Amendment No. 5

to the

IBEW Local 347 Electrical Workers Health and Welfare Fund
Combination Plan Document and Summary Plan Description

WHEREAS, Section 13.10 of the IBEW Local 347 Electrical Workers Health and Welfare Fund Combination Plan Document and Summary Plan Description ("Plan"), restated effective September 1, 2012 provides that the Board of Trustees has complete power and discretion to amend the Plan, in whole or in part, at any time;

WHEREAS, it is the desire of the Board of Trustees to amend the provisions of the Plan;

NOW, THEREFORE, BE IT RESOLVED that the Plan shall be amended as follows:

ARTICLE I – ELIGIBILITY

Effective August 1, 2015, Article I shall be amended at Section 1.10 by deleting the Section in its entirety and inserting in its place the following Section 1.10:

Section 1.10 – Retiree Benefits and Options

When you become a Retiree in accordance with Section 1.06 or Section 1.07, you may elect to receive either Plan A Coverage or Plan B Coverage.

If you are a Retiree and you elect Plan A Coverage, you may elect to change to Plan B Coverage. The change from Plan A Coverage to Plan B Coverage will be effective the first day of the month following the month that the Fund Office receives your Retiree Plan B Notification. **Once you elect Plan B Coverage, you may not subsequently elect Plan A Coverage.**

Plan A Coverage and Plan B Coverage are defined as follows:

(a) Plan A Coverage

Plan A Coverage is identical to the coverage provided under the Plan to Covered Employees, except that it does not include Short-Term Disability Benefits. The following chart explains how the Retiree Premium for Plan A Coverage is calculated:

If you are…	Your Dependent(s) Covered by the Plan are…	The Retiree Premium is…
A Retiree who does not have Medicare	You do not have any Dependents covered by the Plan	50% of the Monthly Premium (i.e. 50% of the amount paid by a Covered Employee)
	You have at least one Dependent covered by the Plan	Equal to the Monthly Premium (i.e. the same as the amount paid by a Covered Employee)
A Retiree who has Medicare as your Primary Plan	You do not have any Dependents covered by the Plan	47.5% of the Monthly Premium (i.e. 47.5% of the amount paid by a Covered Employee)
	Your Dependent child(ren)	97.5% of the Monthly Premium (i.e. 97.5% of the amount paid by a Covered Employee)
	Your spouse	95% of the Monthly Premium (i.e. 95% of the amount paid by a Covered Employee)

	Your spouse and Dependent child(ren)	95% of the Monthly Premium (i.e. 95% of the amount paid by a Covered Employee)

(b) Plan B Coverage

Plan B Coverage is identical to the coverage provided under the Plan to Covered Employees, except that it does not include Short-Term Disability Benefits, Dental Benefits or Maternity Services. The following chart explains how the Retiree Premium for Plan B Coverage is calculated:

If you are...	**Your Dependent(s) Covered by the Plan are...**	**The Retiree Premium is...**
A Retiree who does not have Medicare	You do not have any Dependents covered by the Plan	40% of the Monthly Premium (i.e. 40% of the amount paid by a Covered Employee)
	You have at least one Dependent covered by the Plan	80% of the Monthly Premium (i.e. 80% of the amount paid by a Covered Employee)
A Retiree who has Medicare as your Primary Plan	You do not have any Dependents covered by the Plan	37.5% of the Monthly Premium (i.e. 37.5% of the amount paid by a Covered Employee)
	Your Dependent child(ren)	77.5% of the Monthly Premium (i.e. 77.5% of the amount paid by a Covered Employee)
	Your spouse	75% of the Monthly Premium (i.e. 75% of the amount paid by a Covered Employee)
	Your spouse and Dependent child(ren)	75% of the Monthly Premium (i.e. 75% of the amount paid by a Covered Employee)

The Board of Trustees has the authority to establish and change the Retiree Premium as it may deem appropriate in its sole and exclusive discretion. The Board of Trustees reserves the right to change or eliminate Retiree coverage or to require Retirees to pay a higher Retiree Premium to continue Retiree coverage even if the Retiree is already Totally and Permanently Disabled, has already reached age 55, or has already elected Plan B Coverage at the time of such change. The Board of Trustees further reserves the right to establish separate sets of benefits available to Retirees and Covered Employees, even if such change would have the effect of reducing benefits to current Retirees.

