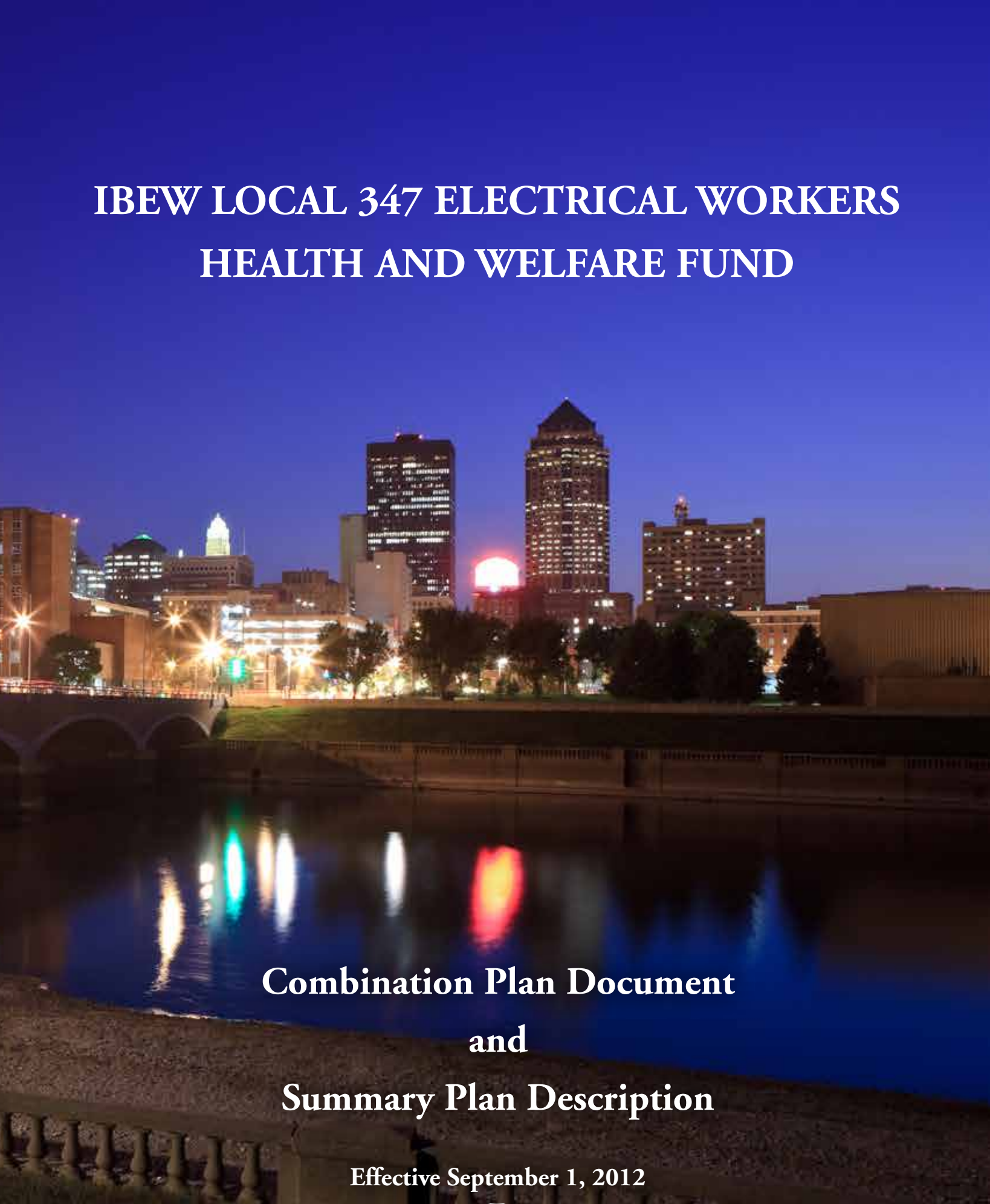
IBEW LOCAL 347 ELECTRICAL WORKERS HEALTH AND WELFARE FUND



Combination Plan Document
and
Summary Plan Description

Effective September 1, 2012

Summary of Material Modification No. 1

to the

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

Effective May 1, 2013, the IBEW Local 347 Electrical Workers Health and Welfare Fund Combination Plan Document and Summary Plan Description is amended as follows:

ARTICLE I – ELIGIBILITY

Article I shall be amended at Section 1.02 by deleting paragraph 1, paragraph 2, paragraph 3, and paragraph 4 and inserting in their place the following:

The Dollar Bank is an account that is established for an Employee. When you work for an Employer, the contributions that you earn are credited to your Dollar Bank.

If you are an Eligible Employee and you have sufficient contributions in your Dollar Bank to cover the Plan's Monthly Premium, the Monthly Premium will be automatically drawn from your Dollar Bank to pay for your coverage. If the contributions in your Dollar Bank exceed the Monthly Premium, the excess contributions will remain in your Dollar Bank until you have accumulated $5,400 in excess contributions. Once you have accumulated the maximum $5,400 of excess contributions, any additional contributions in your Dollar Bank will automatically be drawn from your Dollar Bank and credited to your Health Reimbursement Arrangement Account ("HRA Account").

If you are an Eligible Employee but you do not have sufficient contributions in your Dollar Bank to cover the Plan's Monthly Premium, you may elect to pay the remaining portion of the Monthly Premium in accordance with the Partial Self-Pay provisions of Section 1.03. If you elect to self-pay the remaining portion of the Monthly Premium in accordance with Section 1.03, you will become a Covered Employee. If you do not elect to self-pay the remaining portion of the Monthly Premium in accordance with Section 1.03, you will not be covered under the Plan (i.e. you will not be a Covered Employee) and the contributions will remain in your Dollar Bank.

The Dollar Bank established for you will merely be a record keeping account with the purpose of keeping track of contributions. Your Dollar Bank will consist solely of Employer contributions. Your Dollar Bank will not be credited with any interest income earned on the Plan's reserves. Your Dollar Bank is a non-vested benefit and can be forfeited.

Article I shall be amended at Section 1.03 by deleting the Section in its entirety and inserting in its place the following Section 1.03:

Section 1.03 – Self-Payment Provisions for Eligible Employees to Become Covered Employees

(a) **Partial Self-Pay**
If you are a Covered Employee, but you do not have sufficient contributions in your Dollar Bank to cover the Plan's Monthly Premium for the next month, the Plan Administrator will notify you that you will not be covered the following month unless you self-pay the difference between the amount of contributions in your Dollar Bank and the Monthly Premium. If you elect to self-pay the difference in accordance with this Section 1.03(a), the entire amount of contributions in your Dollar Bank will be applied to the Monthly Premium before any self-pay amounts are applied (i.e. you cannot keep contributions in your Dollar Bank by increasing the amount that you self-pay). You may use the contributions in your HRA Account to self-pay the Monthly Premium. For example, if your

Dollar Bank has $100, your HRA Account has $100, and the Monthly Premium is $300, you can use your Dollar Bank to pay $100 of the Monthly Premium, your HRA Account to pay $100 of the Monthly Premium, and you can write a check to pay the remaining $100. In this example, you are required to use the $100 in your Dollar Bank before any self-payments are applied (e.g. you cannot use your Dollar Bank to pay $50 of the Monthly Premium, and use your HRA Account and another source of funds to pay the remaining $250).

The self-pay amount is due in full on the first day of the month for which you intend to receive coverage. Your coverage 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 termination of coverage for failure to make timely self-payments unless your eligibility and coverage are reinstated in accordance with Section 1.15 (other than under any continuation rules required by applicable law). You may make unlimited consecutive self-payments under this provision as long as the amount in your Dollar Bank is greater than zero. The Plan will not accept any self-payment amounts that exceed the difference between the contributions in your Dollar Bank and the Monthly Premium. If your self-pay coverage terminates, you are still eligible at the time of termination for COBRA continuation coverage.

(b) **Complete Self-Pay**

If you are a Covered Employee and do not have any contributions in your Dollar Bank, you may self-pay the entire Monthly Premium amount. You may use the contributions in your HRA Account to self-pay the Monthly Premium.

Self-payments are due in full on the first day of the month for which you intend to receive coverage. Your coverage 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 termination of coverage for failure to make timely self-payments unless your eligibility and coverage are reinstated in accordance with Section 1.15 (other than under any continuation rules required by applicable law).

The amount of time you are permitted to self-pay under this provision depends on whether you use your HRA Account or another source of funds to make self-payments as explained in (1) and (2) below.

(1) Self-payments made through your HRA Account

You may make unlimited consecutive self-payments in accordance with this Section 1.03(b)(1) if you use your HRA Account to self-pay the Monthly Premium. If you use your HRA Account to make self-payments, and your HRA Account has sufficient contributions to pay the entire Monthly Premium, you cannot use your HRA Account to pay part of the Monthly Premium and another source of funds to pay the rest of the Monthly Premium. The only time you may use a combination of your HRA Account and another source of funds to pay the Monthly Premium is if your HRA Account does not have sufficient contributions to pay the entire Monthly Premium. If this occurs, you may use a combination of your HRA Account and other funds to pay the Monthly Premium, but the Plan will not accept any self-payment amounts that exceed the difference between the contributions in your HRA Account and the Monthly Premium. For example, if your HRA Account has $500 and the Monthly Premium is $200, you cannot use your HRA Account to pay $100 of the Monthly Premium and write a check to pay the other $100 of the Monthly Premium. On the other hand, if your HRA Account has $100 and the Monthly Premium is $200, you can use your HRA Account to pay $100 of the Monthly Premium and can write a check to pay the remaining $100.

(2) Self-payments made through any source other than your HRA Account

You may self-pay the Monthly Premium in accordance with this Section 1.03(b)(2) for up to 12 consecutive months if you use any source of funds other than your HRA Account to self-pay the

Monthly Premium (for example, if you self-pay by writing a check). Partial self-payments made in accordance with Section 1.03(a) above do not count toward the 12 month maximum. Complete self-payments made in accordance with Section 1.03(b)(1) above likewise do not count toward the 12 month maximum. If contributions are credited to your Dollar Bank during this 12 month period, and they are applied towards your Monthly Premium for a month (either automatically in accordance with Section 1.02 or through Partial Self-Pay in accordance with Section 1.03(a)), and after that month the amount in your Dollar Bank is back to zero, you will be permitted to elect to self-pay the entire premium amount for another 12 consecutive months (so long as you do not have a lapse in coverage).

The Plan will not accept any self-payment amounts that exceed the amount of the Monthly Premium. If your self-pay coverage terminates, you are still eligible at the time of termination for COBRA continuation coverage.

Article I shall be amended at Section 1.09 by deleting the Section in its entirety and inserting in its place the following Section 1.09:

Section 1.09 – Retiree Premium

The Retiree Premium is the dollar amount required for a Retiree to receive a month of coverage from the Plan. The Retiree Premium changes each month. 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 Retiree Premium will depend in part on a Retiree's age and level of benefit coverage in accordance with Section 1.10. The Trustees have the authority to set different Retiree Premiums for Medicare-eligible and non-Medicare eligible Retiree's and to require an additional premium amount for Dependents of Retirees.

If you are a Retiree and you have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium, the Retiree Premium will be automatically drawn from your Dollar Bank to pay for your coverage.

If you are a Retiree and you do not have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium, you may elect to self-pay the remaining portion of the Retiree Premium in accordance with this Section 1.09. The first month that you will not have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium for the following month, the Plan Administrator will notify you that you will not be covered the following month unless you self-pay the difference between the amount of contributions in your Dollar Bank and the Retiree Premium. You may use the contributions in your HRA Account to self-pay the Retiree Premium.

Self-payments are due in full on the first day of the month for which you intend to receive coverage. Unless there are extenuating circumstances as determined solely by the Plan Administrator and/or the Board of Trustees, coverage for you and your Dependents will terminate if the required self-pay amount if not received by the Fund Office by the fifth business day of the month. Retiree coverage may not be reinstated following termination of coverage for failure to make timely self-payments unless the Retiree regains coverage as a Covered Employee and subsequently retires in accordance with Sections 1.13(b) and 1.16.

Article I shall be amended at Section 1.13 by deleting the Section in its entirety and inserting in its place the following Section 1.13:

Section 1.13 – Termination of Eligibility and Coverage for Employees and Retirees

The Plan is intended to exist and provide benefits to Participants indefinitely. However, under certain circumstances coverage may terminate for certain individuals, for all Participants, or for any group of Participants. If the Trustees find it appropriate to terminate the Plan, then all Participants will lose coverage under the Plan. The Trustees reserve the right to amend the Plan at any time, and these

amendments may eliminate certain benefits for all Participants or terminate all benefits for certain Participants such as Retirees.

In addition, an Employee's or Retiree's eligibility and coverage under the Plan will terminate in accordance with Section 1.13(a) or Section 1.13(b) as applicable.

(a) Termination of Eligibility and Coverage for Employees

An Employee's eligibility and coverage as a Covered Employee will terminate (i.e. he will no longer be an Eligible Employee or a Covered Employee) as of 12:01 a.m. on the earliest of the following days:

(1) The first day of the calendar month in which he does not have enough contributions in his Dollar Bank to pay the Monthly Premium and he does not self-pay the difference between the amount of contributions in his Dollar Bank and the Monthly Premium in accordance with Section 1.03;

(2) The first day of the calendar month following the month that he has received coverage in accordance with the Complete Self-Pay provisions of Section 1.03(b)(2) for 12 consecutive months;

(3) The effective date of his Retiree coverage under the Plan;

(4) The date that he enters the Uniformed Services on active duty, except that he will have the right to extend his coverage under the USERRA provisions or other applicable law;

(5) If the Employee becomes employed in the electrical industry by an employer having no obligation to contribution to this Plan, the first day of the calendar month following the month that the work for the non-contributing employer was first performed;

(6) The date his Dollar Bank and/or HRA Account is frozen in accordance with Section 1.14(a)(2) and/or Section 17.03(a)(2); or

(7) The first day of the calendar month following his death.

If an Employee's eligibility and coverage are terminated in accordance with this Section 1.13(a), the Employee will only regain eligibility and coverage as a Covered Employee if his eligibility and coverage are reinstated in accordance with Section 1.15(a) (other than under any continuation rules required by applicable law).

(b) Termination of Eligibility and Coverage for Retirees

A Retiree's eligibility and coverage under the Plan will terminate as of 12:01 a.m. on the earliest of the following days:

(1) The first day of the calendar month in which he does not have enough contributions in his Dollar Bank to pay the Retiree Premium and he does not self-pay the difference between the amount of contributions in his Dollar Bank and the Retiree Premium in accordance with Section 1.09;

(2) The date he enters the Uniformed Services on active duty, except he will have the right to extend his coverage under the USERRA provisions or other applicable law;

(3) The first day of the calendar month that he no longer meets the definition of Retiree;

(4) If the Retiree becomes employed in the electrical industry by an employer having no obligation to contribute to this Plan, the first day of the calendar month following the month during which the work for the non-contributing employer was first performed;

(5) The first day of the calendar month following his death; or

(6) If the Retiree has not yet attained age 55 and he is receiving coverage due to a Total and Permanent Disability in accordance with Section 1.07, the first day of the second calendar month after he no longer meets at least one of the criteria required to be considered Totally and Permanently Disabled in accordance with Section 1.07.

