are available only for reimbursement of Eligible HRA Expenses not previously reimbursed or reimbursable elsewhere. To the extent an Eligible HRA Expense is payable or reimbursable from another source, the other source must pay or reimburse the expense prior to payment or reimbursement from the HRA.

H. AMENDMENT AND TERMINATION

The Board of Trustees reserves the right to amend or terminate the HRA at any time and for any reason. The HRA is not intended to be a vested right, and you have no vested interest in your HRA account, or contributions credited to it.

I. TAX CONSEQUENCES AND CORRECTION OF MISTAKES

The Plan makes no guarantee that amounts paid under the HRA are excludable from gross income for federal, state, or local income tax purposes. As a recipient of an HRA reimbursement payment, it is your obligation to determine if it is excludable from gross income and to notify the Plan Office immediately if you have any reason to believe that it is not excludable.

If you receive an HRA reimbursement payment on a tax-free basis that does not qualify for tax-free treatment, you must indemnify and reimburse the Plan for any liability it incurs for failure to withhold taxes. If there is a mistake related to HRA participation, account allocations, or 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

There are non-discrimination requirements and limits under Code Section 105(h) on reimbursements to "highly compensated individuals". They are not expected to affect Participants. If they do, the Trustees reserve the right to limit reimbursements or treat them as taxable compensation as they deem necessary to comply.

ARTICLE VII

CLAIMS AND APPEAL PROCEDURES AND EXTERNAL REVIEW

A. DEFINITIONS

The following terms, when used as capitalized terms, will have the meaning indicated for purposes of the Plan's Claims and Appeal Procedures.

"**Denial**" or "**Denied**" means an adverse benefit determination including: (1) a denial, reduction, termination of, or failure to pay all or part of a Claim; and (2) a "rescission" of coverage which is a coverage cancellation with a retroactive effect other than for nonpayment, regardless of whether there is an adverse effect on a benefit at the time of the Claim.

"**Claim**" means a request for a Plan benefit made in accordance with its Claims and Appeal Procedures. Casual inquiries about benefits or when they might be payable, requests for prior approval of a benefit when it is not required, and requests about general eligibility, are not considered Claims. However, if a request for a specific benefit is filed as required and Denied because the claimant is not eligible, the benefit request will be considered a Claim.

"**Concurrent Care Claim**" means a Claim for an ongoing course of treatment that was pre-authorized but is being reconsidered before the pre-authorized period or treatments end.

"**Death/AD&D Claim**" means a Claim for Life Insurance or Accidental Death and Dismemberment Benefits.

"**Disability Claim**" means a Claim conditioned on disability when the Plan determines disability based on the medical evidence and does not rely on another party's determination for non-Plan purposes.

"**Health Care Professional**" means a Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

"**Post-Service Claim**" means a Claim for medical benefits that is not a Pre-Service Claim, Concurrent Care Claim, or Urgent Care Claim.

"**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 services or treatment.

"**Relevant"** means the following with respect to a Claim related document, record, or information: (1) it was relied upon in deciding the Claim; (2) it was submitted, considered, or generated in the course of

deciding the Claim regardless of reliance; (3) it demonstrates compliance with administrative processes and safeguards designed to accomplish consistent and accurate Claim decisions; or (4) it is a statement of Plan policy or guidance for a Denied treatment option or benefit for the diagnosis regardless of reliance.

"**Urgent Care Claim**" means a Claim for medical care or treatment when applying the normal time periods for Pre-Service Claims (1) could seriously jeopardize the claimant's life, health, or ability to regain maximum function, or (2) would subject the claimant to severe pain that cannot be adequately managed without the claimed care or treatment. A Claim will be considered an Urgent Care Claim if a Physician with knowledge of claimant's medical condition determines that it satisfies either condition.

B. CLAIMANT AND AUTHORIZED REPRESENTATIVE

Participants and Beneficiaries may appoint an authorized representative to act on their behalf for the purpose of the Claims and Appeal Procedures. This is done by giving written notice and any required documents to the Plan Office. For Urgent Care Claims, a Health Care Professional familiar with the patient's medical condition may act as the patient's authorized representative.

Whenever "you" is used in these Claims and Appeal Procedures, it means a Participant, Beneficiary, or authorized representative thereof, who is making a Claim or appealing a Denial.

C. CLAIMS PROCEDURE

To receive a Plan benefit or related determination, a Claim must be filed in a form acceptable to the Plan in accordance with its Claim Procedure. Claim forms are available without charge upon request to the Plan Office. Claims not properly and timely filed will be Denied, and no benefits will be payable.

Upon receipt of a Claim, the Plan may request information, forms, and documents that it deems necessary to decide the Claim. If more time is needed because additional information is needed, the Plan's response deadline will be suspended (or tolled) from the date you are notified of the information needed until you respond or, if earlier, until your deadline to respond. Voluntary extensions of time may be agreed to by the parties. For Plan purposes, an expense is "incurred" on the date the service or supply giving rise to the expense is furnished.

Urgent Care Claims. You or your provider must call the Plan's Utilization Review ("UR") Coordinator and provide the requested information for your claim. The UR Coordinator will then decide if it qualifies as an Urgent Care Claim based on the judgment of a prudent layperson with an average knowledge of health and medicine. However, if a Physician with knowledge of your medical condition notifies the UR Coordinator that the Claim is an Urgent Care Claim, it will be treated as such.

If properly filed, the UR Coordinator will provide notice of its determination to you or your provider by telephone as soon as possible, considering medical exigencies, and within 72 hours after receiving the Claim. The determination will be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine if, and to what extent, benefits are covered or payable, the UR Coordinator will notify you or your provider as soon as

possible, and within 24 hours after receipt of the Claim, of the specific information needed with a response deadline of at least 48 hours. Notice of the decision will be provided as soon as possible and within 48 hours after receipt of the requested information or, if earlier, the response deadline.