Effective January 1, 2016, Article I shall be amended at Section 1.12 by deleting the Section in its entirety and inserting in its place the following Section 1.12:

Section 1.12 – Retiree's Return to Work for an Employer

As indicated in Section 15.42, an individual does not meet the Plan's definition of Retiree if he engages in either of the following types of employment for 120 hours or more during a consecutive three month period after the effective date of his Retiree coverage unless his Retiree eligibility and coverage are subsequently reinstated in accordance with Section 1.16:

- Covered Employment; or
- employment or self-employment in a non-bargaining position for an Employer.

For purposes of Section 15.42 as well as this Section 1.12, an individual is considered to have performed work for 120 hours or more during any consecutive three-month period on the first day of the third month after he has completed the 120 hours. This means that if you are a Retiree and you return to Covered

Employment or employment or self-employment in a non-bargaining position for an Employer, you will no longer be considered a Retiree on the first day of the third month after you have worked 120 hours in a consecutive three-month period.

If an individual no longer meets the definition of Retiree, his eligibility and coverage under the Plan as a Retiree will be terminated in accordance with Section 1.13(b)(3). If a Retiree's eligibility and coverage are terminated in accordance with Section 1.13(b)(3), the individual will not be permitted to receive coverage from the Plan as a Retiree for the period of time specified in (a) or (b) below (as applicable).

(a) General Rule

Except as provided in Section 1.12(b), if a Retiree's eligibility and coverage are terminated in accordance with Section 1.13(b), the Retiree will not be permitted to receive coverage from this Plan as a Retiree for 12 consecutive months from the date his Retiree eligibility and coverage were terminated (i.e. he cannot receive coverage from this Plan as a Retiree for a 12 month period that starts the first day of the third month after he completed 120 hours). The individual may be permitted to receive coverage under the Plan as a Covered Employee during these 12 months if his eligibility and coverage as a Covered Employee are reinstated in accordance with Section 1.15(b).

The following chart illustrates how this works. The years 2012 and 2013 listed in the chart are solely for the purpose of illustrating how the return to work for an Employer works. The years do not mean that these are the only years that these rules are in place (i.e., this does not mean these rules were not in effect in 2011 or that they will not be in effect in 2014).

If you return to Covered Employment or employment or self-employment in a non-bargaining position for an Employer for 120 hours or more within 3 consecutive months and the month you completed the 120 hours is…	You will no longer meet the definition of Retiree and your eligibility and coverage as a Retiree will terminate on…	If the 120 hours you worked were in Covered Employment you will become an Eligible Employee in accordance with Section 1.15(b) on… (once you become an Eligible Employee you may also become a Covered Employee if you pay the Monthly Premium in accordance with Section 1.15(b))	The earliest you will be permitted to have your eligibility and coverage as a Retiree reinstated in accordance with Section 1.16 is…
January 2012	April 1, 2012	April 1, 2012	April 1, 2013
February 2012	May 1, 2012	May 1, 2012	May 1, 2013
March 2012	June 1, 2012	June 1, 2012	June 1, 2013
April 2012	July 1, 2012	July 1, 2012	July 1, 2013
May 2012	August 1, 2012	August 1, 2012	August 1, 2013
June 2012	September 1, 2012	September 1, 2012	September 1, 2013
July 2012	October 1, 2012	October 1, 2012	October 1, 2013
August 2012	November 1, 2012	November 1, 2012	November 1, 2013
September 2012	December 1, 2012	December 1, 2012	December 1, 2013
October 2012	January 1, 2013	January 1, 2013	January 1, 2014
November 2012	February 1, 2013	February 1, 2013	February 1, 2014
December 2012	March 1, 2013	March 1, 2013	March 1, 2014

(b) Special Rule for Retirees who Return to Covered Employment Between January 1, 2015 and September 30, 2016

If a Retiree meets all of the following requirements, he will not be subject to the rule in Section 1.12(a) above which prohibits a Retiree from receiving coverage from this Plan as a Retiree for 12 consecutive months from the date that his Retire eligibility and coverage were terminated:

- He returned to Covered Employment between January 1, 2015 and September 30, 2016;
- His eligibility and coverage were terminated in accordance with Section 1.13(b) between January 1, 2015 and December 31, 2016; and
- After the occurrence of the events in both of the bullet points above, he completely ceased working in Covered Employment between January 1, 2015 and December 31, 2016.

This means that if a Retiree meets all of the requirements above, he may receive coverage from the Plan as a Retiree on the first day of the month after he has fulfilled all of the requirements of Section 1.06 or Section 1.07, as applicable.

Effective August 1, 2015, Article I shall be amended at Section 1.22 by deleting subsection (f) and inserting in its place the following subsection (f):

(f) After the surviving spouse receives two free years of coverage in accordance with Section 1.22(c), the determination of whether the surviving spouse is required to pay the Monthly Premium, the Retiree Premium for Plan A Coverage or the Retiree Premium for Plan B Coverage will be made as follows:

(1) A surviving spouse will be required to pay the Monthly Premium until the first day of the month following the surviving spouse's 55th birthday.