If a Retiree's eligibility and coverage are terminated in accordance with this Section 1.13(b), he may only regain coverage as a Retiree if his eligibility and coverage are reinstated in accordance with Section 1.16 (other than under any continuation rules required by applicable law).

Article I shall be amended at Section 1.14 by deleting the Section in its entirety and inserting in its place the following Section 1.14:

Section 1.14 – Forfeiture of Dollar Bank and Termination of Eligibility for Employees and Retirees

(a) Forfeiture of Dollar Bank and Termination of Eligibility for Employees
An Employee's Dollar Bank will be forfeited and he will no longer be eligible for coverage (i.e. he will not be an Eligible Employee and he will not be allowed to self-pay) if (1), (2), (3), or (4) occurs:

(1) If an Employee or former Employee becomes employed in the electrical industry by an employer having no obligation to contribute to the Plan, the Employee (or former Employee) will permanently forfeit all of the contributions in his Dollar Bank on the first day of the month following the month during which the work for the non-contributing employer was first performed;

(2) If an Employee or former Employee becomes employed in a non-bargaining unit position for an Employer on or after January 1, 2011, and he no longer has contributions remitted to the Plan on his behalf, he can use the contributions in his Dollar Bank to pay the Monthly Premium for a maximum of three months. After three months, the Employee's (or former Employee's) Dollar Bank will be frozen (i.e. his Dollar Bank will be frozen on the first day of the fourth month after he begins working in a non-bargaining unit position for an Employer). After seven years, the Employee will permanently forfeit the contributions in his Dollar Bank unless he re-establishes eligibility under the Plan in accordance with Section 1.15(a);

(3) If an Employee or former Employee is not covered under the Plan for seven years and he does not have any contributions credited to his Dollar Bank during those seven years (i.e. he is not covered under the Plan for 84 consecutive months and he does not have any contributions credited to his Dollar Bank during those 84 months), he will permanently forfeit all of the contributions in his Dollar Bank; or

(4) If an Employee or former Employee dies and on the date of his death he does not have a surviving spouse who is eligible to continue coverage under the Plan in accordance with Section 1.22, all of the contributions in the Employee's (or former Employee's) Dollar Bank will be forfeited on the first day of the month following his death. If an Employee or former Employee dies and on the date of his death he has a surviving spouse who is eligible to continue coverage under the Plan in accordance with Section 1.22, the date the surviving spouse is no longer

eligible to continue coverage shall be treated as the date of the Employee's (or former Employee's) death for purposes of this Section 1.14(a)(4). In other words, if an Employee's (or former Employee's) surviving spouse is eligible to continue coverage in accordance with Section 1.22, and she subsequently loses eligibility for coverage, all of the contributions in the Employee's (or former Employee's) Dollar Bank will be forfeited on the first day of the month following the day the surviving spouse is no longer eligible to continue coverage under the Plan.

(b) Forfeiture of Dollar Bank and Termination of Eligibility for Retirees

A Retiree's Dollar Bank will be forfeited and he will no longer be eligible for coverage (i.e. he will not be allowed to self-pay) if (1) or (2) occurs:

(1) If a Retiree becomes employed in the electrical industry by an employer having no obligation to contribute to this Plan, the Retiree will permanently forfeit all of the contributions in his Dollar Bank on the first day of the month following the month during which the work for the non-contributing employer was first performed; or

(2) If a Retiree dies and on the date of his death he does not have a surviving spouse who is eligible to continue coverage under the Plan in accordance with Section 1.23, all of the contributions in the Retiree's Dollar Bank will be forfeited on the first day of the month following his death. If a Retiree dies and on the date of his death he has a surviving spouse who is eligible to continue coverage under the Plan in accordance with Section 1.23, the date the surviving spouse is no longer eligible to continue coverage shall be treated as the date of the Retiree's death for purposes of this Section 1.14(b)(2). In other words, if a Retiree's surviving spouse is eligible to continue coverage in accordance with Section 1.23, and she subsequently loses eligibility for coverage (for example, if her coverage is terminated in accordance with Section 1.23 or if she was using other coverage in accordance with Section 1.19(b) and she did not elect coverage under this Plan within 90 days of losing the other coverage), all of the contributions in the Retiree's Dollar Bank will be forfeited on the first day of the month following the day the surviving spouse is no longer eligible to continue coverage under the Plan.

Article I shall be amended at Section 1.22 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 1.22(b) above, will receive two free years of coverage from the Plan following a Covered Employee's death. This means that the surviving spouse will not have to pay a Monthly Premium or a Retiree Premium for coverage for 24 months after the Covered Employee's death. The two year period will begin the first day of the month following the Covered Employee's death. After the two years of free coverage, the surviving spouse and the surviving spouse's Dependents who are covered under the Plan in accordance with Section 1.22(b) above will be required to pay the Monthly Premium or Retiree Premium (as applicable) to be covered under the Plan as follows:

(1) Beginning on the first day of the 25th month following the Employee's death, the Monthly Premium or Retiree Premium (as applicable), will be automatically drawn from the deceased Employee's Dollar Bank to pay for coverage for the surviving spouse and her Dependents who are covered under the Plan in accordance with Section 1.22(b). This will continue until there are no longer sufficient contributions in the deceased Employee's Dollar Bank to pay the Monthly Premium or Retiree Premium as applicable.

(2) The first month that the deceased Employee's Dollar Bank does not have sufficient contributions to cover the Plan's Monthly Premium or Retiree Premium (as applicable) 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 Employee's Dollar Bank and the Monthly Premium or Retiree Premium, as applicable. The surviving spouse may use the contributions in the deceased Employee's HRA Account to self-pay the Monthly Premium or Retiree Premium (as applicable). Self-payments are due on the first day of the month for which the surviving spouse intends to receive coverage. Coverage for the surviving spouse and her Dependents who are covered under the Plan in accordance with Section 1.22(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 1.22 depends on whether she uses the deceased Employee'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 Employee'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 Monthly Premium or Retiree Premium (as applicable) the surviving spouse cannot use the HRA Account to pay part of the premium and another source of funds to pay the rest of the premium. The only time a surviving spouse may use a combination of the deceased Employee's HRA Account and another source of funds to pay the Monthly Premium or Retiree Premium (as applicable) is if the HRA Account does not have sufficient contributions to pay the entire Monthly Premium or Retiree Premium (as applicable). If this occurs, the surviving spouse may use a combination of the deceased Employee's HRA Account and other funds to pay the Monthly Premium or Retiree Premium (as applicable), but the Plan will not accept any self-payment amounts that exceed the difference between the contributions in the HRA Account and the Monthly Premium or Retiree Premium (as applicable). For example, if the deceased Employee's HRA Account has $500 and the Monthly Premium is $200, the surviving spouse cannot use the HRA Account to pay $100 of the Monthly Premium and write a check to pay the other $100 of the Monthly Premium. On the other hand, if the deceased Employee's HRA Account has $100 and the Monthly Premium is $200, the surviving spouse can use the HRA Account to pay $100 of the Monthly Premium and can write a check to pay the remaining $100 of the Monthly Premium.

ii. If the surviving spouse uses any source of funds other than the deceased Employee'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 Employee's HRA Account to pay the Monthly Premium or Retiree Premium (as applicable).

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.

ARTICLE VIII – BENEFIT EXCLUSIONS AND LIMITATIONS

Article VIII shall be amended at Section 8.01 by inserting the following sentence at the end of such Section:

The Benefit Exclusions and Limitations in this Section do not apply to the HRA Benefits in Article XVII. See Section 17.06 for the HRA Benefit Exclusions and Limitations.

ARTICLE IX – CLAIMS AND APPEALS PROCEDURES

Article IX shall be amended at Section 9.02 by inserting the following subsection (f):

(f) HRA Benefit Claims

HRA Benefit claims must be filed with Wilson-McShane Corporation at the address shown on page 1 of this Summary Plan Description. To have your claim reimbursed, you must submit a claim form and itemized receipt to Wilson-McShane Corporation. Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com.

To receive reimbursement for prescribed over-the-counter medicines, you must submit one of the following items with your claim:

- A receipt from a pharmacy which identifies the name of the purchase (or name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
- A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.

Article IX shall be amended at Section 9.03 by deleting the Section in its entirety and inserting in its place the following Section 9.03:

Section 9.03 – Deadline for Filing a Claim

Claims for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits and Vision Benefits must be filed within 12 months after the date of treatment.

Claims for Short-Term Disability Benefits must be filed within 12 months after the end of the Period of Disability.

Claims for Death Benefits must be filed within 12 months from the date of death.

Claims for HRA Benefits must be filed within 12 months after the date the expense was incurred.

You can only file claims after the periods described above with the express approval of the Trustees. If you cannot file your claim within this period, you must send a written request to file a late claim to the Trustees that includes an explanation of the circumstances preventing timely filing.

Article IX shall be amended at Section 9.04 by deleting subsection (a) and inserting in its place the following subsection (a):

(a) Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, and HRA Benefits

Claims for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, and HRA Benefits will be decided and notice of the benefit determination will be sent to

you within a reasonable period of time, but not later than 30 days after your claim is received by the Plan. The Plan may extend this period one time by up to 15 days if the Plan:

(1) determines that an extension of time is necessary due to matters beyond the control of the Plan; and

(2) sends you a written notice of the extension within the initial 30 day period, explaining the circumstances requiring the extension of time and the date that the Plan expects to render a decision.

If the extension is necessary because the Plan needs additional information, the notice of the extension will specifically describe the required information and you will be allowed at least 45 days from receipt of the notice to provide the specified information. The time period for deciding the claim will be suspended (tolled) from the date on which the notice requesting additional information is sent until the date the Plan receives your response, or until 45 days have passed since the date the notice was sent, whichever happens first. The Plan will grant you additional time to supply the requested information upon written request. When the Plan receives your response (or 45 days have passed and you have not provided a response), the Plan will make a decision on the claim within 15 days.

Article IX shall be amended at Section 9.07 by deleting the Section in its entirety and inserting in its place the following Section 9.07:

Section 9.07 – Deadline for Filing an Appeal
A request for review of claims (i.e. an appeal) for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits, Short-Term Disability Benefits and HRA Benefits must be made within 180 days after you receive notice of the adverse benefit determination.

A request for review of claims (i.e. an appeal) for Death Benefits must be made within 60 days after you receive notice of the adverse benefit determination.

ARTICLE XIII – MISCELLANEOUS PROVISIONS

Article XIII shall be amended at Section 13.11 by deleting the first bullet point and inserting in its place the following:

- **Wilson-McShane Corporation:** Provides day-to-day administration for the Plan as its third-party administrator. This day-to-day administration includes, but is not limited to, determining whether an individual is eligible for coverage, issuing Certificates of Creditable Group Health Plan Coverage and administering COBRA. Wilson-McShane Corporation also processes claims for Comprehensive Medical Benefits, Short-Term Disability Benefits, Death Benefits, and HRA Benefits.

ARTICLE XV – DEFINITIONS

Article XV shall be amended by adding the following Sections 15.51 and 15.52:

Section 15.51 –Allowable HRA Expense
"Allowable HRA Expense" means an expense that meets the criteria of Section 17.05.

Section 15.52 – Health Reimbursement Arrangement Account or HRA Account
"Health Reimbursement Arrangement Account" or "HRA Account" means an account that is established for a Participant and credited with the contributions in a Participant's Dollar Bank that exceed

the maximum $5,400 of excess contributions that a Participant is allowed to accumulate in his Dollar Bank. The contributions in a Participant's HRA Account may be used to reimburse a Participant and/or his Dependent's for Allowable HRA Expenses in accordance with the rules in Article XVII – Health Reimbursement Arrangement ("HRA") Benefits. A HRA Account is merely a record keeping account with the purpose of keeping track of contributions. A HRA Account consists solely of Employer contributions and is not credited with any income earned on the Plan's reserves. A HRA Account is a non-vested benefit and it can be forfeited in accordance with the rules in Article XVII – Health Reimbursement Arrangement ("HRA") Benefits. For purposes of this Section 15.52, the term Participant includes a deceased Participant whose surviving spouse is covered under the Plan in accordance with Section 1.22 or Section 1.23.

The Plan shall be amended by inserting the following Article XVII:

ARTICLE XVII - HEALTH REIMBURSEMENT ARRANGEMENT ("HRA") BENEFITS

This Article describes the Health Reimbursement Arrangement ("HRA") Benefits which go into effect on May 1, 2013. Throughout this Article, the term Participant includes a deceased Participant whose surviving spouse is covered under the Plan in accordance with Section 1.22 or Section 1.23.

To understand the Plan's HRA Benefits, there are two definitions you need to know about. You need to know (1) the definition of HRA Account; and (2) the definition of Allowable HRA Expense.

A HRA Account is an account that is established for a Participant. When a Participant has accumulated $5,400 of excess contributions in his Dollar Bank, any additional contributions will automatically be drawn from his Dollar Bank and credited to his HRA Account. The contributions in a Participant's HRA Account can be used to reimburse the Participant and his Dependents for Allowable HRA Expenses.

In general, an Allowable HRA Expense is an expense that is incurred by a Covered Person for medical care after May 1, 2013 and is not reimbursed by any other source or taken as an income tax deduction. Monthly Premium and Retiree Premium payments are considered Allowable HRA Expenses.

These rules are explained in greater detail below.

Section 17.01 – Eligibility for HRA Benefits

The HRA Benefits in this Article XVII are available for Participants and their Dependents.

Section 17.02 – Definitions for this Article XVII Only

The following terms will have a specific meaning when they are used within this Article:

(a) "Coverage Period" means a calendar year, with the following exceptions:

(1) For an individual who is a Participant on May 1, 2013, his first "Coverage Period" shall begin on May 1, 2013 (rather than January 1, 2013);

(2) For an individual who becomes a Participant after May 1, 2013, his first "Coverage Period" shall begin on the day he becomes a Participant; and

(3) For an individual who has his coverage terminated in accordance with Article I – Eligibility, his last "Coverage Period" shall end on the date his coverage is terminated (other than under any continuation rules required by applicable law).

(b) "Maximum Dollar Amount" means the maximum amount that may be credited to a Participant's HRA Account during a "Coverage Period". The "Maximum Dollar Amount" is the amount of contributions in a Participant's Dollar Bank during the "Coverage Period" that exceeds $5,400 (i.e. the amount of contributions in a Participant's Dollar Bank minus $5,400 equals the "Maximum Dollar Amount").

(c) "Maximum Reimbursement Amount" means the maximum amount that may be reimbursed to a Participant and/or his Dependents during a "Coverage Period". The "Maximum Reimbursement Amount" is the amount credited to a Participant's HRA Account during a "Coverage Period", plus the amount of the carryover of his unused HRA Account balance from a prior "Coverage Period".