If a potential Urgent Care Claim is improperly submitted but you or your provider notifies a person customarily responsible for handling Plan benefit matters with your name, specific medical condition or symptom, and specific treatment, service, or product for which approval is requested, you or your provider will be notified as soon as possible and within 24 hours after receipt of the information, of the proper procedures for filing the Urgent Care Claim. The notice may be oral unless written notice is requested. Unless the potential Urgent Care Claim is resubmitted properly, it will not qualify as an Urgent Care Claim under the Plan.

Pre-Service Claims. Some inpatient admissions and extended stays, outpatient procedures, and medical services, require pre-certification by the Plan's UR Coordinator before the admission or provision of medical care. They are described in the Schedule of Benefits.

When pre-certification is required, the UR Coordinator must be provided with the requested information to decide the Pre-Service Claim. It will then notify you or your provider of its decision within 15 days after receipt of the Claim. If additional time is needed for reasons beyond its control, up to 15 more days may be taken if you or your provider is notified of the extension, why it is needed, and when a decision is expected, before the initial 15-day response period ends.

If an extension is required because of the need for additional information, you or your provider will be notified of the information needed and given at least 45 days to provide it. The normal response deadline will be suspended from the date of the extension notice until the earlier of (1) receipt of the requested information, or (2) the response deadline. The UR Coordinator will then have 15 days to notify you of its determination. If the information is not provided, the Claim will be Denied.

If a Pre-Service Claim is improperly filed but you or your provider notifies a person customarily responsible for handling Plan benefit matters with your name, specific medical condition or symptom, and the specific treatment, service, or product for which approval is requested, you or your provider will be notified as soon as possible and within five (5) days after receipt of the information, of the proper procedures for filing the Pre-Service Claim. Notice may be oral unless written notice is requested. Unless the potential Pre-Service Claim is resubmitted properly, it will not qualify as a Pre-Service Claim under the Plan.

Concurrent Care Claims. Concurrent Care Claims involve a decision by the Plan's UR Coordinator to terminate or reduce a previously approved course of treatment. If a Concurrent Care Claim arises, the UR Coordinator will notify you of the intended reduction or termination sufficiently in advance to allow you to request an appeal and receive a decision before it occurs.

Concurrent Care Claims do not involve the initial filing of a Claim or situation where you want to extend a course of treatment beyond previously approved limits. If that occurs, you or your provider must file a Claim based on the requirements that apply to its type as determined at filing.

If a Claim qualifying as an Urgent Care Claim is filed to extend a previously approved course of treatment and is received by the UR Coordinator at least 24 hours before treatment is due to end, it will decide the Claim within 24 hours after receipt. If a Claim that does not qualify as an Urgent Care Claim is filed to extend a previously approved course of treatment, the UR Coordinator will decide the Claim within the response period that applies to the type of Claim being filed.

Post-Service Claims. You must file a written Claim and adequate proof with the Plan Office (or as otherwise directed by the Plan) within 90 days after the claimed expense is incurred or the date of loss, unless it is not reasonably possible to do so, in which case it must be filed as soon as reasonably possible and within one (1) year after such date. You will then be notified of the Plan's decision within 30 days after receipt of the Claim. If additional time is needed due to matters beyond the Plan's control, up to 15 more days may be taken if you are notified of the extension, why it is needed, and when a decision is expected, before the initial 30-day response period ends.

If an extension is required because of the need for additional information, you must be notified of the additional information needed and given at least 45 days to provide it. The normal response deadline will be suspended from the date of the extension notice until the earlier of (1) the date the information is provided, or (2) the response deadline. The Plan will then have 15 days to notify you of its decision. If the information is not provided, the Claim will be Denied.

If additional information is needed, the Plan may issue a combined request for information and notice of Denial, which explains that if the information is not provided by the response deadline, the Claim will be Denied and that the timeframe for filing an appeal will run from the response deadline.

Death/AD&D Claims. If the Claim is for a Life Insurance or Accidental Death and Dismemberment ("AD&D") Benefit that is insured and provided through a Policy, you must file a written Claim in the form and within the time required by the Policy. If the benefit is self-insured by the Fund and not insured through a Policy, or the Policy does not require a particular form or time for filing a claim, you must file a written Claim in accordance with the Post-Service Claim requirements. In the case of death, the Claim must include a certified copy of the death certificate and decedent's social security number. You will be notified of the Plan's decision within 90 days after receipt of the Claim. If additional time is needed due to matters beyond the Plan's control, up to 90 more days may be taken if you are notified of the extension, why it is needed, and when a decision is expected, before the initial 90-day response deadline ends.

Disability Claims. You must file a written Claim and adequate proof of disability with the Plan Office (or as otherwise directed by the Plan), within 90 days after you first become disabled or, if it is not reasonably possible to do so, as soon as reasonably possible and within one year after you first become disabled. You will be notified of the Plan's decision within 45 days after the Claim is filed. If additional time is needed, this response deadline may be extended initially for up to 30 days, and again for another 30 days, but only if you are notified before the end of the initial 45-day response period, or the first 30-day extension (as applicable), of the extension, why it is needed, when a decision is expected, the standards on which it will be based, the unresolved issues, and any additional information needed to resolve those issues, with at least 45 days to provide the information.

Please note that if a Disability Claim is under review, initially or on appeal, any Plan decision about hiring, compensating or terminating a medical or vocational expert related to the review will *not* be based on the likelihood of the expert's support of a particular outcome.

Notice of Determination. If your Claim is Denied, written notice of the following information (as applicable) will be provided to you:

1. Specific reasons for Denial and the Plan or Policy provisions on which it is based.

2. Any additional material or information necessary to perfect the Claim, and why it is needed.

3. A copy of the Appeal Procedure.

4. A statement of your right to bring a civil action under ERISA Section 502(a) if benefits are Denied on appeal.

5. Specific internal rules, guidelines, protocols, standards, or Plan criteria relied upon in making the Denial or statement they do not exist (does not apply to Death/AD&D Claims).

6. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information Relevant to the Claim.

7. If the decision 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 (does not apply to Death/AD&D Claims).

8. For Urgent Care Claims, a description of the expedited review process. Notice may be given orally within the required period if written notice is furnished three days thereafter.

9. Information sufficient to identify the Claim including date of service, health care provider, amount, and availability, upon request, of the diagnosis and treatment codes and their meaning.

10. For Denial of Claims involving medical benefits, (i) the denial codes and Plan standards used to Deny the Claim; (ii) a description of the Plan's internal appeals and external review processes; and (c) the availability and contact information for any ombudsman established to assist you with the internal claims and appeals and external review processes. You may receive, free of charge, any new or additional evidence that is considered, relied upon, or generated by the Plan for the Claim, and any new or additional rationale relied upon in deciding the Claim. It must be provided as soon as possible and sufficiently in advance of when notice of the Claim decision is due to allow a reasonable opportunity to respond before that date.

11. For Disability Claims where proof of disability is not established: (i) a discussion of the decision and basis for disagreeing with or not following the views of your treating health care professionals and evaluating vocational professionals, the views of any such experts whose advice was obtained by or for the Plan regardless of reliance, and any Social Security Administration disability determination presented to the Plan; and (ii) 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.

D. APPEAL PROCEDURE

If your Claim is Denied on the initial filing, you may appeal the decision and receive a full and fair review in accordance with the Plan's Appeal Procedure as described in this Section.

Time Period to File Appeal. To appeal a Denial, you must file a written request for review with the Plan Office (or as otherwise instructed in the notice of Denial) within the following time periods: (1) for Death/AD&D Claims, within 60 days after receipt of the Denial; and (2) for other all types of Claims, within 180 days (or a reasonable time for a Concurrent Care Claim) after receipt of the Denial. For Urgent Care Claims, Pre-Service Claims, and Concurrent Care Claims, the appeal may also be made by calling the Plan Office or other appropriate party within the required period. If the appeal is timely filed as required, it will be forwarded to the reviewer for a determination. *If the appeal is not timely filed as required, the initial decision on the Claim will be final.*

Claimant's Rights on Appeal. If the appeal is filed timely as required, you 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 your Claim. The reviewer on appeal will consider all comments, documents, records, and information submitted and related to your Claim, regardless of whether they were submitted or considered in the initial decision.

You may obtain the names of medical or vocational experts whose advice was obtained by the Plan related to the initial decision, without regard to reliance (does not apply to Death/AD&D Claims).

The review on appeal will comply with the following requirements:

1. No deference will be given to the initial determination (does not apply to Death/AD&D Claims).

2. For appeals related to insured benefits provided through an insurance policy ("**Policy**"), the review will be conducted as provided by the Policy. Otherwise, it will be conducted by the Board of Trustees, or its designated reviewer provided it is not the same person or entity that initially decided the Claim, or a subordinate thereof.

3. If the initial decision is based on medical judgment (e.g., if it involves Medical Necessity or if 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 consulted, with the initial decision (does not apply to Death/AD&D Claims).

4. Provide for identification of medical or vocational experts whose advice was obtained on the Plan's behalf without regard to reliance in making the benefit decision.

5. For Urgent Care Claims and Concurrent Care Claims, information and the review process may be transmitted and handled by telephone, facsimile, or other expeditious method.

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

   (a) Any new or additional evidence considered, relied upon, or generated by the Plan or other person making the disability determination for the Plan, which must be provided as soon as possible and sufficiently in advance to give you a reasonable opportunity to respond before the date notice of a Denial on appeal is due; and

   (b) Before the Claim can be Denied on appeal based on a new or additional rationale, you must be provided with the rationale, free of charge, as soon as possible and sufficiently in advance to give you a reasonable opportunity to respond before the date notice of a Denial on appeal is due.

Time Period for Claim Determination on Appeal. Notice of the decision on appeal will be given within a reasonable period after a timely filed appeal is received, without regard to whether all necessary information is filed, and in accordance with the following time periods:

1. *Urgent Care Claims* - as soon as possible considering the medical exigencies and within 72 hours after receipt of the appeal.

2. *Pre-Service Claims* - within 30 days after receipt of the appeal.

3. *Post-Service Claims and Disability Claims* - no later than the first regularly scheduled Board meeting after receipt of the appeal unless received less than 30 days before the meeting, in which case the Board will have until its second regularly scheduled meeting after receipt of the appeal. If more time is needed due to special circumstances, the Board will have until its third regularly scheduled meeting after receipt of the appeal, provided you are notified in writing, before the extension, of the special circumstances and date by which a decision will be made. You will be notified of the final decision on appeal as soon as possible and within five (5) days after the decision is made. If an extension is taken because information is needed from you, the time for deciding the appeal will be suspended (or tolled) from the date you are notified of the information needed until you provide it or, if earlier, the deadline to provide it. Voluntary extensions of time may be agreed to by the parties.

4. *Death/AD&D Claims* - within a reasonable period 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 you are notified in writing, before the initial period ends, of the extension, why it is needed and when a decision will be made.

5. *Concurrent Care Claims* – decisions on appeal will be made in accordance with the period that applies to the nature of the Claim.

Notice of Determination on Appeal. You will be notified in writing of the decision on appeal, and for Denials, the notice will include the following information written in a manner that is understandable:

1. Specific reasons for the Denial and Plan provisions on which it is based.

2. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to your Claim and a statement of your right to bring an action under ERISA Section 502(a).

3. Any internal rule, guideline, protocol, or similar criterion relied upon in making the Denial, or statement that it was relied upon and that a copy is available, free of charge, upon request (does not apply to Death/AD&D Claims).