(2) A surviving spouse may elect to pay the Retiree Premium for Plan A Coverage or Plan B Coverage once the surviving spouse has attained 55 years of age (i.e. the month after the surviving spouse's 55th birthday). Plan A Coverage and Plan B Coverage are explained in Section 1.10. **Once a surviving spouse elects Plan B Coverage, she may not subsequently elect Plan A Coverage.** The following chart explains how the Retiree Premium for a surviving spouse is calculated:

If you are...	Your Dependent(s) Covered by the Plan are...	Your Type of Coverage is...	The Retiree Premium is...
A surviving spouse who does not have Medicare	You do not have any Dependent children covered by the Plan	Plan A	50% of the Monthly Premium
		Plan B	40% of the Monthly Premium
	You have at least one Dependent child covered by the Plan	Plan A	Equal to the Monthly Premium
		Plan B	80% of the Monthly Premium
A surviving spouse who has Medicare as your Primary Plan	You do not have any Dependents children covered by the Plan	Plan A	47.5% of the Monthly Premium
		Plan B	37.5% of the Monthly Premium
	You have at least one Dependent child covered by the Plan	Plan A	97.5% of the Monthly Premium
		Plan B	77.5% of the Monthly Premium

Effective August 1, 2015, Article I shall be amended at Section 1.23 by deleting subsection (c) and inserting in its place the following subsection (c):

(c) The surviving spouse and the surviving spouse's Dependents who are covered under the Plan in accordance with Section 1.23(b) above will be required to pay the Retiree Premium to be covered under the Plan as follows:

(1) Beginning on the first day of the month following the Retiree's death, the Retiree Premium will be automatically drawn from the deceased Retiree's Dollar Bank to pay for coverage for the surviving spouse and her Dependents who are covered under the Plan in accordance with Section 1.23(b). This will continue until there are no longer sufficient contributions in the deceased Retiree's Dollar Bank to pay the Retiree Premium.

(2) The first month that the deceased Retiree's Dollar Bank does not have sufficient contributions to cover the Plan's Retiree Premium for the following month, the Plan Administrator will notify the surviving spouse that she will not be covered the following month unless she self-pays the difference between the amount of contributions in the deceased Retiree's Dollar Bank and the Retiree Premium. The surviving spouse may use the contributions in the deceased Retiree's HRA Account to self-pay the Retiree Premium. Self-payments are due on the first day of the month for which the surviving spouse intends to receive coverage. Unless there are extenuating circumstances as determined solely by the Plan Administrator and/or the Board of Trustees, coverage for the surviving spouse and her Dependents who are covered under the Plan in accordance with Section 1.23(b) will terminate if the required self-pay amount is not received by the Fund Office by the fifth business day of the month. Coverage may not be reinstated following the termination of coverage for any reason, including but not limited to the failure to make timely self-payments. The amount of time a surviving spouse is permitted to self-pay under this Section 1.23 depends on whether she uses the deceased Retiree's HRA Account or another source of funds to make self-payments as explained in (i) and (ii) below.

i. If the surviving spouse uses the deceased Retiree's HRA Account to make self-payments, she may make unlimited consecutive self-payments even if she remarries. If the HRA Account has sufficient contributions to pay the entire Retiree Premium, the surviving spouse cannot use the HRA Account to pay part of the Retiree Premium and another source of funds to pay the rest of the Retiree Premium. The only time a surviving spouse may use a combination of the deceased Retiree's HRA Account and another source of funds to pay the Retiree Premium is if the HRA Account does not have sufficient contributions to pay the entire Retiree Premium. If this occurs, the surviving spouse may use a combination of the deceased Retiree's HRA Account and other funds to pay the Retiree Premium, but the Plan will not accept any self-payment amounts that exceed the difference between the contributions in the HRA Account and the Retiree Premium. For example, if the deceased Retiree's HRA Account has $500 and the Retiree Premium is $200, the surviving spouse cannot use the HRA Account to pay $100 and write a check to pay the other $100. On the other hand, if the deceased Retiree's HRA Account has $100 and the Retiree Premium is $200, the surviving spouse can use the HRA Account to pay $100 of the Retiree Premium and can write a check to pay the remaining $100 of the Retiree Premium.

ii. If the surviving spouse uses any source of funds other than the deceased Retiree's HRA Account to make self-payments (for example, if she self-pays by writing a check), she may make unlimited consecutive self-payments unless she remarries. If a surviving spouse remarries, she will no longer be permitted to make self-payments (except in accordance with COBRA continuation coverage) and coverage for the surviving spouse and her Dependents will terminate on the first day of the month following the month that the surviving spouse remarries. In other words, eligibility and coverage for a surviving spouse and her Dependents will terminate on the first day

of the month following a month that the surviving spouse is remarried and uses a source of funds other than the deceased Retiree's HRA Account to pay the Retiree Premium.