Section 17.03 – HRA Account

Effective May 1, 2013, a HRA Account will be established for each Participant. This means that if you are a Participant on May 1, 2013, a HRA Account will be established for you on May 1, 2013. If you are a Participant on May 1, 2013, and you have less than $5,400 of contributions in your Dollar Bank at that time, the opening balance in your HRA Account will be $0. If you are a Participant on May 1, 2013, and you have greater than $5,400 of contributions in your Dollar Bank at that time, the opening balance in your HRA Account will equal the amount of contributions in your Dollar Bank on May 1, 2013 minus $5,400 (see examples 1 and 2 on page 13 for an illustration of how this works).

If you become a Participant after May 1, 2013, a HRA Account will be established for you on the day that you become a Participant in the Plan. If you become a Participant in the Plan after May 1, 2013, the opening balance in your HRA Account will be $0. Once you have accumulated the maximum $5,400 of excess contributions in your Dollar Bank, any additional contributions will automatically be drawn from your Dollar Bank and credited to your HRA Account.

After your HRA Account has been established, it will be credited each time that you accumulate the maximum $5,400 of excess contributions in your Dollar Bank. This means the most frequently your HRA Account can be credited is once a month. The amount credited to your HRA Account each month will equal the amount of contributions in your Dollar Bank in excess of $5,400 (i.e. the amount credited to your HRA Account will equal the contributions in your Dollar Bank minus $5,400).

If you are a Covered Employee and you are working in Covered Employment, the Plan Administrator will process contributions in the following order to determine the amount to credit your HRA Account each month (see example 3 on pages 13 and 14 for an illustration of how this works):

- The Plan Administrator will credit your Dollar Bank with any new contributions;

- The Plan Administrator will draw contributions from your Dollar Bank to pay the Monthly Premium; and then

- The Plan Administrator will draw any contributions from your Dollar Bank that exceed $5,400 and credit those contributions to your HRA Account.

The contributions in your HRA Account can be used to reimburse you and your Dependents for Allowable HRA Expenses. Your HRA Account will be reduced each time you or your Dependent(s) receives a reimbursement from your HRA Account. The amount available to you for reimbursement of Allowable HRA Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you (and/or your Dependent(s)) as of that date. To find out your HRA Account balance on any given date, you can call the Fund Office or visit the website www.ibew347benefits.com.

At the end of each "Coverage Period", the unused amount (if any) in your HRA Account will be carried over to reimburse you (and/or your Dependents) for Allowable HRA Expenses incurred during a following "Coverage Period". There is no limit to the amount that can be carried over from one "Coverage Period" to another "Coverage Period".

The HRA Account established for you will merely be a record keeping account with the purpose of keeping track of contributions. Your HRA Account will consist solely of Employer contributions. Your HRA Account will not be credited with any interest income earned on the Plan's reserves. Your HRA Account is a non-vested benefit and can be forfeited. The contributions in your HRA Account may not be paid to you in cash or any other taxable or non-taxable benefit other than the reimbursement of Allowable HRA Expenses.

The following examples illustrate how the HRA Account works. The contribution rates, Monthly Premium amounts, and Retiree Premium amounts listed in these examples are hypothetical numbers used solely for the purpose of illustrating how the HRA Account works. The numbers listed in these examples do not reflect the actual contribution rates or Monthly Premium or Retiree Premium amounts. For information concerning the actual contribution rate, the Monthly Premium, or the Retiree Premium contact the Fund Office.

Example 1

On May 1, 2013, Phillip is a Covered Employee and he has $1,000 in his Dollar Bank. On May 1, 2013, a HRA Account is established for Phillip. The opening balance in Phillip's HRA Account is $0. The balance in Phillip's HRA Account will remain $0 until Phillip has accumulated the maximum $5,400 in his Dollar Bank. Once Phillip has accumulated the maximum $5,400 in his Dollar Bank, any additional contributions will automatically be drawn from his Dollar Bank and credited to his HRA Account.

Example 2

On May 1, 2013, Phillip is a Retiree and he has $10,000 in his Dollar Bank. On May 1, 2013, a HRA Account is established for Phillip. In May 2013, the Retiree Premium is $100. On May 1, 2013, the Plan Administrator will automatically take $100 out of Phillip's Dollar Bank to pay the Retiree Premium. On May 1, 2013, the Plan Administrator will also automatically take $4,500 out of Phillip's Dollar Bank and will credit that $4,500 to Phillip's HRA Account (i.e. the difference between the contributions in Phillip's Dollar Bank and the maximum $5,400 that a Participant can accumulate in his Dollar Bank). The $4,500 that is credited to Phillip's HRA Account can be used to reimburse Phillip and/or his Dependents for Allowable HRA Expenses.

Example 3

From January 1, 2013 through December 31, 2013, the Collective Bargaining Agreement requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In February 2013, Phillip works 100 hours in Covered Employment. In March 2013, Phillip works 200 hours in Covered Employment.

On April 30, 2013, Phillip is a Covered Employee and he has $5,350 in his Dollar Bank. In May 2013, the Monthly Premium is $100. On May 1, 2013, the Plan Administrator will credit Phillip's Dollar Bank with $100 in contributions for his February 2013 hours. On May 1, 2013, the Plan Administrator will also automatically take $100 out of Phillip's Dollar Bank to pay the Monthly Premium.

On May 1, 2013, a HRA Account is established for Phillip. The opening balance in Phillip's HRA Account is $0. On May 31, 2013, Phillip has $5,350 in his Dollar Bank. On June 1, 2013, the $200 for Phillip's March work hours is credited to his Dollar Bank and the total amount in his Dollar Bank becomes $5,550. The Monthly Premium in June 2013 is $100. On June 1, 2013, the Plan Administrator will automatically take $100 out of Phillip's Dollar Bank to pay the Monthly Premium.

On June 1, 2013, the Plan Administrator will also automatically take $50 out of Phillip's Dollar Bank and will credit that $50 to Phillip's HRA Account (i.e. the difference between the maximum $5,400 that a Participant can accumulate in his Dollar Bank and the $5,450 of contributions in his Dollar Bank). The $50 that is credited to Phillip's HRA Account can be used to reimburse Phillip and/or his Dependents for Allowable HRA Expenses.

Section 17.04 – Forfeiture of HRA Account

(a) Forfeiture of HRA Account for Employees

An Employee's HRA Account will be forfeited if (1), (2), (3), or (4) occurs:

(1) If an Employee or former Employee becomes employed in the electrical industry by an employer having no obligation to contribution to this Plan, the Employee (or former Employee) will permanently forfeit all of the contributions in his HRA Account on the first day of the month following the month during which the work for the non-contributing employer was first performed;

(2) If an Employee or former Employee becomes employed in a non-bargaining unit position for an Employer on or after January 1, 2011, and he no longer has contributions remitted to the Plan on his behalf, he can use the contributions in his HRA Account for a maximum of three months so long as he is covered by the Plan during those three months. After three months, the Employee's (or former Employee's) HRA Account will be frozen (i.e. his HRA Account will be frozen on the first day of the fourth month after he begins working in a non-bargaining unit position for an Employer). After seven years, the Employee will permanently forfeit the contributions in his HRA Account unless he re-establishes eligibility under the Plan in accordance with Section 1.15(a);

(3) If an Employee or former Employee is not covered under the Plan for seven years and he does not have any contributions remitted to the Plan on his behalf during those seven years (i.e. he is not covered under the Plan for 84 consecutive months and he does not have any contributions remitted to the Plan on his behalf for those 84 months), he will permanently forfeit all of the contributions in his HRA Account; or

(4) If an Employee or former Employee dies and on the date of his death he does not have a surviving spouse who is eligible to continue coverage in accordance with Section 1.22, all of the contributions in the Employee's (or former Employee's) HRA Account will be forfeited on the first day of the month following his death. If an Employee or former Employee dies and on the date of his death he has a surviving spouse who is eligible to continue coverage under the Plan in accordance with Section 1.22, the date the surviving spouse is no longer eligible to continue coverage shall be treated as the date of the Employee's (or former Employee's) death for purposes of this Section 17.04(a)(4). In other words, if an Employee's (or former Employee's) surviving spouse is eligible to continue coverage in accordance with Section 1.22, and she subsequently loses eligibility for coverage, all of the contributions in the Employee's (or former Employee's) HRA Account will be forfeited on the first day of the month following the day the surviving spouse is no longer eligible to continue coverage under the Plan.

(b) Forfeiture of HRA Account for Retirees

A Retiree's HRA Account will be forfeited if (1) or (2) occurs:

(1) If a Retiree becomes employed in the electrical industry by an employer having no obligation to contribute to this Plan, the Retiree will permanently forfeit all of the contributions in his HRA Account on the first day of the month following the month during which the work for the non-contributing employer was first performed; or

(2) If a Retiree dies and on the date of his death he does not have a surviving spouse who is eligible to continue coverage under the Plan in accordance with Section 1.23, all of the contributions in the Retiree's HRA Account will be forfeited on the first day of the month following his death. If a Retiree dies and on the date of his death he has a surviving spouse who is eligible to continue coverage under the Plan in accordance with Section 1.23, the date the surviving spouse is no longer eligible to continue coverage shall be treated as the date of the Retiree's death for purposes of this Section 17.04(b)(2). In other words, if a Retiree's surviving spouse is eligible to continue coverage in accordance with Section 1.23, and she subsequently loses eligibility for coverage (for example, if her coverage is terminated in accordance with Section 1.23 or if she was using other coverage in accordance with Section 1.19(b) and she did not elect coverage under this Plan within 90 days of losing the other coverage), all of the contributions in the Retiree's HRA Account will be forfeited on the first day of the month following the day the surviving spouse is no longer eligible to continue coverage under the Plan.

Section 17.05 – Allowable HRA Expenses

The contributions in a Participant's HRA Account may be used to reimburse a Participant and his Dependents for Allowable HRA Expenses. An Allowable HRA Expense is an expense that meets the criteria of (a), (b), (c), (d), (e), and (f) below:

(a) The expense was incurred by a Covered Person while he is eligible for benefits under the Plan and during a "Coverage Period". This means expenses incurred when an individual is not covered by the Plan are not Allowable HRA Expenses. This also means that expenses incurred before May 1, 2013 are not Allowable HRA Expenses;

(b) The expense is for "medical care" as that term is defined by Internal Revenue Code Section 213(d) (see below for examples of items that meet this criteria);

(c) If the expense is incurred for medicine or drugs (other than insulin), the medicine or drug must be prescribed even if the medicine or drug is an over-the-counter drug. This means over-the-counter drugs (other than insulin) are only Allowable HRA Expenses if they are purchased with a prescription;

(d) The expense is not specifically excluded by Section 17.06;

(e) The expense was not reimbursed (and will not be reimbursed) by any other health plan, insurance, or other source or entity; and

(f) The expense was not taken (and will not be taken) as a tax deduction on a Participant's (or his Dependent's) income tax return.

The following is a list of examples of medical care expenses that meet the criteria of Sections 17.05(b), (c), and (d) above. Please note that for an item listed below to be considered an Allowable HRA Expense, it must also meet the criteria of 17.05(a), (e), and (f) above.

This is only a partial list and it does not include all expenses that meet the criteria of Sections 17.05(b), (c), and (d) above. For information on whether a specific expense is considered an Allowable HRA Expense contact the Fund Office.

- Abortion (as long as it is a legal operation)
- Acupuncture
- Alcoholism Treatment

- Ambulance Service
- Artificial Limbs
- Artificial Teeth
- Bandages
- Birth Control Pills (as long as they are prescribed, even if available without a prescription)
- Body Scans
- Braille Books and Magazines (only amounts above the cost of regular printed material)
- Breast Pumps and Supplies
- Breast Reconstruction Surgery Following Mastectomy
- Chiropractic Care
- Christian Science Practitioner (only fees paid for medical care)
- Co-insurance Amounts (as long as the underlying service/item qualifies)
- Contact Lenses, Materials, and Equipment (only if the contact lenses are needed for medical purposes. Does not include contact lenses for cosmetic purposes, such as to change eye color)
- Co-payments (as long as the underlying service/item qualifies)
- Crutches
- Deductibles (as long as the underlying service/item qualifies)
- Dental Treatment (includes preventative treatment, x-rays, fillings, braces, extractions, and dentures. Does not include teeth whitening)
- Diagnostic Items and Services
- Drug Addiction Treatment
- Drugs and Medicine (only if the drug or medicine is prescribed or is Insulin)
- Eye Examinations, Eyeglasses, Equipment, and Materials (only if needed for medical purposes. Includes prescription sunglasses)
- Eye Surgery (includes laser eye surgery)
- Fertility Enhancements (only to the extent procedures are intended to overcome an inability to have children)
- Guide Dog or other Service Animal
- Hearing Aids
- Hospital Services
- Laboratory Fees
- Lead-Based Paint Removal (only if it is to prevent a child who has (or has had) lead poisoning from eating the paint)
- Long-term Care Services and Insurance Premiums (only amounts paid for qualified long-term care services and premiums paid for qualified long-term care insurance contracts)
- Medicare Part B Premiums

- Monthly Premium and Retiree Premium Payments (only if they are paid to the IBEW Local 347 Electrical Workers Health and Welfare Fund in accordance with Section 1.03, Section 1.09, Section 1.22 or Section 1.23. Does not include COBRA premiums)
- Operations (as long as it is a legal operation and is not a cosmetic procedure)
- Osteopath Fees
- Oxygen and Oxygen Equipment
- Physical Exams
- Psychiatric Care
- Psychologist Fees
- Smoking Cessation Programs (does not include amounts paid for drugs that are not prescribed)
- Sterilization Procedures (including a vasectomy)
- Telephone and Television Equipment for Hearing-Impaired Persons
- Therapy (only amounts paid for medical treatment)
- Transplants (includes surgical, hospital, and laboratory services as well as transportation expenses for organ donors)
- Transportation Expenses (only amounts paid for transportation primarily for, and essential to, medical care)
- Tuition for Special-needs Program (only if the primary purpose is medical care)
- Weight-loss Programs and/or Drugs Prescribed to Induce Weight Loss (only if recommended by a physician to treat a specific medical condition (such as obesity, hypertension, or heart disease). This includes fees paid for membership in a weight reduction group as well as fees for attendance at periodic meetings. This also includes special food if it does not satisfy normal nutritional needs, it alleviates or treats an illness, and the need for the food is substantiated by a physician. See Section 17.06 for exclusions related to weight-loss)
- Wheelchairs
- Wigs (only if it is prescribed by a physician for the mental health of a patient who has lost all of his hair from disease or treatment)
- X-ray Fees

Section 17.06 – HRA Benefit Exclusions and Limitations

HRA Benefits will not be payable for:

(a) Expenses that are not for "medical care" as that term is defined by Internal Revenue Code Section 213(d);

(b) Claims for HRA Benefits filed more than 12 months after the date the expense is incurred;

(c) Controlled substances that are in violation of federal law, even if a state allows its use with a physician's prescription (for example, marijuana or laetrile prescribed to treat a specific medical condition);

(d) Cosmetic surgery (including electrolysis, hair removal, hair transplants, and teeth whitening), except when it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease;

(e) Dancing lessons and swimming lessons that are only for the improvement of general health, even if the lessons are recommended by a doctor;

(f) Diapers or diaper service, except when used to relieve the effects of a diagnosed medical condition;

(g) Funeral expenses;

(h) Health club dues or amounts paid for the purpose of improving general health or relieving physical or mental discomfort that is not related to a particular medical condition;

(i) Insurance premiums (including COBRA premiums), except as specifically provided in the chart in Section 17.05 (i.e. HRA Benefits will not be payable for any insurance premiums except Medicare Part B Premiums, qualified long-term care premiums and Monthly Premium and Retiree Premium payments that are paid to the Plan in accordance with Section 1.03, Section 1.09, Section 1.22, or Section 1.23);

(j) Maternity clothes;

(k) Nonprescription drugs and medicines, except for insulin;

(l) Nutritional supplements, vitamins, herbal supplements, and natural medicines unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician;

(m) Weight-loss programs and drugs prescribed to induce weight loss, unless recommended by a physician to treat a specific medical condition; and

(n) Special food and beverages, unless the food or beverages are prescribed by a medical practitioner to treat a specific illness or ailment and do not substitute for normal nutritional needs.