4. If the Denial is based on medical necessity or experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to your medical circumstances, or a statement that it will be provided free of charge upon request (does not apply to Death/AD&D Claims).

5. A statement describing any available voluntary alternative dispute resolution options (such as mediation) and that you may contact the local Department of Labor office or state insurance regulatory agency to determine any available options.

6. For Denial of Claims involving medical benefits, a statement of the right to request, free of charge, diagnosis, treatment and denial codes and their meaning; Plan standards used to Deny the Claim; information needed to perfect the Claim; a description of the Plan's External Review Process; and the availability with contact information for any ombudsman established to assist individuals with their internal claims, appeals and external review processes.

7. For Disability Claims Denied for failure to establish satisfactory proof of disability:

   (a) A discussion of the decision and basis for disagreeing with or not following the views of your treating health care professionals and evaluating vocational professionals presented to the Plan, as well as the views of such experts whose advice was obtained by or for the Plan, without regard to reliance, in making the determination, and any Social Security Administration disability determination presented to the Plan;

   (b) Any specific internal rules, guidelines, protocols, standards, or similar criteria of the Plan relied upon in making the Denial or a statement that they do not exist; and

   (c) A description of any contractual limitations period that applies to your right to bring legal action, including the calendar date on which it ends for the Claim.

A decision on appeal of any Claim made under the Plan in accordance with its Appeal Procedure will be final and binding on all persons except as described below in the "Standard and Expedited External Review of Claims" Section.

E. STANDARD AND EXPEDITED EXTERNAL REVIEW OF CLAIMS

Standard External Review of Claims.

1. **Claims Qualifying for External Review** – After exhausting the Plan's Claims and Appeal Procedures set forth above, you may request further review by an Independent Review Organization ("IRO") for Denials that involve any of the following:

   (a) Medical judgment such as medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or determination that a treatment is Experimental or Investigational (the IRO will decide if a Denial involves a medical judgment).

   (b) Rescission of coverage regardless of whether it impacts a particular benefit at that time.

   (c) The no surprise medical billing provisions of the No Surprises Act, including determinations as to whether those protections apply and the scope of the protections.

2. **Deadlines for Filing Request for External Review and Preliminary Review**

   (a) Your written request is due four (4) months after you receive the Denial.

   (b) The Plan then has five (5) business days after receipt of your request to complete a "**Preliminary Review**" to determine if you were covered when the health care service or item was requested or furnished, if the Claims and Appeal Procedures were exhausted (except in limited circumstances), and if a complete request has been submitted.

   (c) Within one (1) business day of completing its Preliminary Review, the Plan must notify you in writing as to whether the threshold requirements for external review have been met and, if not, the reasons why and any additional information that must be submitted to perfect the request.

3. **Review by Independent Review Organization (IRO)**

   If the request for External Review is complete and eligible, the Plan will assign it to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood of its support of the Plan's Denial. The Plan will maintain contracts with more than one IRO and rotate assignments for external review. Once assigned, the following procedures apply:

   (a) The IRO will notify you in writing as to eligibility and acceptance and how to submit additional information about the Claim.

(b) The Plan must timely provide the IRO with the documents and information it considered in making the Denial.

(c) The IRO will promptly forward to the Plan any additional information submitted by you, and the Plan may reconsider its Denial. If the Plan reverses its Denial, it must promptly provide written notice to you and the IRO, and the IRO will terminate its external review.

(d) If external review is not terminated, the IRO will consider all information and documents timely received and decide the Claim on a de novo basis. The IRO is bound by the Plan's terms (unless contrary to law) and benefit requirements but not by its decisions reached during the Claims and Appeal Procedures. The IRO may consider additional information if available and appropriate, recommendations or other information from treating health care providers, you or the Plan, reports from appropriate health care officials or practice guidelines, the Plan's clinical review criteria, and the opinion of IRO's clinical reviewer, unless inconsistent with applicable law.

(e) The IRO will provide written notice of its decision to you and the Plan within 45 days after receipt of the request, with the following information unless inconsistent with applicable law: (i) general description of the reason external review was requested and identification of the Claim; (ii) dates of receipt of the external review assignment and decision; (iii) references to evidence or documentation, including specific coverage provisions and evidence-based standards, considered and discussion of the principal reasons for the decision; (iv) statement that the decision is binding except to the extent remedies are available under State or Federal law; (v) statement that judicial review may be available; and (vi) current contact information for any office of health insurance consumer assistance or ombudsman established to assist with external review processes.

Expedited External Review of Claims

1. **Claims Qualifying for Expedited External Review** – You may request an Expedited External Review if you receive:

   (a) A Claim Denial involving a medical condition where the timeframe to complete an expedited internal appeal would seriously jeopardize your life, health, or ability to regain maximum function, and you have filed an expedited internal appeal request; or

   (b) A final internal Claim Denial involving (i) a medical condition where the timeframe for completing standard external review would seriously jeopardize your life, health, or ability to regain maximum function, or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility.

2. **Preliminary Review**

Immediately upon receipt of a request for expedited external review, the Plan will complete a Preliminary Review, as described above for Standard External Review, and immediately notify you of its reviewability assessment as described.

3. Review by Independent Review Organization (IRO)

If the Plan determines that the Expedited External Review request qualifies, it will assign an IRO and expeditiously provide all necessary documents and information considered in Denying the Claim. The IRO must consider all available information and documents and follow the review and notice content guidelines described above for a Standard External Review. Notice of its final decision must be given as expeditiously as the medical condition and circumstances require, but in no event more than 72 hours after its receipt of the request for review. If the initial notice is not given in writing, written confirmation of the decision must be given to you and the Plan within 48 hours after initial notice is given.