(3) The Retiree Premium for a surviving spouse is based on a number of factors, including whether or not the surviving spouse has Medicare and whether or not the surviving spouse has any Dependent children who are also covered by the Plan. The following chart explains how the Retiree Premium for a surviving spouse is calculated:

If you are...	Your Dependent(s) Covered by the Plan are...	Your Type of Coverage is...	The Retiree Premium is...
A surviving spouse who does not have Medicare and the Retiree did not have Medicare at the time of his death	You do not have any Dependent children covered by the Plan	Plan A	50% of the Monthly Premium
		Plan B	40% of the Monthly Premium
	You have at least one Dependent covered by the Plan	Plan A	Equal to the Monthly Premium
		Plan B	80% of the Monthly Premium
A surviving spouse who has Medicare as your Primary Plan and/or you are a surviving spouse of a Retiree who had Medicare as his Primary Plan at the time of his death	You do not have any Dependent children covered by the Plan	Plan A	47.5% of the Monthly Premium
		Plan B	37.5% of the Monthly Premium
	You have at least one Dependent child covered by the Plan	Plan A	97.5% of the Monthly Premium
		Plan B	77.5% of the Monthly Premium

Effective January 1, 2015, Article I shall be amended at Section 1.25 by deleting the Section in its entirety and inserting in its place the following Section 1.25:

Section 1.25 – Certificate of Creditable Coverage

The Plan will issue a Certificate of Creditable Group Health Plan Coverage to a Covered Person (or, former Covered Person) upon receipt of a written request that is submitted to the Plan Administrator by the Covered Person (or, former Covered Person). To request a Certificate of Creditable Group Health Plan Coverage or obtain additional information contact:

CompuSys of Utah, Inc.
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
PO Box 26068
Salt Lake City, UT 84126-0068
Toll Free: (844) 347-IBEW (4239)
www.ibew347benefits.com

Effective July 2, 2015, Article II shall be amended at Section 2.17 by deleting the Section in its entirety and inserting in its place the following Section 2.17:

ARTICLE II – COMPREHENSIVE MEDICAL BENEFITS

Section 2.17 – Hospital – Emergency Room Services

The Plan covers use of a Hospital emergency room. The Plan also covers the treatment and services that a Covered Person receives when he is in a Hospital emergency room. The treatment and services covered

under this Section includes treatment for mental health and substance abuse. After a Covered Person has met his Deductible and paid a $50 Copay, the Plan will pay 100% of Covered Charges for Hospital - Emergency Room Services provided by a PPO Provider and 80% of Covered Charges for Hospital - Emergency Room Services provided by a non-PPO provider.

When a Covered Person receives treatment for a Medical Emergency from a non-PPO Physician at a PPO Hospital emergency room and the Covered Person is subsequently admitted to the Hospital, the Plan will pay 100% of Covered Charges for the services provided by the non-PPO Physician in the PPO Hospital emergency room after the Covered Person has met his Deductible. This rule only applies to services that are provided by the non-PPO Physician while the Covered Person is in a Hospital emergency room.

When a Covered Person receives treatment for a Medical Emergency at a non-PPO Hospital emergency room, either because of circumstances beyond his control or because the time necessary to obtain treatment from a PPO Provider could endanger his life, the Plan will pay 100% of Covered Charges for the Hospital - Emergency Room Services after the Covered Person has met his Deductible and paid a $50 Copay (in other words, the Plan will pay the same benefits that it would have paid if the treatment was provided by a PPO Provider). Once the Covered Person is medically stable, he has two options:

- The Covered Person may transfer to a PPO Provider and the Plan will pay 80% of all future incurred Covered Charges; or

- The Covered Person may elect to stay at the non-PPO provider and the Plan will pay 60% of all future incurred Covered Charges.

If the Covered Person is admitted to the Hospital, the $50 Copay will be waived. Once a Covered Person is admitted to the Hospital, benefits will be paid in accordance with Section 2.18.