Section 17.07 – Filing a Claim

The contributions in your HRA Account can be used to reimburse you and your Dependents for Allowable HRA Expenses. Generally, you must pay for all services, supplies, and prescription drugs at the time you receive them and then submit a claim for reimbursement from your HRA Account within 12 months from the date the claim was incurred in accordance with the rules listed in Section 17.07(a) below.

The Plan does allow one exception to the rule that you must pay for expenses and then submit a claim for reimbursement. This exception is explained in Section 17.07(b) below and it allows you to file a claim to have your Monthly Premium or Retiree Premium payments automatically drawn from your HRA Account.

(a) Filing a Claim for Reimbursement

Claims for reimbursement from your HRA Account must be filed with Wilson-McShane Corporation at the address shown on page 1 of this Summary Plan Description. To receive reimbursement for an Allowable HRA Expense, you must submit a claim form to Wilson-McShane Corporation within 12 months after the date the expense was incurred. An expense incurred by a Covered Person during one "Coverage Period" may be reimbursed during a subsequent "Coverage Period" as long as the claim is submitted within 12 months after the date the expense is incurred.

You must file claims for reimbursement on the Plan's HRA claim forms which are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com. The general rules for filing a claim for reimbursement of Allowable HRA Expenses are as follows:

- The minimum required claim amount is $25. That means that you should not submit a claim for reimbursement until the amount of the aggregate claims you are submitting for reimbursement is at least $25. If the balance in your HRA Account is less than $25, the Plan will only reimburse a claim if it is for the entire remaining balance.

- You must have already received the services, supplies, or prescription drugs for which you are requesting reimbursement.

- The claim may be filed by the person who incurred the Allowable HRA Expense, his authorized representative, or his personal representative (see Section 9.01 for additional information regarding when an individual is considered an authorized representative or a personal representative).

- You must include an itemized receipt for every Allowable HRA Expense. The receipt must include information describing the service or product, the date of the service or sale, and the amount. Neither a canceled check nor a credit card bill is an acceptable form of receipt.

- If the claim is for prescribed over-the-counter medicines, you must submit one of the following items with your claim:

    - A receipt from a pharmacy which identifies the name of the purchase (or name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or

    - A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.

- If you have other insurance coverage that is secondary to this Plan, your claim must be filed with your secondary carrier before your claim for reimbursement is processed. You must include a copy of the secondary carrier's explanation of benefits (EOB) with your claim.

- You must certify that the information on the claim form is complete and accurate. You must also certify that any expenses reimbursed are for you or your Dependent and that the expenses have not and will not be reimbursed by any other source or entity nor claimed as an income tax deduction. If the claim form is filed by a minor child, both the Participant and the minor child must provide these certifications.

(b) Authorizing Payment of the Monthly Premium or the Retiree Premium (as applicable)

If you are a Covered Employee or Retiree and you have sufficient contributions in your Dollar Bank to cover the Plan's Monthly Premium or Retiree Premium (as applicable), the Monthly Premium or Retiree Premium (as applicable) will automatically be drawn from your Dollar Bank to pay for your coverage in accordance with Section 1.02 or Section 1.09. If you are covered by the Plan as a surviving spouse in accordance with Section 1.22 or Section 1.23 and the deceased Participant's Dollar Bank has sufficient contributions to cover the Plan's Monthly Premium or Retiree Premium (as applicable), the Monthly Premium or Retiree Premium (as applicable) will automatically be drawn from the deceased Participant's Dollar Bank to pay for coverage for you and your Dependents who are covered under the Plan in accordance with Section 1.22 or Section 1.23.

If you are a Covered Employee, Retiree, or surviving spouse, and you will not have sufficient contributions in your Dollar Bank (or in the case of a surviving spouse, the deceased Participant's Dollar Bank) to pay the Monthly Premium or Retiree Premium (as applicable) for the next month, the Plan Administrator will notify you that you will not be covered the following month unless you self-pay the difference between the amount of contributions in your (or for a surviving spouse, the deceased Participant's) Dollar Bank and the Monthly Premium or Retiree Premium (as applicable). Once you receive this notification, you may authorize the Plan Administrator to automatically draw the Monthly Premium or Retiree Premium (as applicable) from your (or in the case of a surviving spouse, the deceased Participant's) HRA Account to pay for coverage for you and your Dependents in accordance with the following rules:

- You must file a claim authorizing the Plan Administrator to automatically draw the Monthly Premium or Retiree Premium from your HRA Account. The claim must be filed with Wilson-McShane Corporation at the address shown on page 1 of this Summary Plan Description. Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com.

- The authorization must be for the entire Monthly Premium (or Retiree Premium) amount (i.e. you cannot authorize the Plan Administrator to draw a portion of the Monthly Premium or Retiree Premium from your HRA Account).

- The claim must be filed by the Participant or surviving spouse (as applicable).

- You must certify that the information on the claim form is complete and accurate. You must also certify that the Monthly Premium or Retiree Premium (as applicable) amount has not and will not be reimbursed by any other source or entity nor claimed as an income tax deduction.

- The authorization will automatically become null and void on the earliest of the following days:

    - The first day that it is determined that the HRA Account will not have sufficient contributions to pay the Monthly Premium or Retiree Premium (as applicable) for the following month (for example, if your HRA Account has $10 and the Monthly Premium for the following month is $100, the automatic authorization is void. You may still pay the $100 Monthly Premium and then submit a claim for reimbursement of the $10 to the Fund Office);

    - The 366th day after you submitted the claim for authorization to the Plan Administrator (in other words, the authorization is only good for a year. After the year, you are allowed to fill out a new claim for authorization);

    - The first day that the Fund Office receives a written request from you to revoke the authorization;

    - The date your HRA Account is forfeited or frozen in accordance with Section 17.04;

    - The first day of the month following your death;

    - The first day the Plan Administrator questions the validity of the certification on your claim form (for example, if the Plan Administrator has reason to believe you are receiving reimbursement for the Monthly Premium from another source); or

    - The date your eligibility and coverage is terminated in accordance with Section 1.13, Section 1.22, or Section 1.23.

Summary of Material Modification No. 2

to the

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

This Summary of Material Modification ("SMM") changes certain provisions of the IBEW Local 347 Electrical Workers Health and Welfare Combination Plan Document and Summary Plan Description ("SPD"). We suggest you keep this SMM with your SPD. This SMM is also available at the website www.ibew347benefits.com.

The SPD is amended and clarified as follows:

ARTICLE I – ELIGIBILITY

Effective March 1, 2013, Article I shall be amended at Section 1.07 by deleting subsection (d) and inserting in its place the following subsection (d):

(d) **Attainment Age 55**

If you are a Disabled Retiree who became eligible for Retiree coverage in accordance with this Section 1.07, and you are still Totally and Permanently Disabled when you attain 55 years of age, then effective 12:01 a.m. on the first day of the month following your 55th birthday, the terms of your eligibility and coverage will become identical to those in place for a Participant who became eligible for Retiree coverage in accordance with Section 1.06. In other words, starting the first day of the month following your 55th birthday, you will no longer be asked periodically to submit proof that you are still Totally and Permanently Disabled in accordance with Section 1.07(b), you will no longer be required to notify the Plan Administrator if you recover from your Total and Permanent Disability in accordance with Section 1.07(b), and you will not lose Retiree coverage if you recover from your Total and Permanent Disability in accordance with Section 1.13(b)(6).

Notwithstanding anything in this Section 1.07(d), a Disabled Retiree must inform the Plan Administrator if he becomes entitled to Medicare even if he has already reached age 55.

The following example illustrates how Section 1.07 works:

In January 2008, Phillip became a Covered Employee. In January 2008, Phillip was 48 years old, and had a 1 year old Dependent child whose coverage under the Plan became effective at the same time as his coverage (i.e. January 2008). From January 1, 2008 through December 31, 2011, Phillip and his Dependent child remained covered under the Plan.

On December 31, 2011, Phillip had $5,000 in his Dollar Bank. In January 2012, the Monthly Premium was $500. On January 1, 2012, $500 was automatically drawn from Phillip's Dollar Bank.

On January 5, 2012, Phillip got injured while working in Covered Employment. On January 10, 2012, Phillip saw a Physician who concluded that he would be prevented from pursuing his trade as an electrician for the rest of this life. On January 11, 2012, Phillip notified the Fund Office of his Total and Permanent Disability, provided the Fund Office with a written opinion from his Physician stating that he would be prevented from pursing his trade as an electrician for the rest of his life, and provided the Fund Office a form requesting Retiree health coverage for himself and declining coverage for his Dependent child. When Phillip requested Retiree health coverage, he was given the option of Plan A Coverage or Plan B Coverage. Phillip elected Plan A Coverage.

In February 2012, the Retiree Premium for Plan A Coverage for a Retiree without any Dependents was $300. On February 1, 2012, $300 was drawn from Phillip's Dollar Bank and he became a Retiree with Plan A Coverage.

On February 1, 2012, Phillip turned 53 years old. From February 1, 2012 through July 1, 2013 Phillip remained Totally and Permanently Disabled; the Fund Office periodically asked Phillip to submit proof that he was still Totally and Permanently Disabled; Phillip submitted an updated opinion from a Physician stating that in his opinion Phillip would be prevented from pursing his trade as an electrician for the rest of his life in response to each request from the Fund Office; and Phillip had sufficient contributions in his Dollar Bank to cover the Plan's Retiree Premium.

On July 2, 2013, Phillip had $0 remaining in his Dollar Bank. From August 1, 2013 until February 28, 2014, Phillip remained Totally and Permanently Disabled; the Fund Office periodically asked Phillip to submit proof that he was still Totally and Permanently Disabled; Phillip submitted an updated opinion from a Physician stating that in his opinion Phillip would be prevented from pursuing his trade as an electrician for the rest of his life in response to each request from the Fund Office; and Phillip self-paid the Retiree Premium in accordance with Section 1.09.

On February 1, 2014, Phillip turned 55 years old. On March 1, 2014, Phillip self-paid the Retiree Premium in accordance with Section 1.09. Beginning March 1, 2014, the Fund Office stopped asking Phillip to submit proof that he was still Totally and Permanently Disabled.

On March 1, 2014, Phillip requested coverage for his child who was now 7 years old. The Fund Office denied the request for coverage for Phillip's child because the child could have been enrolled on the date of Phillip's retirement (i.e. February 1, 2012) but Phillip declined coverage for his child at that time. Phillip continued to be covered under the Plan as a Retiree with Plan A Coverage continuously through August 31, 2014.

On August 31, 2014, Phillip elected Plan B Coverage. On September 1, 2014, the Retiree Premium for Plan B Coverage for a Retiree without any Dependents was $250. On September 1, 2014, Phillip self-paid the $250 and he became a Retiree with Plan B Coverage. Phillip may not subsequently elect to go back to Plan A Coverage.

Effective March 1, 2013, Article I shall be amended at Section 1.09 by deleting the Section in its entirety and inserting in its place the following Section 1.09:

Section 1.09 – Retiree Premium

The Retiree Premium is the dollar amount required for a Retiree to receive a month of coverage from the Plan. The Retiree Premium changes each month. 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 Retiree Premium will depend in part on a Retiree's level of benefit coverage in accordance with Section 1.10. The Trustees have the authority to set different Retiree Premiums for Medicare-eligible and non-Medicare eligible Retiree's and to require an additional premium amount for Dependents of Retirees.

If you are a Retiree and you have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium, the Retiree Premium will be automatically drawn from your Dollar Bank to pay for your coverage.

If you are a Retiree and you do not have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium, you may elect to self-pay the remaining portion of the Retiree Premium in accordance with this Section 1.09. The first month that you will not have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium for the following month, the Plan Administrator will notify you that you will not be covered the following month unless you self-pay the difference between the amount of contributions in your Dollar Bank and the Retiree Premium. You may use the contributions in your HRA Account to self-pay the Retiree Premium.

Self-payments are due in full on the first day of the month for which you intend to receive coverage. Unless there are extenuating circumstances as determined solely by the Plan Administrator and/or the Board of Trustees, coverage for you and your Dependents will terminate if the required self-pay amount is not received by the Fund Office by the fifth business day of the month. Retiree coverage may not be reinstated following termination of coverage for failure to make timely self-payments unless the Retiree regains coverage as a Covered Employee and subsequently retires in accordance with Sections 1.13(b) and 1.16.

Effective March 1, 2013, 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 Retiree Premium for a Retiree and at least one Dependent will equal the Monthly Premium (i.e. the amount paid by a Covered Employee). The Retiree Premium for a Retiree without any Dependents will equal 50% of the Monthly Premium (i.e. 50% 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 Retiree Premium for a Retiree and at least one Dependent will equal 80% of the Monthly Premium (i.e. 80% of the amount paid by a Covered Employee). The Retiree Premium for a Retiree without any Dependents will equal 40% of the Monthly Premium (i.e. 40% 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 March 1, 2013, 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**.

Effective March 1, 2013, Article I shall be amended at Section 1.23 by deleting subsection (d) and inserting in its place the following subsection (d):

(d) Whether the surviving spouse and her Dependents will have Plan A Coverage or Plan B Coverage will be determined as follows:

(1) If the Retiree had Plan A Coverage on the date of his death, the surviving spouse may elect to change to Plan B Coverage. **Once a surviving spouse elects Plan B Coverage, she may not subsequently elect Plan A Coverage.**

(2) If the Retiree had Plan B Coverage on the date of his death, the surviving spouse will have Plan B Coverage. The surviving spouse will not be permitted to change from Plan B Coverage to Plan A Coverage.

ARTICLE II – COMPREHENSIVE MEDICAL BENEFITS

Article II shall be clarified at Section 2.24 by deleting the Section in its entirety and inserting in its place the following Section 2.24:

Section 2.24 – Physician Office Visits
The Plan covers services and treatment (including diagnostic treatment and surgical treatment) received during a Physician Office Visit. The treatment and services covered under this Section includes treatment for mental health and substance abuse. It also includes Specialty Drugs (including IV infusion therapy) that are administered during the Physician Office Visit.