After Standard or Expedited External Review of Claims

If the IRO reverses the Plan's Denial, the Plan will immediately, upon receipt of the decision, provide coverage or payment for the reviewed Claim consistent therewith; however, the Plan may then seek judicial remedy to reverse or modify the IRO's decision as permitted by law. If the IRO upholds the Plan's Denial, no coverage or payment will be provided by the Plan for the Denied Claim; however, you may then seek judicial review as permitted by ERISA Section 502(a).

F. TIME LIMIT ON LEGAL ACTION

Before legal action, such as filing a lawsuit, may be brought by or for you to receive benefits under the Plan, you must follow, and timely exhaust, all available Plan procedures discussed in this Article. Once these procedures are timely exhausted and there is a final Claim decision, there is a one (1) year time limit for bringing legal action with respect to your Claim. If the Claim involves an insured benefit that is payable under a Policy purchased by the Fund, the time limit for bringing legal action regarding the insured benefit will be the time limit in the Policy if different from the Plan's one (1) year period.

ARTICLE VIII

PAYMENT, SUBROGATION AND REIMBURSEMENT

A. PAYMENT AND ASSIGNMENT

All benefits will be paid upon receipt and verification of a timely filed Claim and adequate proof of loss in accordance with the Plan's Claims Procedure. Your right to receive benefits or payments under the Plan shall not be alienable by or for you by assignment or any other method and shall not be subject to claims by your creditors by any process whatsoever. Any attempt to do so will not be recognized by the Plan except to the extent required by law.

Without limiting the foregoing, no claim for Plan benefits and no rights related thereto (including the right (1) to pursue an internal claim or appeal; (2) to pursue litigation for payment of benefits, breach of fiduciary duty, or recovery of statutory penalties; or (3) to assign payment) may be assigned to an OON Provider without the Plan Administrator's written consent. In its discretion, the Plan

Administrator may voluntarily pay, or cause to be paid, benefits directly to an OON Provider on your behalf, and such payment will not constitute an assignment of rights or benefits, or be deemed a waiver of this anti-assignment provision, for you.

The Plan may, at its option and subject to any contractual agreement for Network Providers to which the Plan is bound, pay any medical benefits due under the Plan for you directly to the provider or to you. Any payment made by or for the Plan in good faith pursuant to this Section will fully discharge the Plan, Fund, and Trustees to the extent of such payment.

If benefits are payable under the Plan to your estate or to a person who is a minor or not competent or capable of executing a valid release, the Plan may, in the absence of notice of a duly appointed legal representative, pay the benefits to the spouse, family member or other person or entity that, in the Plan Administrator's opinion, is entitled to receive payment for such person. Any payment so made in good faith will fully discharge the Plan, Fund, and Trustees to the extent of such payment.

B. PLAN'S SUBROGATION, RECOVERY AND REIMBURSEMENT RIGHTS

If you suffer an Illness or Injury in an accident 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, and receive medical benefits under the Plan, the Plan will have all claims, demands, actions, and rights of recovery that you have against a responsible third party or any insurer for the benefits paid or payable by the Plan to or for you. The Plan is not in place of worker's compensation coverage, and its benefits are not payable when an Illness or Injury is covered by a state or federal worker's compensation law. If you receive Plan benefits for an Illness or Injury that is later found to be covered by a worker's compensation law, you must immediately notify the Plan and reimburse the Fund for benefits paid in error.

The Plan may condition payment of benefits upon execution, by you and/or your attorney, of the Plan's subrogation and reimbursement agreement ("Agreement"), with language acceptable to the Plan, before receiving Plan benefits or at any time after receiving Plan benefits pending the Plan's recovery of its benefits paid. The Agreement may require certification that: (1) no other payments have been made in satisfaction of your claims; (2) your claims are disputed; (3) the responsible third party is withholding payment pending resolution of the dispute; and (4) any other provisions required by the Plan. The Plan may also withhold future benefit payments if the Agreement is signed but later violated.

Any benefits paid or payable 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 you are obligated to comply with all of the following requirements:

1. To reimburse the Plan out of the first proceeds of any recovery or settlement payable (a) by the responsible third-party or an insurer with respect to such third-party liability, or (b) pursuant to worker's compensation laws, or (c) 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 application of any make-whole or other doctrine that allocates proceeds to non-medical expenses or damages.

2. To reimburse the Plan from any gross amount recovered before payment of attorneys' fees and costs and without regard to whether you are paid for all claimed damages.

3. To cooperate fully with the Plan, to execute and provide all documents and information requested by the Plan to protect, enforce, and facilitate its subrogation, reimbursement, and recovery rights, and to refrain from taking action that would interfere with the Plan's rights.

4. To recognize that the Plan has no obligation to pay you or your attorneys for legal fees and litigation costs incurred in pursuing claims against others.

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

6. To notify the Plan before starting legal action or filing a lawsuit against an allegedly liable third-party or insurer, and to make no settlement or release without the Plan's prior written consent.

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.

8. To protect the Plan's subrogation, reimbursement, and recovery rights and take no action that would prejudice its rights. The Trustees have sole discretion to determine the amount of recovery from any third party, insurer, or workers' compensation insurer.

If you refuse or fail to comply with these obligations, to cooperate as required, or to reimburse the Plan when required, the Plan may (1) take legal action to recover its benefits paid, and (2) withhold payment of other Plan benefits due for related or unrelated claims, to or for you or your Dependents, as an offset against amounts owed to the fullest extent permitted by law.