ARTICLE III –PRESCRIPTION DRUG BENEFITS

Effective July 17, 2015, Article III shall be amended at Section 3.03 by deleting the Section in its entirety and inserting in its place the following Section 3.03:

Section 3.03 – Covered Prescription Drugs
The Plan covers:

(a) Federal legend drugs, except as specifically excluded by this Article or Article VIII – Benefit Exclusions and Limitations;

(b) Self-administered injectables including, but not limited to, Depo-Provera (up to a 90 day supply), Epinephrine (Ana-Guard, Epi-Pen, and Epi-Pen JR); Glucagon, Lunelle, migraine agents, Vitamin B-12 and other Specialty Drugs;

(c) Anti-wrinkle agents (e.g. Renova);

(d) Syringes for self-administered injectables;

(e) Compounded medication containing at least one Federal Legend ingredient;

(f) Disposable insulin needles/syringes, disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips and Tes-Tape), blood glucose monitors and lancets;

(g) Prescription smoking cessation products;

(h) Legend contraceptives, including oral, patches, diaphragms (including gels) and Nuvaring;

(i) Prenatal vitamins prescribed during pregnancy;

(j) Pediatric vitamins;

(k) Potassium Chloride when used to treat blood pressure conditions;

(l) Acne relief drugs prescribed to a Covered Persons who is less than 30 years old;

(m) Erectile dysfunction drugs prescribed to a Covered Person who is at least 50 years old; and

(n) Immunization agents, including, but not limited to, immunization agents that are necessary for travel purposes.

NOTE: Drugs and medicines that are administered or provided during a Physician Office Visit, at a Facility, at a Hospital, or by a home health agency are not covered under this Article. Refer to Article II – Comprehensive Medical Benefits for a description of coverage for drugs administered during a Physician Office Visit, at a Facility, at a Hospital, or by a home health agency.

Effective July 17, 2015, Article III shall be amended at Section 3.05 by deleting subsection (e) and inserting in its place the following subsection (e):

(e) Infertility drugs, biological and allergy sera, blood or blood plasma;

Effective August 1, 2016, Article III shall be amended at Section 3.05 by deleting the Section in its entirety and inserting in its place the following Section 3.05:

Section 3.05 – Prescription Drug Benefit Exclusions and Limitations
Prescription Drug Benefits will not be payable for:

(a) Drugs, medicines and quantity limits that are not in compliance with the Federal Food and Drug Administration (FDA) guidelines;

(b) Drugs purchased at a Wal-Mart or Sam's Club pharmacy;

(c) Drugs or medicines covered under Article II – Comprehensive Medical Benefits;

(d) Contraceptive devices (i.e. non-oral contraceptives) except as specifically provided for in this Article;

(e) Infertility drugs, biological and allergy sera, blood or blood plasma;

(f) Administration of any drug or medicine;

(g) Any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date;

(h) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances except as specifically provided for in this Article;

(i) Growth hormones, except when prescribed in connection with pediatric growth hormone deficiency;

(j) Levonorgestrel (Norplant);

(k) Dermatologicals and hair growth stimulants;

(l) Anorectics (any drug used for the purpose of weight loss), except for the following drugs that will be covered specifically for the treatment of Attention Deficit Disorder (ADD): Amphetamine/ Dextroamphetamine (Adderall), Dextroamphetamine (Dexedrine) and Methamphetamine HCL (Desoxyn);

(m) Topical dental products;

(n) Vitamins, singly or in combination, mineral and nutritional supplements, food supplements or substitutes except as specifically provided for in this Article;

(o) Non-legend drugs (i.e. over the counter drugs) other than insulin;

(p) Prescriptions for a Covered Person who enrolls in Medicare Part D for prescription coverage;

(q) Marijuana, even if prescribed for medicinal purposes;

(r) Specialty Drugs that are not purchased at the LDI Specialty Pharmacy except as specifically provided for in this Article;

(s) Services and treatment excluded under Article VIII – Benefit Exclusions and Limitations; and

(t) New to market drugs that are not purchased at the LDI Pharmacy. For purposes of this Section, a new to market drug is an oral, injectable, infused, or inhaled medication that was recently approved by the FDA and is currently under review by the LDI Formulary Management Committee.

ARTICLE VIII –BENEFIT EXCLUSIONS AND LIMITATIONS

Effective July 17, 2015, Article VIII shall be amended at Section 8.01 by deleting subsection (uu) and inserting in its place the following subsection (uu):

(uu) Immunizations necessary for travel purposes, except as specifically provided for in Article III-Prescription Drug Benefits; and

IN WITNESS WHEREOF, we have hereunto affixed our signatures and approved this Amendment this 17th day of October, 2016.

UNION TRUSTEE

Chairman

EMPLOYER TRUSTEE

Secretary