The Plan will pay the following percentages for Physician Office Visits:

- For Physician Office Visits to a PPO Provider, the Plan will pay 100% of Covered Charges after a Covered Person has paid a $20 Copay (Deductibles do not apply).
- For Physician Office Visits to a non-PPO provider, the Plan will pay 60% of Covered Charges after a Covered Person has met his Deductible.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will continue to pay 100% of Covered Charges after the $20 Copay for Physician Office Visits to PPO Providers. The Plan will begin to pay 80% of Covered Charges for Physician Office Visits to non-PPO providers.

Article II shall be clarified at Section 2.28 by deleting the Section in its entirety and inserting in its place the following Section 2.28:

Section 2.28 – Surgical Services
The Plan covers inpatient and outpatient surgical procedures provided by a Physician at a Physician's office, Facility or Hospital. The Plan also covers services performed in connection with and related to covered surgical procedures including preoperative care, postoperative care and anesthesia.

The following covered Surgical Services are subject to special terms and conditions:

(a) Bariatric Surgery:

The Plan covers bariatric surgery when a Covered Person meets all of the following criteria:

- He is at least 18 years old;
- He has completed a six month Physician-supervised weight loss program;
- He has passed a pre-surgical psychological evaluation; and
- He is morbidly obese. A Covered Person is considered morbidly obese if he has either (1) or (2) below:

  (1) Class III obesity, (Body Mass Index (BMI) greater than 40 kg/m2); or
  (2) Class II obesity (BMI of 35 to 39 kg/m2) in the presence of one or more of the following co-morbidities:

    i. Type 2 diabetes;
    ii. Cardiovascular disease (e.g. stroke, myocardial infarction, stable or unstable angina pectoris, hypertension or coronary artery bypass); or
    iii. Life-threatening cardiopulmonary problems (e.g. severe sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy).

The Plan provides a free program to assist Covered Persons in determining whether they meet the criteria listed above. This free program is called the UnitedHealthcare Bariatric Program and is available to all Covered Persons. To utilize the program, please contact UnitedHealthcare at (888) 936-7246.

(b) Mastectomy Surgery:

The Plan covers mastectomies and related services in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA). If a Covered Person who is receiving benefits from the Plan in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, the Plan will provide coverage for the following treatments in a manner determined in consultation with the attending Physician and the patient:

(1) Reconstruction of a breast on which a mastectomy has been performed;
(2) Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance in a manner determined between the patient and attending Physician; and
(3) Coverage for prostheses and physical complications of all states of mastectomy (including lymph edemas).

The Plan will pay the following percentages for Surgical Services:

- For Surgical Services that are performed during a Physician Office Visit, the Plan will cover such services under Section 2.24.
- For Surgical Services provided by a PPO Provider at a Hospital or Facility, the Plan will pay 80% of Covered Charges after a Covered Person has met his Deductible.
- For Surgical Services provided by a non-PPO provider at a Hospital or Facility, the Plan will pay 60% of Covered Charges after a Covered Person has met his Deductible.

Once a Covered Person has met his Annual Out-of-Pocket maximum, the Plan will pay 100% of Covered Charges for Surgical Services provided by a PPO Provider at a Hospital or Facility and 80% of Covered Charges for Surgical Services provided by a non-PPO provider at a Hospital or Facility.

ARTICLE XIII – MISCELLANEOUS PROVISIONS

Effective May 9, 2013, Article XVIII shall be amended at Section 13.07 by deleting the Section in its entirety and inserting in its place the following Section 13.07:

Section 13.07 – Name and Address of the Person Designated as an Agent for Service of Legal Process

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266

Service of Legal process may also be made upon the Board of Trustees or any individual Trustee.

Effective May 1, 2013, Article XIII shall be amended at Section 13.08 by deleting the Section in its entirety and inserting in its place the following Section 13.08:

Section 13.08 – Names, Titles and Addresses of the Trustees

Union Trustees	Employer Trustees
Mr. Kevin Clark IBEW Local 347 850 18th Street Des Moines, IA 50314	Ms. Angela S. Bowersox Iowa Chapter, NECA 2900 Westown Parkway, Suite 140 West Des Moines, IA 50266
Mr. Matt DeAngelo IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. John Irving Baker Electric 111 S Jackson Street Des Moines, IA 50315
Mr. Allen DeHeer IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. Jim Davis The Waldinger Corporation 2601 Bell Avenue Des Moines, IA 50321
Mr. Doug Wolf IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. Michael Price Commonwealth Electric of the 1530 Second Ave Des Moines, IA 50314
Mr. Jerry Kurimski (alternate) IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. Don Bridgeman (alternate) Wolin Mechanical & Electrical 1720 Fuller Road West Des Moines, IA 50265

The Board of Trustees may be contacted at the following Fund Office address and phone number:

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266
Telephone: (515) 224-4308
Toll-Free: (877) 224-4308

Grandfathered Status

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (515) 224-4308 or toll free at (877) 224-4308. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or: www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

TABLE OF CONTENTS

IMPORTANT NUMBERS

IBEW LOCAL 347 ELECTRICAL WORKERS HEALTH AND WELFARE FUND
CLAIMS ADMINISTRATOR AND PLAN ADMINISTRATOR
Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266
Telephone: (515) 224-4308
Toll-Free: (877) 224-4308
www.ibew347benefits.com

PPO AND CASE MANAGEMENT PROVIDER
UnitedHealthcare
UnitedHealth Integrated Services
PO Box 30783
Salt Lake City, UT 84130-0783
Toll Free: (866) 596-8447 (Provider Services)
You can locate a Preferred Provider by visiting: http://welcometouhc.com/uhss

PRESCRIPTION BENEFIT MANAGER
LDI Integrated Pharmacy Services
701 Emerson, Suite 301
Creve Coeur, MO 63141
Toll-Free: (866) 516-3121
www.LDIRx.com

DENTAL PROVIDER
Delta Dental of Iowa
PO Box 9000
Johnston, IA 50131-9000
Toll-Free: (800) 544-0718
www.deltadentalia.com

VISION PROVIDER
VSP Vision Care
PO Box 997105
Sacramento, CA 95899-7105
Toll-Free: (800) 877-7195
www.vsp.com

MENTAL HEALTH AND SUBSTANCE USE COUNSELING
Iowa Health EAP
1301 Penn Avenue, Suite 305
Des Moines, IA 50316
Toll Free: (800) 732-4490

MEDICARE
Enrollment (thru Social Security): (800) 772-1213
Other Questions: (800) MEDICARE/(800) 633-4227
www.medicare.gov

TIPS TO BE A SMART HEALTH CARE CONSUMER

Following the suggestions listed below will not only save the Plan money, but they will also save you money.

Top Ten Ways to Save

1. Utilize providers in the UnitedHealthcare (UHC Options PPO) network whenever possible.
2. Enroll in Medicare as soon as you are eligible for Part A and Part B coverage.
3. Utilize the mail order prescription services for maintenance drugs that you take on an on-going basis. You should also inquire about the cost of medications. Generic drugs often cost less than name brands and your Physician will prescribe them if you ask.
4. Review your copy of all provider billings to make sure you received the services they are billing for. Question all discrepancies.
5. Utilize urgent care Facilities rather than the emergency department of a Hospital if you need non-emergent care outside the office hours of your Physician.
6. Enroll in UHC's Health Pregnancy Program as soon as you discover you are pregnant.
7. Ask your provider to request prior authorization from UHC before you are admitted to a Hospital, undergo surgery, rent or purchase Durable Medical Equipment, or receive Therapy Services, Transplant Services, Home Health Care Services, Hospice Care Services, or Skilled Nursing Facility Services. While the Plan does not require prior authorization for any service or treatment, the Plan does allow your provider to request prior authorization. By having your provider request prior authorization, you could avoid receiving a service that is not covered by the Plan.
8. If a third party could be responsible for your medical services, (e.g. automobile coverage, workers compensation, home owners insurance), be sure to make the Fund Office aware of the other liability and utilize the Plan's subrogation rules.
9. Be sure your vision provider knows that you are a VSP member before your appointment. You will only receive vision benefits at the Preferred Provider rate if your doctor is a VSP Preferred Provider and you inform him that you are a VSP member before your appointment.
10. Maintain a healthy lifestyle. Many sicknesses and injuries can be prevented. Major illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet, and stress are a few of the factors that can cause illness. By eating right, getting enough sleep, and exercising regularly, you can prevent many sicknesses.

INTRODUCTION

The Board of Trustees of the IBEW Local 347 Electrical Workers Health and Welfare Fund is pleased to provide you with this updated Combination Plan Document and Summary Plan Description ("Booklet"). The Plan described in this Booklet is effective September 1, 2012 and replaces all other Plan documents previously provided to you.

The Plan is established on a non-insured basis. This means that all liability for payment of benefits is assumed by the Fund. The Board of Trustees has the power and discretion to amend, change, add to, interpret or terminate the Plan.

If something in this Booklet is not clear, you should contact the Fund Office for more information. We have included a list of important numbers in the front of this Booklet that you can refer to if you need information or clarification.

The Plan provides the following benefits:

- Comprehensive Medical Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Death Benefits; and
- Short-Term Disability Benefits.

You should remember that by saving the Fund money, we are able to provide better benefits. Saving the Fund money also helps lessen the need to increase the hourly contribution rate, which may ultimately decrease your paycheck. There are certain things you can do to help in this effort, such as using providers in the PPO Provider network and using generic prescription drugs whenever possible. If you feel you are overcharged by a provider, please call the provider and ask for an itemized bill of your expenses.

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

Please take some time to review this Booklet. If you are married, share this Booklet with your spouse. We recommend that you keep this Booklet with your important papers so that you can refer to it when needed.

We hope that you find this Booklet useful, and we hope that you and your family will enjoy the protections of the Plan for years to come.

Sincerely,

Trustees of the IBEW Local 347 Electrical Workers Health and Welfare Fund

IMPORTANT NOTICE

This Booklet is intended to describe the medical, prescription, dental, vision, short-term disability and death benefits adopted by the Trustees. Only the full Board of Trustees has the authority to interpret the benefits described in this Booklet. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. The Plan contains appeal procedures that may be used if you feel that benefits have been wrongfully denied. The Trustees' decision can be challenged in court only after those procedures are exhausted. No Employer or Union nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees.

The Board of Trustees has complete power and discretion to amend or terminate the Plan, in whole or in part, at any time. This means that the Trustees can reduce or eliminate benefits, terminate all benefits for certain Participants, or modify the availability, nature, and extent of benefits, and the conditions for and method of payment of benefits. The Trustees may also modify the eligibility and coverage requirements and the rules surrounding a Participant's Dollar Bank. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time a claim occurs.

The Board has authorized the Fund Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Fund Office for a definitive answer. As a courtesy to you, the Fund Office may also respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Notices of Plan changes will be sent to each Participant's last known address. It is extremely important that you notify the Fund Office, in writing, of any address change!

Notice of Plan Changes

Notices of any changes to the Plan rules and benefits will be sent to each Participant's last known address. Please be sure to read all Plan announcement letters about benefit changes and keep them with this Booklet. In order for you to be aware of the benefits available to you and your Dependents, please read this Booklet carefully prior to obtaining medical care. If you have any questions about the benefits described in this Booklet, please contact the Fund Office.

Defined Terms

Certain words have specific meaning and are capitalized when used in the Plan. These words are listed in Article XV – Definitions. It is important to understand the meanings of the defined terms when using this Booklet.

GRANDFATHERED STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (515) 224-4308 or toll free at (877) 224-4308. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or: www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund offers the UnitedHealthcare network of Physicians, Hospitals, Facilities and other health care providers. UnitedHealthcare contracts with these providers to offer medical treatment to Participants and Dependents at reduced rates. This network of providers is called a Preferred Provider Organization (PPO) and the providers in the network are called PPO Providers.

The Fund's Preferred Provider Organization (PPO) is UnitedHealthcare.

For up-to-date provider information, visit UnitedHealthcare's website at http://welcometouhc.com/uhss, click on "Find a Doctor/Hospital", and choose UnitedHealthcare Options PPO.

You are not required to use a PPO Provider to receive benefits from the Plan. However, by using a PPO Provider, you benefit from these important advantages:

- You will pay a lower percentage of the Covered Charges for most treatments; and
- You will not have to pay charges that exceed the Prevailing Charge. The Plan specifically excludes payment for any part of a charge for treatment that exceeds Prevailing Charges. When you receive treatment from a PPO Provider, you will not be billed for more than the total Prevailing Charge. If you do not use a PPO Provider, that provider could bill for more than the total Prevailing Charge.

It is always a good idea to verify if your provider is in the PPO network before receiving treatment. Visit UHC's website at http://welcometouhc.com/uhss for the most up-to-date provider information. Once there, click on Find a Doctor/Hospital and then choose UnitedHealthcare Options PPO Provider. You can also call the Fund Office at (515) 224-4308 or toll-free at (877) 224-4308. PPO Provider directories are available free of charge.

No matter how you access a directory, it is recommended that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm PPO network participation with your provider when making an appointment.

LIFE EVENTS AT A GLANCE

There are several significant events that may occur while you are covered under the Plan. Contact the Fund Office, in writing immediately, if any of the following occurs:

- **YOUR ADDRESS OR TELEPHONE NUMBER CHANGES.**
- **YOU MARRY OR DIVORCE.** You must also submit the appropriate legal documents (for example: marriage certificate or divorce decree).
- **YOU CHANGE YOUR BENEFICIARY.**
- **YOUR DEPENDENT CHILD NO LONGER QUALIFIES AS A DEPENDENT UNDER THE TERMS OF THE PLAN.**
- **YOU BECOME A PARENT.** You must also submit the child's state-certified birth certificate, decree of adoption or placement for adoption, a Qualified Medical Child Support Order, or other legal documentation.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE.**
- **YOU BEGIN RECEIVING WORKERS' COMPENSATION BENEFITS.**
- **<u>BEFORE</u> YOU TURN AGE 65 AND BECOME ELIGIBLE FOR MEDICARE, PLEASE CONTACT THE FUND OFFICE. SEE SECTION 10.04 FOR MORE DETAILS.**
- **YOU RETIRE.**

EMPLOYEE ASSISTANCE PROGRAM

The Plan provides a free program to help Covered Persons cope with personal difficulties that can affect their lives both at home and at work.

This free program is called the Iowa Health Employee Assistance Program ("EAP") and is available to all Covered Persons. The EAP assists Covered Persons with a variety of life problems including alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship discord; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and educational and career related problems. All contact with the EAP is confidential.

The Trustees encourage you to take advantage of the services offered by the EAP before you seek inpatient or outpatient treatment for mental health or substance abuse.

To utilize this program, please contact the Iowa Health EAP at (515) 263-4004 or (800) 732-4490. Information is also available at: www.ihsdesmoines.org.