C. RECOVERY OF OVERPAYMENTS AND IMPROPER PAYMENTS

The Plan's subrogation, reimbursement, and recovery rights shall apply equally to any benefits paid by the Plan in error for any reason including: (1) false or erroneous representations made by you, a provider, or other third-party; or (2) your failure to notify the Plan as required (e.g., of a change in address, loss of Dependent status, or other change affecting coverage). If this happens and the Plan does not recover the overpayment or improper payment after notice and demand, you and any third-party recipient will be obligated to reimburse the Plan for the overpayment or improper payment. Further, the Plan may (1) take legal action as needed for recovery, and/or (2) withhold payment of other Plan benefits payable for you or your Dependents, for related or unrelated claims, as an offset against amounts owed, to the fullest extent permitted by law and until recovery in full.

ARTICLE IX

ADMINISTRATION OF PLAN

The Plan will be administered by the Board of Trustees, which has full and exclusive authority and discretion to determine all matters arising under the Plan. This includes questions of eligibility, benefits payable, methods of providing and arranging for benefits, and the interpretation and construction of the Plan and Trust Agreement. Any determination, interpretation, or construction adopted by the Trustees

in good faith is conclusive and binding on all parties, including but not limited to the Employers, Union, Participants, and Beneficiaries. Any such determination, interpretation, or construction will be given deference in any arbitration, mediation, or judicial proceeding.

The Trustees have all necessary and appropriate powers to carry out their responsibilities and duties, including the following:

1. To interpret Plan and Fund documents; decide ambiguities, inconsistencies, and omissions; and determine all questions of coverage, eligibility, methods of providing benefits (including the purchase of insurance contracts), and rules for processing, deciding, and paying claims.

2. To establish administrative rules and procedures as needed to administer the Plan and Fund, to carry out their duties and powers, and to delegate duties as they see fit.

3. To employ, appoint, and retain persons and entities as they deem necessary or desirable to administer and carry out the daily functions of the Plan and Fund, including but not limited to an Administrative Manager, Plan Office employees, auditors, accountants, actuaries, consultants, third-party administrators, legal counsel, investment advisors, and insurers.

4. To require Participants to furnish information and complete forms as needed for proper administration and to receive benefits, and to determine facts affecting eligibility or benefits.

5. To provide Plan documents and related information as permitted or required by law.

6. To authorize payment or reimbursement of expenses incurred by or for the Plan and Fund.

ARTICLE X

PLAN AMENDMENT AND TERMINATION

The Board of Trustees reserves the right to amend or terminate the Plan, for any reason, and to merge with any other fund established for similar purposes consistent with the Trust Agreement and applicable law. The Trustees may exercise this right at any time, at their sole discretion. This right includes the right to change the level of benefits, method of paying benefits, contribution amounts, and eligibility.

Changes 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.

The Trustees will notify Participants of any material modifications to the Plan as required by law. If the Plan is terminated, the Trustees will, within the limits of the remaining Plan assets in the Fund, adopt a plan to discharge all outstanding obligations and provide that all remaining assets be used in a manner which best carries out the purpose for which the Plan was established (which may include a transfer of assets to another welfare plan to provide benefits to Employees), or are otherwise disposed of in a manner that is consistent with the Trust Agreement and applicable law.

ARTICLE XI

HIPAA PRIVACY AND SECURITY

The law known as "**HIPAA**" resulted in federal privacy and security standards that require group health plans, such as this Plan, to protect the confidentiality of your **Protected Health Information,** sometimes referred to as **"PHI". "HIPAA",** as used in this Article, means the Privacy and Security Standards and implementation specifications set forth in 45 CFR Parts 160-164. The terms used in this Article will be interpreted in a manner consistent with **HIPAA**.

"**PHI**" is defined under **HIPAA** and generally includes health information, including demographic information, collected from you, or created or received by the Plan in any form, from which it is possible to individually identify you. The information must relate to your past, present, or future health or physical or mental condition, or providing health care, or paying for health care.

The Plan will comply with **HIPAA**. It will use and disclose **PHI** only to the extent permitted or required by **HIPAA,** as described below, or permitted by a **HIPAA**-compliant authorization. The Plan also requires its "business associates" (for example, its consultants and attorney), that may create or receive **PHI** on the Plan's behalf, to comply with the privacy and security rules under **HIPAA**.

You have certain rights under HIPAA with respect to your PHI. You have the right to file a complaint with the Plan or HHS if you believe your rights have been violated. A complete description of these privacy rights can be found in the Plan's Privacy Notice, which is distributed at enrollment. A copy is also available upon request to the Plan Office. For questions about the privacy or security of health information or filing a complaint under HIPAA, contact the Administrative Manager, who serves as the Plan's Privacy and Security Officer.

Permitted Uses and Disclosures of PHI by Plan:

Treatment, Payment & Health Care Operations - The Plan may use and disclose **PHI** for your treatment, payment, and health care operations. "**Treatment"** is providing, coordinating, or managing health care treatment and related services by providers. "**Payment**" includes any activity undertaken by the Plan to collect money due to it or to determine or fulfill its responsibility for payment of benefits. "**Health care operations**" include activities related to Plan administration such as case management, care coordination, providing information about treatment alternatives and Plan benefits, underwriting, enrollment, arranging for medical reviews, and cost analysis. Plan administration functions do not include employment-related functions or functions related to other benefit plans. The Plan will not use or disclose **PHI** that is genetic information for underwriting purposes.

Other Permitted Uses and Disclosures - The Plan may also use and disclose **PHI** in the following circumstances: (1) as required by law; (2) as permitted for public health activities and health oversight activities; (3) as permitted for disclosures about victims of abuse, neglect or domestic violence; (4) in response to a court, administrative order, subpoena, discovery request, or other lawful process permitted under **HIPAA**; (5) for law enforcement purposes; (6) to coroners, medical examiners, and funeral directors concerning decedents; (7) to facilitate organ procurement or transplantation if you are an organ donor; (8) for research purposes when individual identifiers are removed or an institutional review or privacy board has approved the proposal and established privacy protocols; (9) if necessary to prevent

a serious threat to a person's health or safety; (10) for specialized government functions and to assist with disaster relief; (11) to comply with workers' compensation or similar programs providing benefits for work-related injuries or illness; and (12) in response to requests from the U.S. Department of Health and Human Services ("**HHS"**) related to the Plan's **HIPAA** compliance.

Uses and Disclosures Requiring an Opportunity to Agree or Object - The Plan may disclose **PHI** to a family member, close friend, or other identified person, directly related to his or her involvement with your health care or payment. You must be told in advance and given an opportunity to agree, object, or limit disclosure, unless it is not possible because of incapacity or emergency circumstances and the Plan decides that disclosure is in your best interest.

Disclosure to Plan Sponsor - the Plan (or its health insurance issuer) may disclose the following **PHI** to the Plan Sponsor without regard to **HIPAA** compliance: (1) Plan enrollment or disenrollment information; (2) summary health information requested for the purpose of (a) obtaining premium bids to provide health coverage or (b) modifying, amending or terminating the Plan; and (3) to the extent permitted by your **HIPAA**-compliant authorization.

Disclosures to Trustees as Plan Sponsor for Plan Administration Purposes - the Plan (or its health insurance issuer) may disclose **PHI** to the Trustees as Plan Sponsor for Plan administration purposes subject to all following conditions:

1. The Privacy Notice must explain the permitted disclosures of **PHI** to Plan Sponsor.

2. The Plan Sponsor must agree to do the following:

   (a) Not use or further disclose **PHI** other than as permitted or required by the Plan or required by law.

   (b) Ensure that any agent or subcontractor, to whom it provides **PHI** received from the Plan, agrees to the same restrictions and conditions for use and disclosure.

   (c) Not use or disclose **PHI** for employment-related actions or decisions, or any of its other benefits or benefit plans, unless permitted by a **HIPAA**-compliant authorization.

   (d) Report any impermissible use or disclosure of **PHI** to the Plan.

   (e) Provide you with your rights under **HIPAA** related to inspection and copying, requesting a disclosure accounting, and amendment of your **PHI.**

   (f) Make its internal practices, books and records related to the use and disclosure of such PHI available to HHS to determine the Plan's HIPAA compliance.

   (g) Return to the Plan or destroy all **PHI** received and maintained in any form and retain no copies when it is no longer needed, or if return or destruction is not feasible, limit further use and disclosure to the purposes that make return or destruction infeasible.

   (h) Establish and maintain adequate separation between it and the Plan.

(i) Provide written certification of its agreement to these disclosure conditions to the Plan.

Plan Sponsor's Security Obligations for E-PHI:

There are additional security obligations that apply if the Trustees, as Plan Sponsor, create, receive, maintain, or transmit **E-PHI** on the Plan's behalf. "**E-PHI**" or "**Electronic Protected Health Information"** means **PHI** that is transmitted by or maintained in electronic media such as computer hard drives, magnetic tapes or disks, and memory cards. It is limited to what the Plan Sponsor creates, receives, maintains, or transmits on the Plan's behalf.

If the Plan Sponsor creates, receives, maintains, or transmits **E-PHI** on the Plan's behalf (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a **HIPAA**-compliant authorization), the Plan Sponsor will do the following:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the **E-PHI;**

2. Ensure that adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures;

3. Ensure that any agent or subcontractor to whom it provides the **E-PHI** agrees to implement reasonable and appropriate security measures to protect it; and

4. Report to the Plan any **Security Incident** involving **E-PHI** of which it becomes aware. A "**Security Incident**" means an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an Information System.

Authorized Recipients of PHI and Disciplinary Policy for Non-Compliance:

Only the following individuals will be given access to **PHI** disclosed by the Plan to the Plan Sponsor: Trustees; Administrative Manager; Office Manager; Administrative Assistant; and Claims Manager. The access given will be restricted to the administrative functions performed by the person for the Plan.

The Plan Sponsor will establish and maintain an effective disciplinary policy to resolve issues of non-compliance by individuals with authorized access to **PHI,** with the restrictions and limitations described in this Article and the Plan's administrative policies and procedures related to **HIPAA** compliance. This disciplinary policy may include the following actions as the Plan Sponsor deems appropriate based on the circumstances and severity of non-compliance: verbal reprimands, written reprimands, counseling, retraining, and discharge.

ARTICLE XII

MISCELLANEOUS

A. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan may release and obtain, to and from any person or entity, information it deems necessary to administer and implement the Plan, without consent or notice to anyone.

B. APPLICABLE LAW

The Plan and Fund are created and accepted in Louisiana. All matters pertaining thereto will be determined in accordance with Louisiana law, except as governed or preempted by federal law.

C. SAVINGS CLAUSE

If any provision of the Plan is held to be unlawful, or unlawful as to any person or instance, such fact will not adversely affect application of the provision to any other person or instance or the other provisions of the Plan, unless the illegality makes functioning of the Plan impossible.

D. GENDER

Unless otherwise specifically indicated or required, use of any one gender will be understood to include all genders.

ARTICLE XIII

IMPORTANT PLAN INFORMATION

A. PLAN NAME AND FUND NAME

The Plan is known as the Electricians Health and Welfare Plan, IBEW 995. The Fund through which the Plan's benefits are provided is known as the International Brotherhood of Electrical Workers 995 Health and Welfare Fund. It is a jointly administered trust fund, initially established effective April 1, 1964, by the Union and certain Employers pursuant to a collective bargaining agreement.

B. TYPE OF PLAN

The Plan is an employee welfare benefit plan within the meaning of ERISA. It provides medical benefits, prescription drug benefits, death benefits, and accidental death and dismemberment benefits.