SUMMARY OF BENEFITS

COMPREHENSIVE MEDICAL BENEFITS (ARTICLE II)		
PLAN LIMITS, DEDUCTIBLES AND MAXIMUMS		
Calendar Year Maximum Payment Limit ..... \$2,000,000* *There is no calendar year maximum payment limit as of January 1, 2014.		
	PPO PROVIDER	**NON-PPO PROVIDER**
Deductible • **Individual** • **Family**	 \$ 200 \$ 600	 \$ 200 \$ 600
When the family maximum is satisfied for a calendar year, Comprehensive Medical Benefits will be payable as if the individual Deductibles had been satisfied for each person in your family.		
Annual Out-of-Pocket Maximum • Individual The Annual Out-of-Pocket Maximum is applied on an individual basis. There is no family level Annual Out-of-Pocket Maximum.	Once you have incurred \$3,000 of eligible Covered Charges in a calendar year, you have met your Annual Out-of-Pocket Maximum and for the rest of that calendar year the Plan will pay 100% of Covered Charges for most Comprehensive Medical Benefits provided by a PPO Provider and 80% of Covered Charges for most Comprehensive Medical Benefits provided by a non-PPO provider. Refer to Section 2.03 for more details.	
COVERAGE (PLAN PAYS)		
SERVICE	**PPO PROVIDER**	**NON-PPO PROVIDER**
AMBULANCE SERVICES	80% after Deductible	80% after Deductible
CHIROPRACTIC SERVICES	100% after \$20 Copay - Deductible Waived	80% after Deductible
COLONOSCOPY SERVICES • **ROUTINE (limited to one every five years)** • **NON-ROUTINE**	 100% - Deductible Waived 80% after Deductible	 100% - Deductible Waived 60% after Deductible
DENTAL SERVICES – ACCIDENT RELATED	80% after Deductible	80% after Deductible
Deductible is waived if treatment is completed within six months of the accident.		
DENTAL SERVICES – IMPACTED TEETH	80% after Deductible	80% after Deductible
DENTAL SERVICES – IMPLANTS FOR CONGENITAL DEFECT	80% after Deductible	80% after Deductible
Limited to \$5,000 per Covered Person per lifetime.		
DENTAL SERVICES – ORAL SURGERY	80% after Deductible	60% after Deductible
DIAGNOSTIC RADIOLOGY AND LABORATORY SERVICES • **OUTPATIENT HOSPITAL OR FACILITY** • **PHYSICIAN'S OFFICE**	 80% after Deductible 100% - Deductible Waived	 60% after Deductible 60% after Deductible
DURABLE MEDICAL EQUIPMENT	80% after Deductible	80% after Deductible

COMPREHENSIVE MEDICAL BENEFITS (ARTICLE II)		
COVERAGE (PLAN PAYS)		
SERVICE	**PPO PROVIDER**	**NON-PPO PROVIDER**
HOME HEALTH CARE SERVICES	80% after Deductible	80% after Deductible
The Plan covers 40 home health care visits per calendar year. A home health care visit is a visit that lasts up to four hours. A visit that lasts more than four hours is considered two visits.		
HOSPICE CARE SERVICES	80% after Deductible	80% after Deductible
HOSPITAL – EMERGENCY ROOM SERVICES	100% after $50 Copay* and Deductible	80% after $50 Copay* and Deductible
* Hospital Emergency Room Copay is waived if admitted.		
HOSPITAL AND FACILITY– INPATIENT SERVICES	80% after Deductible	60% after Deductible
HOSPITAL AND FACILITY – OUTPATIENT SERVICES	80% after Deductible	60% after Deductible
INFERTILITY SERVICES		
• **OUTPATIENT HOSPITAL OR FACILITY**	80% after Deductible	60% after Deductible
• **PHYSICIAN'S OFFICE**	100% Deductible Waived	60% after Deductible
Limited to $4,000 per Covered Person per lifetime. Not available to Dependent children.		
MAMMOGRAM SERVICES		
• **ROUTINE (Limited to one per calendar year)**	100% - Deductible Waived	100% - Deductible Waived
• **NON-ROUTINE**	80% after Deductible	60% after Deductible
MATERNITY SERVICES	80% after Deductible	60% after Deductible
Not available to Retirees with Plan B Coverage and their Dependents.		
NURSE PRACTITIONER RETAIL CLINIC VISIT	100% after $10 Copay - Deductible Waived	60% after Deductible
PHYSICIAN OFFICE VISITS	100% after $20 Copay - Deductible Waived	60% after Deductible
ROUTINE PHYSICAL EXAMS	100% after $20 Copay - Deductible Waived	60% after Deductible
SECOND SURGICAL OPINION	100% - Deductible Waived	100% - Deductible Waived
SKILLED NURSING FACILITY SERVICES	80% after Deductible	80% after Deductible
Limited to 120 days per Sickness or Injury.		
SURGICAL SERVICES	80% after Deductible	60% after Deductible
THERAPY SERVICES	80% after Deductible	60% after Deductible
TRANSPLANT SERVICES	80% after Deductible	60% after Deductible

COMPREHENSIVE MEDICAL BENEFITS (ARTICLE II)		
	COVERAGE (PLAN PAYS)	
SERVICE	**PPO PROVIDER**	**NON-PPO PROVIDER**
WELL CHILD CARE	100% - Deductible and Copay waived	60% - Deductible and Copay waived
Limited to: • Seven visits from the time a child is born until the child is one year old; • Two visits while the child is one year old; • One visit per year while the child is two, three, four, five, and six years old; and • Zero visits per year after the child's seventh birthday. Visits in addition to this allowed schedule may be available under the Routine Physical Exam benefit.		
WIGS AND HAIR PROSTHESES	80% after Deductible	80% after Deductible
Limited to $300 per Covered Person per lifetime.		

PRESCRIPTION DRUG BENEFITS (ARTICLE III)		
PRESCRIPTION DRUG TYPE	**WALK-IN RETAIL PHARMACY** (Up to a 34 Day Supply)	**MAIL ORDER PHARMACY** (Up to a 90 Day Supply)
GENERIC	100% after the greater of: 20% or $7 Copay	100% after $10 Copay
PREFERRED BRAND	100% after the greater of: 20% or $15 Copay *	100% after $10 Copay *
* If a generic equivalent is available, only the generic drug may be dispensed unless your Physician has indicated "Dispense as Written" on your prescription. In such cases you will be required to pay the applicable Copay plus the price difference between the generic drug and the preferred brand name drug.		
NON-PREFERRED BRAND	100% after the greater of: 25% or $30 Copay*	100% after $70 Copay *
* If a generic equivalent is available, only the generic drug may be dispensed unless your Physician has indicated "Dispense as Written" on your prescription. In such cases you will be required to pay the applicable Copay plus the price difference between the generic drug and the non-preferred brand name drug.		
SPECIALTY	100% after a $50 Copay *	100% after $50 Copay *
* Specialty drugs are limited to a 30 day supply.		

DENTAL BENEFITS (ARTICLE IV)	
SERVICE	**COVERAGE (PLAN PAYS)**
Preventive – Dental Care Unit 1 **Basic – Dental Care Unit 2** **Major – Dental Care Unit 3** **Amelogenesis Imperfecta**	100% up to Maximum Plan Payment Limit, after $10 Copay
Dental Implants **(not due to a congenital defect)**	50% up to Maximum Plan Payment Limit

DENTAL BENEFITS (ARTICLE IV)

Maximum Plan Payment Limit:

- Dental Care Units 1, 2, 3 and Amelogenesis Imperfecta (combined) ..... $ 2,500 per calendar year
- Amelogenesis Imperfecta (on permanent teeth)..... $ 15,000 per lifetime
- Dental Implants (not due to a congenital defect) ..... $ 5,000 per lifetime

Maximum Payment Limits for Dental Care Units 1, 2 and 3 and for Amelogenesis Imperfecta do not apply to Covered Persons under age 19. The Maximum Payment Limit for Dental Implants applies to all Covered Persons regardless of age.

VISION BENEFITS (ARTICLE V)

COVERAGE (PLAN PAYS)

BENEFIT	FREQUENCY ALLOWED	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Examination	Once Per Calendar Year	100% after $10 Copay	100% after $10 Copay to a maximum of $50
Single Vision Lenses (pair)	Once Every Other Calendar Year	100% after $20 Copay	100% after $20 Copay to a maximum of $50
Lined Bifocal Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $75
Lined Trifocal Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $100
Lined Lenticular Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $125
Frames	Once Every Other Calendar Year	100% after $20 Copay to a maximum of $120 plus 20% off any out-of-pocket expense	100% after $20 Copay to a maximum of $70
Elective Contact Lenses/Evaluation/ Fitting	Once Every Other Calendar Year as a substitute for all other lenses and frames benefits	100% to a maximum of $120	100% to a maximum of $105
Medically Necessary Contact Lenses/Evaluation/Fitting	Once Every Other Calendar Year as a substitute for all other lenses and frames benefits	100% after $20 Copay	100% after $20 Copay to a maximum of $210

DEATH BENEFIT (ARTICLE VI)

The Designated Beneficiary of a Death Benefit Participant may receive a Death Benefit in the amount of $25,000.

SHORT-TERM DISABILITY BENEFITS (ARTICLE VII)

Covered Employees may receive Short-Term Disability Benefits during any period that the Covered Employee is not retired and is unable to work for at least one week due to an Injury or Sickness. The maximum Short-Term Disability Benefit is $500 gross amount per week for a maximum of 26 weeks.

ARTICLE I – ELIGIBILITY

The following topics are discussed under this Article on Eligibility:

To understand how coverage under this Plan works for Employees, there are two key concepts you need to know about. You need to know (1) how you become eligible; and (2) once you are eligible, how you become covered.

Your eligibility hinges on the amount of hours you work. Once you have met the requirements to obtain eligibility from the Plan (i.e. it is the first day of the third month after you have worked 120 hours in accordance with Section 1.01 or 1.15 as applicable), you will become an Eligible Employee. An Eligible Employee is covered under the Plan only if he is also a Covered Employee. The Plan will not pay any claims for an Eligible Employee unless the Eligible Employee is also a Covered Employee on the date the claims are incurred.

An Eligible Employee is also a Covered Employee if he either has at least the Monthly Premium amount in his Dollar Bank on the last day of the preceding month or self-pays the Monthly Premium. A Covered Employee is eligible to receive benefits from this Plan. This information is explained in greater detail below.

Section 1.01 – Initial Eligibility

(a) Becoming an Eligible Employee: Except as provided for in Section 1.05, an Employee is required to work in Covered Employment for a minimum of 120 hours before he becomes an Eligible Employee. An Employee becomes eligible to participate in this Plan (i.e. an Eligible Employee) on the first day of the third month after he has completed 120 total hours of Covered Employment. Once an Employee becomes an Eligible Employee, his coverage will begin (i.e. he will become a Covered Employee), provided he has sufficient contributions in his Dollar Bank to cover the Monthly Premium, or he self-pays the difference between the amount in his Dollar Bank and the Monthly Premium.

The following examples illustrate how this works:

Example 1
Phillip works 120 hours in Covered Employment in January 2011. Phillip becomes an Eligible Employee on April 1, 2011.

Example 2
Phillip works in Covered Employment for 40 hours in January 2011, 40 hours in February 2011, and 40 hours in June 2011. Phillip becomes an Eligible Employee on September 1, 2011 because it is the third month after he earned a total of 120 hours.

(b) Termination of Eligibility (i.e. ceasing to be an Eligible Employee) Prior to Becoming a Covered Employee: If an Eligible Employee does not become a Covered Employee (i.e. he does not pay the Monthly Premium) on the first day of the third month after he has completed 120 hours of Covered Employment, the contributions will remain in his Dollar Bank; however, he will lose eligibility (i.e. he will no longer be an Eligible Employee) and he will be required to meet the requirements of Section 1.01(c) before his eligibility is reinstated.

The following example illustrates how this works:

Example 1
In January 2011, Phillip works 120 hours in Covered Employment. In February and March 2011, Phillip does not work in Covered Employment. On April 1, 2011, Phillip becomes an Eligible Employee. On April 1, 2011, Phillip does not have sufficient contributions in his Dollar Bank to cover the Monthly Premium and he does not self-pay the difference between the amount in his Dollar Bank and the Monthly Premium. Because Phillip does not pay the Monthly Premium on April 1, 2011, he does not become a Covered Employee and he loses eligibility (i.e. he is no longer an Eligible Employee).

(c) Reinstatement of Eligibility (i.e. becoming an Eligible Employee) Prior to Becoming a Covered Employee: If an Eligible Employee loses eligibility in accordance with Section 1.01(b) above, his eligibility will be reinstated (i.e. he will become an Eligible Employee) on the first day of the third month after he has completed one hour of Covered Employment.

The following example illustrates how this works:

Example 1
In January 2011, Phillip works 120 hours in Covered Employment. In February and March 2011, Phillip does not work in Covered Employment. On April 1, 2011, Phillip becomes an Eligible Employee. On April 1, 2011, Phillip does not have sufficient contributions in his Dollar Bank to cover the Monthly Premium and he does not self-pay the difference between the amount in his Dollar Bank and the Monthly Premium. Because Phillip does not pay the Monthly Premium on April 1, 2011, he does not become a Covered Employee and he loses eligibility (i.e. he is no longer an Eligible Employee). In May 2011, Phillip works 10 hours. On August 1, 2011, Phillip's eligibility is reinstated (i.e. he becomes an Eligible Employee).

Section 1.02 – Dollar Bank and Becoming a Covered Employee
The Dollar Bank is an account that is established for an Employee. When you work for an Employer, the contributions that you earn are credited to your Dollar Bank.

If you are an Eligible Employee and you have sufficient contributions in your Dollar Bank to cover the Plan's Monthly Premium, the Monthly Premium will be automatically drawn from your Dollar Bank to pay for your coverage. If the contributions in your Dollar Bank exceed the Monthly Premium, the excess contributions

will remain in your Dollar Bank. This allows you to accumulate contributions in your Dollar Bank which you can use for the payment of Monthly Premiums during periods of slack employment, total layoff or retirement.

If you are an Eligible Employee but you do not have sufficient contributions in your Dollar Bank to cover the Plan's Monthly Premium, you may elect to pay the remaining portion of the Monthly Premium in accordance with the Partial Self-Pay provisions of Section 1.03. If you elect to self-pay the remaining portion of the Monthly Premium in accordance with Section 1.03, you will become a Covered Employee. If you do not elect to self-pay the remaining portion of the Monthly Premium in accordance with Section 1.03, you will not be covered under the Plan (i.e. you will not be a Covered Employee) and the contributions will remain in your Dollar Bank.

The Dollar Bank established for you will merely be a record keeping account with the purpose of keeping track of contributions. Your Dollar Bank will consist solely of Employer contributions. Your Dollar Bank will not be credited with any interest income earned on the Plan's reserves. Your Dollar Bank is a non-vested benefit and can be forfeited.

The following chart illustrates how initial eligibility and coverage works:

If You Complete 120 Hours of Covered Employment In…	You Become an Eligible Employee In…	You Become a Covered Employee In…(to become a Covered Employee you must have sufficient contributions in your Dollar Bank to cover the Monthly Premium or self-pay the difference between the amount of contributions in your Dollar Bank and the Monthly Premium)…
January	April	April
February	May	May
March	June	June
April	July	July
May	August	August
June	September	September
July	October	October
August	November	November
September	December	December
October	January	January
November	February	February
December	March	March

The following examples illustrate how the Dollar Bank works. The contribution rates and Monthly Premium amounts listed in these examples are hypothetical numbers used solely for the purpose of illustrating how the Dollar Bank works. The numbers listed in the examples do not reflect the actual contribution rates or Monthly Premium amounts. For information concerning the actual contribution rate and/or Monthly Premium contact the Fund Office.