C. PLAN SPONSOR AND ADMINISTRATOR

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

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

D. PLAN ADMINISTRATION

The Board of Trustees is the named fiduciary charged with responsibility to administer the Plan in accordance with the Plan documents and applicable law. The Trustees have full and exclusive authority and discretion to determine all Plan matters that arise. Any determination, interpretation, or construction they adopt is binding on all persons. No officer, agent, or employee of the Union or an Employer is authorized to speak for or on behalf of the Trustees on any Plan matter. The individual Trustees currently serving on the Board are as follows.

Union Trustees	**Employer Trustees**
Jason Dedon IBEW Local Union No. 995 8111 Tom Drive Baton Rouge, LA 70815	Tim Alexander Buffalo Electric 3207 Jefferson Street Baker, LA 70714
Darryl McGaha IBEW Local Union No. 995 8111 Tom Drive Baton Rouge, LA 70815	Glen Ledoux Ledoux's Control Systems Inc. 2860 Needham Drive Baton Rouge, LA 70814
Jordan Henderson IBEW Local Union No. 995 8111 Tom Drive Baton Rouge, LA 70815	Josh Overhultz Buffalo Electric 3207 Jefferson Street Baker, LA 70714

The Trustees have delegated certain responsibilities for the Plan's day-to-day operations to an Administrative Manager who is employed by the Fund and works in the Plan Office. The contact information for the Administrative Manager and Plan Office is:

Administrative Manager
Electricians Health and Welfare Plan, IBEW 995
8111 Tom Drive
Baton Rouge, LA 70815
Telephone: (225) 927-6340

E. AGENT FOR SERVICE OF LEGAL PROCESS

The Administrative Manager has been designated as agent for service of legal process on the Plan and may be served at the address listed above. Legal process may also be served on the Board of Trustees or any Trustee using the addresses listed above.

F. 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 by the Trustees to the Plan is 501.

G. PLAN YEAR

The records of the Plan are kept based on a fiscal year, which begins on January 1 and ends on the following December 31. This fiscal year is also known as the "Plan Year".

H. IDENTITY OF FUNDING MEDIUM USED FOR ACCUMULATION OF ASSETS

The Plan is "self-insured", which means that benefits are paid solely from the Plan's assets accumulated in the Fund and are not guaranteed by an insurance company except as described in the following paragraph. The Fund is administered by the Trustees, in accordance with the Trust Agreement, to provide Plan benefits and pay its administrative expenses. Plan assets are held in the custody of one or more national banks (currently Bank of Labor, Regions Bank, and Bank of Oklahoma). The Trustees have appointed qualified investment advisors to assist with the investment of Plan assets.

The Trustees have purchased an insurance policy ("Policy") to provide the Life Insurance and Accidental Death and Dismemberment Benefits on an insured basis (other than the Life Insurance benefit for surviving spouses which is self-insured by the Fund). The current Policy is issued by Dearborn Life Insurance Company, Administrative Office located at 701 E. 22nd Street, Lombard, IL 60148, 1-800-721-7987. There is no liability on the part of any Trustee or other individual or entity to pay benefits over and above the amount available in the Fund and Policy.

I. CONTRIBUTION SOURCE

Contributions to the Plan are made primarily by Employers in accordance with Collective Bargaining Agreements and Participation Agreements. The CBAs require contributions to the Plan at fixed rates per hour of Covered Employment for Bargaining Unit Employees. Participation Agreements require fixed contribution amounts, as established by the Trustees, for Non-Bargaining Unit Employees. Information about whether a particular Employer or employee organization participates in the Plan and, if so, their address is available upon request to the Plan Office.

A complete list of the individual Employers and employee organizations participating in the Plan is available for inspection at the Plan Office. A copy may also be obtained by employees, dependents, retirees, and beneficiaries upon written request to the Plan Office. ERISA allows the Plan to charge a reasonable fee for copying costs. You should ask the amount of the fee before requesting copies.

Employees and Dependents are not allowed to contribute to the Plan, except in limited circumstances when continuation of coverage on a self-payment basis is permitted. In such cases, the Board of Trustees determines the amount of the required self-payment based upon the cost of providing coverage and related administrative costs as permitted by law.

J. COLLECTIVE BARGAINING AND PARTICIPATION AGREEMENTS

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 at fixed rates. You may examine these agreements at the Plan Office upon ten days' prior written request. You may also obtain copies upon written request to the Plan Office. The Plan may charge a reasonable fee for copying costs. You should ask the amount of the fee before requesting copies.

K. EXAMINING AND OBTAINING ADDITIONAL PLAN DOCUMENTS

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

(1) Trust Agreement and amendments.
(2) Plan document and amendments.
(3) Annual Report.
(4) Form 5500 and required attachments.
(5) List of contributing Employers.
(6) Documents under which the Plan was established or is operated.

You may obtain copies of these documents by making a written request to the Plan Office and paying the fee for copying costs.

L. SELECTION OF PHYSICIANS AND FACILITIES

The Plan provides benefits for covered medical expenses. It is not the service provider. The Plan is not responsible for acts or omissions by Hospitals, Physicians, or other facilities or medical providers.

ARTICLE XIV

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

This statement of your rights under ERISA is required by federal law and regulation. As a participant in the Plan, you are entitled to the following rights and protections under ERISA:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

Examine, without charge, at the Plan Office and 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 Office, 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 Administrative Manager may make a reasonable charge for the copies.

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

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to:

Continue health care coverage for yourself or your Dependent spouse or children if there is a loss of coverage under the Plan because of a qualifying event. You and your Dependents may have to pay for such coverage. Review this Plan document 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 the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or 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 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.

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 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 Claims and Appeal Procedures described in this Plan document before you may file suit 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, the period allowed under the insurance policy). In no event may you bring legal action in court later than this one-year period (or period allowed under the insurance policy if applicable).

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Office. 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, you should: (1) contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U. S. Department of Labor, listed in your telephone directory; or (2) call the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272); or (3) visit the EBSA website at www.dol.gov/ebsa; or (4) 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, Suite N-5625
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272).

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