Example 1

From January 1, 2011 through December 31, 2011, the Collective Bargaining Agreement requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In January 2011, Phillip works 120 hours in

Covered Employment. In February and March 2011, Phillip does not work in Covered Employment. On April 1, 2011, Phillip becomes an Eligible Employee. On April 1, 2011, Phillip has $120 in his Dollar Bank. The Monthly Premium in April 2011 is $200. Phillip does not self-pay the remaining $80 (i.e. the difference between the Monthly Premium of $200 and the $120 of contributions in his Dollar Bank). Phillip is not a Covered Employee in April 2011. Because Phillip does not become a Covered Employee on April 1, 2011, he loses eligibility (i.e. he is no longer an Eligible Employee). The $120 in contributions for Phillip's January 2011 hours will remain in his Dollar Bank.

Example 2

From January 1, 2011 through December 31, 2011, the Collective Bargaining Agreement requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In January 2011, Phillip works 120 hours in Covered Employment. In February and March 2011, Phillip does not work in Covered Employment. On April 1, 2011, Phillip becomes an Eligible Employee. On April 1, 2011, Phillip has $120 in his Dollar Bank. The Monthly Premium in April 2011 is $200. On April 1, 2011, Phillip self-pays the remaining $80 (i.e. the difference between the Monthly Premium of $200 and the $120 of contributions in his Dollar Bank). The $120 in contributions for Phillip's January 1, 2011 hours are drawn from his Dollar Bank and Phillip is a Covered Employee in April 2011.

Example 3

From January 1, 2011 through December 31, 2011, the Collective Bargaining Agreement requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. Phillip works in Covered Employment for 50 hours in January 2011, 60 hours in February 2011, and 100 hours in June 2011. Phillip does not work in Covered Employment in July or August 2011. On September 1, 2011 Phillip becomes an Eligible Employee. The Monthly Premium in September 2011 is $200. On September 1, 2011, Phillip has $210 in his Dollar Bank. The Plan Administrator will automatically take $200 out of Phillip's Dollar Bank and Phillip will become a Covered Employee on September 1, 2011. The extra $10 in contributions will remain in Phillip's Dollar Bank.

Example 4

From January 1, 2011 through December 31, 2011, the Collective Bargaining Agreement requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. Phillip works in Covered Employment for 120 hours in January 2011, 50 hours in February 2011, and 50 hours in March 2011. Phillip does not work in Covered Employment in May or June 2011.

On April 1, 2011, Phillip becomes an Eligible Employee. On April 1, 2011, Phillip has $120 in his Dollar Bank. The Monthly Premium in April 2011 is $200. Phillip does not self-pay the remaining $80. Phillip is not a Covered Employee in April 2011. Because Phillip does not become a Covered Employee on April 1, 2011, he loses eligibility (i.e. he is no longer an Eligible Employee). The $120 in contributions for Phillip's January hours will remain in his Dollar Bank.

On May 1, 2011, Phillip's eligibility is reinstated (i.e. he becomes an Eligible Employee) because it is the first day of the third month after he completed one additional hour of Covered Employment. On May 1, 2011, Phillip has $170 in his Dollar Bank ($120 from January and $50 from February). The Monthly Premium in May 2011 is $210. Phillip does not self-pay the remaining $40. Phillip is not a Covered Employee in May 2011. Because Phillip does not become a Covered Employee on May 1, 2011, he loses eligibility (i.e. he is no longer an Eligible Employee). The $170 in contributions for Phillip's January and February hours will remain in his Dollar Bank.

On June 1, 2011, Phillip's eligibility is reinstated (i.e. he becomes an Eligible Employee) because it is the first day of the third month after he completed one additional hour of Covered Employment. On June 1, 2011, Phillip has $220 in his Dollar Bank ($120 from January, $50 from February, and $50 from March). The Monthly Premium in June 2011 is $220. The Plan Administrator will automatically take $220 out of Phillip's Dollar Bank and Phillip will become a Covered Employee in June 2011.

Example 5

From January 1, 2011 through December 31, 2011, the Collective Bargaining Agreement requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In January 2011, Phillip works 200 hours in Covered Employment. In February and March 2011, Phillip does not work in Covered Employment. On April 1, 2011, Phillip becomes an Eligible Employee. On April 1, 2011, Phillip has $200 in his Dollar Bank. The Monthly Premium in April 2011 is $210. Phillip does not self-pay the remaining $10 (i.e. the difference between the Monthly Premium of $210 and the $200 of contributions in his Dollar Bank). Phillip is not a Covered Employee in April 2011. Because Phillip does not become a Covered Employee on April 1, 2011, he loses eligibility (i.e. he is no longer an Eligible Employee). The $200 in contributions for Phillip's January 2011 hours will remain in his Dollar Bank.

The Monthly Premium in May 2011 is $190. Because Phillip is not an Eligible Employee, the Plan Administrator will not take the contributions from Phillip's Dollar Bank, Phillip will not be allowed to self-pay the Monthly Premium, and Phillip cannot become a Covered Employee in May 2011.

In June 2011, Phillip works 10 hours in Covered Employment. On September 1, 2011, Phillip's eligibility is reinstated (i.e. he becomes an Eligible Employee). The Monthly Premium in September 2011 is $210. The Plan Administrator will automatically take $210 out of Phillip's Dollar Bank and Phillip will become a Covered Employee on September 1, 2011.

Section 1.03 – Self-Payment Provisions for Eligible Employees to Become Covered Employees

(a) Partial Self-Pay

If you are a Covered Employee, but you do not have sufficient contributions in your Dollar Bank to cover the Plan's Monthly Premium for the next month, the Plan Administrator will notify you that you will not be covered the following month unless you self-pay the difference between the amount of contributions in your Dollar Bank and the Monthly Premium. If you elect to self-pay the difference in accordance with this Section 1.03(a), the entire amount of contributions in your Dollar Bank will be applied to the Monthly Premium before any self-pay amounts are applied (i.e. you cannot keep contributions in your Dollar Bank by increasing the amount that you self-pay). The self-pay amount is due in full on the first day of the month for which you intend to receive coverage. Your coverage 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 termination of coverage for failure to make timely self-payments unless your eligibility and coverage are reinstated in accordance with Section 1.15 (other than under any continuation rules required by applicable law). You may make unlimited consecutive self-payments under this provision as long as the amount in your Dollar Bank is greater than zero.

(b) Complete Self-Pay

If you are a Covered Employee and do not have any contributions in your Dollar Bank, you may self-pay the entire Monthly Premium amount. The self-payment is due in full on the first day of the month for which you intend to receive coverage. Your coverage 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 termination of coverage for failure to make timely self-payments unless your eligibility and coverage are reinstated in accordance with Section 1.15 (other than under any continuation rules required by applicable law).

You may elect to self-pay the entire Monthly Premium in accordance with this Section 1.03(b) for up to 12 consecutive months. Partial self-payments made in accordance with Section 1.03(a) above do not count toward the 12 month maximum. If contributions are credited to your Dollar Bank during this 12 month period, and they are applied towards your Monthly Premium for a month (either automatically in accordance with Section 1.02 or through Partial Self-Pay in accordance with Section 1.03(a)), and after that month the amount in your Dollar Bank is back to zero, you will be permitted to elect to self-pay the

entire premium amount for another 12 consecutive months (so long as you do not have a lapse in coverage).

The Plan will not accept any self-payment amounts that exceed the difference between the contributions in your Dollar Bank and the Monthly Premium.

If your self-pay coverage terminates, you are still eligible at the time of termination for COBRA continuation coverage.

Section 1.04 – Continuing Eligibility and Coverage

Once you become a Covered Employee, coverage will continue for each month that you have at least the Monthly Premium amount in your Dollar Bank on the last day of the preceding month or you self-pay the Monthly Premium in accordance with Section 1.03 so long as your eligibility and coverage have not been terminated in accordance with Section 1.13(a).

(a) Continuation of Eligibility and Coverage While on Leave Pursuant to the Family and Medical Leave Act

A Covered Employee on qualified leave under the Family and Medical Leave Act of 1993 (FMLA) shall not lose health benefits under this Plan as a result of such leave. The determination of whether a Covered Employee is entitled to FMLA-qualified leave shall be made by the Covered Employee's Employer. The Employer granting the FMLA leave shall make contributions to the Fund on behalf of the Covered Employee as if the Covered Employee had continued working during the FMLA leave. Contributions will be paid in an amount equal to the product of the average number of hours worked by that Covered Employee in the six consecutive weekly pay periods immediately preceding the week in which the leave began multiplied by the hourly contribution rate set forth in the Collective Bargaining Agreement.

Generally, in order to be eligible for FMLA benefits, a Covered Employee must:

- Work for a covered Employer;
- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within 75 miles.

In addition, a Covered Employee will be eligible for FMLA benefits if an Employer is required by State or other law, or any applicable Collective Bargaining Agreement, to maintain health coverage for a Covered Employee for additional periods.

If a Covered Employee is eligible for FMLA coverage, the Plan will accept contributions for such hours as if the Covered Employee had actually worked those hours. The Plan will credit a Covered Employee's Dollar Bank with all contributions that are received in accordance with this Section 1.04(a) as if the Covered Employee had actually worked such hours.

(b) Continuation of Eligibility and Coverage While Away from Work Due to Disability

A Covered Employee will receive one Monthly Premium credit per month for each month that the Covered Employee meets the following requirements:

- He is absent from work for at least two consecutive weeks because he is totally unable to work due to an Injury or Sickness; and

- He is receiving Short-Term Disability Benefits from this Plan or he is receiving benefits under Workers Compensation (or similar law or program) during the period that he is unable to work.

The Monthly Premium credit will equal the Monthly Premium in effect for the third month following the month that the Covered Employee was unable to work. The Monthly Premium credit will be applied on the first day of the third month following the month that the Covered Employee was unable to work. This means that a Covered Employee will be covered under the Plan during the third month following the month that he was unable to work regardless of the amount of contributions in his Dollar Bank.

Benefits paid based on any type of partial disability will not qualify the Covered Employee for the Monthly Premium credit.

(c) Continuation of Eligibility and Coverage While Attending Apprenticeship School

An Eligible Employee who will not have sufficient contributions in his Dollar Bank to pay the Monthly Premium for the following month because he was unable to work while he was attending apprenticeship school, may apply for an advance against his future Dollar Bank.

The maximum advance an Eligible Employee may receive is the product of the contribution rate in the Collective Bargaining Agreement multiplied by the hours that would have been reported if he was working full-time during the week he attended apprenticeship school. The maximum amount of hours that may be used for this purpose is 40 hours per training period.

An Eligible Employee must fill out an application form to apply for an advance. The application form must be approved by the apprenticeship instructor and filed with the Plan Administrator.

Dollar Bank advances will only be granted if the amount of the advance combined with the amount of contributions in an Eligible Employee's Dollar Bank is sufficient to cover the Plan's Monthly Premium for the following month. The amount of an advance may not exceed the difference in an Eligible Employee's Dollar Bank and the Plan's Monthly Premium for the following month. As soon as an Employee accumulates enough contributions in his Dollar Bank to repay the advance **and** pay the Plan's Monthly Premium for the following month, the Plan Administrator will automatically deduct the amount of the advance from his Dollar Bank.

If an Employee leaves Covered Employment before he re-pays the Dollar Bank advance, he will be liable for the amount of the advance plus interest from the date of the advance.

(d) Continuation of Eligibility and Coverage During and After a Period of Uniformed Service

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) or other applicable Federal law, an Employee and his Dependents may be entitled to continued eligibility and coverage or COBRA benefits during certain periods of service in the United States Uniformed Services. Employees should contact the Plan Administrator upon receiving notification that they are being called to duty in the Uniformed Services. The Board of Trustees has established a written USERRA Policy that describes the Plan's procedures with respect to service of Employees in the Uniformed Services. The Plan's USERRA Policy is consistent with the following general principles.

(1) Uniformed Services refers to the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty; the commissioned corps of the Public Health Service any other category of persons designated by the President in time of war or national emergency; and to any other category of persons as may be designated by Congress under USERRA. An Employee performs service in the Uniformed Services if he performs duty on a voluntary or involuntary basis in a Uniformed Service under competent authority.

Such service includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any duty and a period for which a person is absent from employment for the purpose of performing funeral honors duty as authorized by Section 12503 of Title 10, U.S.C. or Section 115 of Title 32, U.S.C.

(2) An Employee must provide advance written or oral notice to his Employer and the Plan Administrator of his service in the Uniformed Services, unless the giving of such notice is precluded by military necessity or, under all of the relevant circumstances, the giving of such notice is otherwise impossible or unreasonable. Military necessity shall be determined with respect to regulations prescribed by the Secretary of Defense.

(3) Continuation of eligibility and coverage shall be available to Employees whose cumulative absence from employment with an Employer for the purpose of performing service in the Uniformed Services does not exceed five years, subject to certain exceptions as may be required by Federal law. All periods of absence for the purpose of performing service in the Uniformed Services shall be aggregated for the purpose of determining the five year maximum.

(4) An Employee must return to work, or must re-apply for employment (by notifying his last Employer and/or the Union and requesting either reinstatement or listing on the out-of-work list, and providing a copy of the returning service member's Form DD-214, if applicable) within the following maximum timeframes:

i. If the absence due to Uniformed Service was for less than 31 days, not later than the first business day following completion of the period of service (completion of the period of service is deemed to occur upon the completion of eight hours following a period to allow for the safe transportation of the person from the place of service to his place of residence following discharge);

ii. If the absence due to Uniformed Service was for more than 30 days but less than 181 days, within 14 days following discharge; or

iii. If the absence due to Uniformed Service was for more than 180 days, within 90 days following discharge.

(5) Provided that advance notice is provided or is excused, and provided the Employee returns to work within the above-stated time frames, an Employee's eligibility and Dollar Bank shall be "frozen" from the date the Employee's absence begins until the date the Employee returns to work, re-applies for work, or notifies his last Employer, the Union, and/or the Fund Office that he intends not to return to work.

(6) The Employee shall be offered continuation of coverage under this Plan for up to 24 months from the date the absence begins, pursuant to the same rules governing COBRA continuation coverage, as set forth in Section 1.24. However, if the Employee's period of service is less than 31 days, no continuation coverage premium shall be required. In addition, no continuation coverage premium shall be required with respect to Dependents of a member of the military reserves for the period beginning the date of the Employee's absence for active duty service in the reserves until the date on which the Employee's Dependents are eligible for dependent health care coverage through the military. USERRA continuation coverage shall end upon the earlier of:

i. 24 months from the date the Employee's absence began;

ii. The date the Employee notifies his last Employer, the Union and/or the Fund Office that he intends not to return to Covered Employment; or

iii. The day following the last day on which the Employee may return to work or re-apply for work in accordance with Section 1.04(d)(4) above.

(7) If the Employee or any of his Dependents experiences a qualifying event for purposes of COBRA continuation coverage during a period of USERRA continuation coverage, he shall be entitled to elect COBRA coverage as set forth in Section 1.24.

(8) In appropriate circumstances, as determined by the Plan Administrator, the Plan may recognize a family member or other person as the personal representative of an Employee performing service in the Uniformed Services. Any action taken by such deemed personal representative shall be binding on the Employee and any affected Dependents.

Section 1.05 – Non-Bargained Employee Eligibility and Coverage

Except as specifically provided in this Section 1.05, an Employee who becomes a Covered Employee through a participation agreement between the Fund and any Employer or Employer's Association, as well as any Dependents of the Covered Employee, will be treated the same as all other Covered Employees and their Dependents under this Plan.

An Employee who has contributions remitted to the Plan on his behalf through a participation agreement between the Fund and any Employer or Employer's Association will gain initial eligibility and coverage (i.e. he will be a Covered Employee) on the effective date of the participation agreement so long as the Monthly Premium has been paid on his behalf. If an Employee begins Covered Employment after the initial effective date of the participation agreement between the Fund and his Employer or Employer's Association, the Employee will become covered (i.e. a Covered Employee) the first day of the month after the Monthly Premium is paid on his behalf.

For Employees who are Covered Employees by reason of a participation agreement between the Fund and an Employer or Employer's Association, the rules regarding contributions that are remitted to the Plan, including but not limited to, the due date of the Monthly Premium and the consequences for the failure to pay the Monthly Premium on time shall be governed by the applicable participation agreement.

Section 1.06 – Retiree Eligibility and Coverage

A Covered Employee may obtain Retiree coverage under this Plan if he meets all of the following requirements:

(a) he is at least 55 years old;

(b) he has been covered by the Plan as a Covered Employee, Retiree or qualified beneficiary for a minimum of 36 of the 60 months immediately preceding the date that he intends to begin receiving coverage as a Retiree in accordance with this Section 1.06;

(c) he is covered by the Plan the month immediately preceding the date that he intends to begin receiving coverage as a Retiree in accordance with this Section 1.06 (i.e. he has not had a lapse in coverage);

(d) he provides the Fund Office with a form requesting Retiree health coverage at the time he notifies the Fund Office of his retirement;

(e) he is not working in the electrical industry for an employer who does not have an obligation to contribute to this Plan and he has completely ceased working in Covered Employment or in employment or self-employment in a non-bargaining position for an Employer;

(f) he provides the Fund Office a signed statement that he is not working in Covered Employment, in employment or self-employment in the electrical industry for an employer who does not have an

obligation to contribute to this Plan, or in employment or self-employment in a non-bargaining position for an Employer; and that he intends to permanently cease working in Covered Employment, in employment or self-employment in the electrical industry for an employer who does not have an obligation to contribute to this Plan, and in employment or self-employment in a non-bargaining position for an Employer;

(g) he has at least the Retiree Premium amount in his Dollar Bank on the last day of the preceding month or he self-pays the Retiree Premium in accordance with Section 1.09; and

(h) his eligibility and coverage as a Retiree have not been terminated in accordance with Section 1.13(b)(3) within the 12 months immediately preceding the date he intends to begin receiving coverage as a Retiree.

Section 1.07 – Retiree Eligibility and Coverage for Totally and Permanently Disabled Employees

(a) Retiree Eligibility and Coverage for Totally and Permanently Disabled Employee

A Covered Employee who is Totally and Permanently Disabled may obtain Retiree coverage under this Plan if he meets all of the following requirements:

(1) he is less than 55 years old;

(2) he is Totally and Permanently Disabled as determined under Section 1.07(b) and he provides the Fund Office with proof that he meets at least one of the criteria in Section 1.07(b);

(3) he has been covered by the Plan as a Covered Employee, Retiree or qualified beneficiary for a minimum of 36 of the 60 months immediately preceding the date that he intends to begin receiving coverage as a Disabled Retiree in accordance with this Section 1.07;

(4) he is covered by the Plan the month immediately preceding the month that he intends to begin receiving coverage as a Disabled Retiree in accordance with this Section 1.07 (i.e. he had not had a lapse in coverage);

(5) he provides the Fund Office with a form requesting Retiree health coverage at the time he notifies the Fund Office of his Total and Permanent Disability;

(6) he is not receiving Short-Term Disability Benefits from this Plan;

(7) he has at least the Retiree Premium amount in his Dollar Bank on the last day of the month immediately preceding the month that he intends to begin receiving Retiree Coverage or he self-pays the Retiree Premium in accordance with Section 1.09; and

(8) his eligibility and coverage as a Retiree have not been terminated in accordance with Section 1.13(b)(3) within the 12 months immediately preceding the date he intends to begin receiving coverage as a Disabled Retiree.

Except as specifically provided in this Section 1.07, a Participant who becomes eligible for Retiree coverage because of a Total and Permanent Disability in accordance with this Section 1.07, will be treated the same as a Participant who becomes eligible for Retiree coverage in accordance with Section 1.06.

(b) Determination of Total and Permanent Disability

A Participant will be considered Totally and Permanently Disabled if he is disabled as the result of Injury or Sickness, either occupational or non-occupational in cause, and he meets one of the following criteria:

(1) He is receiving Social Security Disability Benefits, or other benefits under the federal Social Security Act on account of his disability, when the determination is based on a finding by the Social Security Administration that he is unable to engage in any substantial gainful activity because of a physical or mental impairment;

(2) He is receiving a Disability Pension Benefit from the National Electrical Benefit Fund; or

(3) He has received a written opinion from a Physician stating one of the following:

i. he will be prevented for life from pursuing his trade as an electrician; or

ii. he has been diagnosed with a terminal illness with a life expectancy of 12 months or less.

The Participant must provide proof of the Total and Permanent Disability to the Plan Administrator to become eligible for coverage as a Disabled Retiree. The Participant may also be required to periodically submit proof that he is still Totally and Permanently Disabled after he becomes covered under the Plan as a Disabled Retiree and before he attains age 55.

The Participant must inform the Plan Administrator immediately if he becomes entitled to Medicare. For the rules regarding the Plan's coordination of benefits with Medicare see Section 10.04.

If a Disabled Retiree is receiving coverage from the Plan in accordance with this Section 1.07, and he has not yet attained age 55, he must notify the Plan Administrator if he recovers from his Total and Permanent Disability. The notification must be provided to the Fund Office within 30 days of the earliest of the following dates:

- the date that the Social Security Administration has determined that he is no longer disabled;
- the date that he is no longer eligible for a Disability Pension Benefit from the National Electrical Benefit Fund; or
- the date that a Physician determines that he is physically and mentally capable of pursuing his trade as an electrician.

A Disabled Retiree's failure to notify the Fund Office that he has recovered from his Total and Permanent Disability in accordance with this Section 1.07(b) will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a Disabled Retiree does not notify the Plan Administrator that he has recovered from his Total and Permanent Disability in accordance with this Section 1.07(b), the Plan may recover any payments made for claims incurred by the Disabled Retiree after the date that his coverage would have terminated in accordance with Section 1.13(b) had he provided the required notification (i.e. after the Disabled Retiree was no longer eligible for coverage from the Plan as a Retiree) in accordance with Section 13.18.

(c) Exclusions

Despite a Covered Employee's Total and Permanent Disability, he will not be eligible to receive coverage in accordance with this Section 1.07 if the Total and Permanent Disability was contracted, suffered or incurred while he was engaged in, or resulting from his having engaged in, a felonious act or enterprise.

(d) Attainment of Age 55

If you are a Disabled Retiree who became eligible for Retiree coverage in accordance with this Section 1.07, and you are still Totally and Permanently Disabled when you attain 55 years of age, then effective 12:01 a.m. on the first day of the month following your 55th birthday, the terms of your eligibility and coverage will become identical to those in place for a Participant who became eligible for Retiree coverage in accordance with Section 1.06. In other words, starting the first day of the month following your 55th birthday, you will no longer be asked periodically to submit proof that you are still Totally and Permanently Disabled in accordance with Section 1.07(b), you will no longer be required to notify the Plan Administrator if you recover from your Total and Permanent Disability in accordance with Section 1.07(b), and you will not lose Retiree coverage if you recover from your Total and Permanent Disability in accordance with Section 1.13(b)(6).

Notwithstanding anything in this Section 1.07(d), a Disabled Retiree must inform the Plan Administrator if he becomes entitled to Medicare even if he has already reached age 55.

The following example illustrates how Section 1.07 works:

In January 2008, Phillip became a Covered Employee. In January 2008, Phillip was 48 years old and had a 1 year old Dependent child whose coverage under the Plan became effective at the same time as his coverage (i.e. January 2008). From January 1, 2008 through December 31, 2011, Phillip and his Dependent child remained covered under the Plan.

On December 31, 2011, Phillip had $5,000 in his Dollar Bank. In January 2012, the Monthly Premium was $500. On January 1, 2012, $500 was automatically drawn from Phillip's Dollar Bank.

On January 5, 2012, Phillip got injured while working in Covered Employment. On January 10, 2012, Phillip saw a Physician who concluded that he would be prevented from pursing his trade as an electrician for the rest of his life. On January 11, 2012, Phillip notified the Fund Office of his Total and Permanent Disability, provided the Fund Office with a written opinion from his Physician stating that he would be prevented from pursing his trade as an electrician for the rest of his life, and provided the Fund Office a form requesting Retiree health coverage for himself and declining coverage for his Dependent child.

In February 2012, the Retiree Premium for Plan A Coverage for a Retiree without any Dependents was $300. On February 1, 2012, $300 was drawn from Phillip's Dollar Bank and he became a Retiree with Plan A Coverage.

On February 1, 2012, Phillip turned 53 years old. From February 1, 2012 through July 1, 2013 Phillip remained Totally and Permanently Disabled; the Fund Office periodically asked Phillip to submit proof that he was still Totally and Permanently Disabled; Phillip submitted an updated opinion from a Physician stating that in his opinion Phillip would be prevented from pursing his trade as an electrician for the rest of his life in response to each request from the Fund Office; and Phillip had sufficient contributions in his Dollar Bank to cover the Plan's Retiree Premium.

On July 2, 2013, Phillip had $0 remaining in his Dollar Bank. From August 1, 2013 until February 28, 2014, Phillip remained Totally and Permanently Disabled; the Fund Office periodically asked Phillip to submit proof that he was still Totally and Permanently Disabled; Phillip submitted an updated opinion from a Physician stating that in his opinion Phillip would be prevented from pursing his trade as an electrician for the rest of his life in response to each request from the Fund Office; and Phillip self-paid the Retiree Premium in accordance with Section 1.09.

On February 1, 2014, Phillip turned 55 years old. On March 1, 2014, Phillip self-paid the Retiree Premium in accordance with Section 1.09. Beginning March 1, 2014, the Fund Office stopped asking Phillip to submit proof that he was still Totally and Permanently Disabled.

On March 1, 2014, Phillip requested coverage for his child who was now 7 years old. The Fund Office denied the request for coverage for Phillip's child because the child could have been enrolled on the date of Phillip's retirement (i.e. February 1, 2012) but Phillip declined coverage for his child at that time. Phillip continued to be covered under the Plan as a Retiree continuously through February 28, 2019.

On February 1, 2019, Phillip turned 60 years old. Beginning March 1, 2019, Phillip is allowed to elect Plan B Coverage in accordance with Section 1.10. If Phillip elects Plan B Coverage, he may not subsequently elect to go back to Plan A Coverage.

Section 1.08 – Effective Date of Retiree Coverage

Retiree coverage begins at 12:01 a.m. on the first day of the month after the Retiree has fulfilled all of the requirements of Section 1.06 or 1.07 as applicable.

Section 1.09 – Retiree Premium

The Retiree Premium is the dollar amount required for a Retiree to receive a month of coverage from the Plan. The Retiree Premium changes each month. 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 Retiree Premium will depend in part on a Retiree's age and level of benefit coverage in accordance with Section 1.10. The Trustees have the authority to set different Retiree Premiums for Medicare-eligible and non-Medicare eligible Retiree's and to require an additional premium amount for Dependents of Retirees.

If you are a Retiree and you have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium, the Retiree Premium will be automatically drawn from your Dollar Bank to pay for your coverage.

If you are a Retiree and you do not have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium, you may elect to self-pay the remaining portion of the Retiree Premium in accordance with this Section 1.09. The first month that you will not have sufficient contributions in your Dollar Bank to cover the Plan's Retiree Premium for the following month, the Plan Administrator will notify you that you will not be covered the following month unless you self-pay the difference between the amount of contributions in your Dollar Bank and the Retiree Premium. The self-pay amount is due on the first day of the month for which you intend to receive coverage. Unless there are extenuating circumstances as determined solely by the Plan Administrator and/or the Board of Trustees, coverage for you and your Dependents will terminate if the required self-pay amount is not received by the Fund Office by the fifth business day of the month. Retiree coverage may not be reinstated following termination of coverage for failure to make timely self-payments unless the Retiree regains coverage as a Covered Employee and subsequently retires in accordance with Sections 1.13(b) and 1.16.

Section 1.10 – Retiree Benefits and Options

If you become a Retiree prior to attaining 60 years of age (i.e. before your 60th birthday), you may only receive Plan A Coverage until the month following your 60th birthday at which time you may elect to receive either Plan A Coverage or Plan B Coverage.

If you become a Retiree after attaining 60 years of age (i.e. after the month of your 60th birthday), you may elect 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, so long as you are at least 60 years old. 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 (only option available for a Retiree until the month after his 60th birthday)
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 Retiree Premium for a Retiree and at least one Dependent will equal the Monthly Premium (i.e. the amount paid by a Covered Employee). The Retiree Premium for a Retiree without any Dependents will equal 50% of the Monthly Premium (i.e. 50% of the amount paid by a Covered Employee).

(b) Plan B Coverage (only available for a Retiree after his 60th birthday)
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 Retiree Premium for a Retiree and at least one Dependent will equal 80% of the Monthly Premium (i.e. 80% of the amount paid by a Covered Employee). The Retiree Premium for a Retiree without any Dependents will equal 40% of the Monthly Premium (i.e. 40% 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.

Section 1.11 – Continuation of Retiree Coverage
Once you become a Retiree, coverage will continue for each month that you meet the Plan's definition of Retiree, and you have at least the Retiree Premium amount in your Dollar Bank on the last day of the preceding month or you self-pay the Retiree Premium in accordance with Section 1.09, so long as your eligibility and coverage as a Retiree have not been terminated in accordance with Section 1.13(b).

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 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 third month after he completed 120 hours). The individual may be permitted to receive coverage under the Plan as a Covered Employee during this 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

Section 1.13 – Termination of Eligibility and Coverage for Employees and Retirees

The Plan is intended to exist and provide benefits to Participants indefinitely. However, under certain circumstances coverage may terminate for certain individuals, for all Participants, or for any group of Participants. If the Trustees find it appropriate to terminate the Plan, then all Participants will lose coverage under the Plan. The Trustees reserve the right to amend the Plan at any time, and these amendments may eliminate certain benefits for all Participants or terminate all benefits for certain Participants such as Retirees.

In addition, an Employee's or Retiree's eligibility and coverage under the Plan will terminate in accordance with Section 1.13(a) or Section 1.13(b) as applicable.

(a) Termination of Eligibility and Coverage for Employees

An Employee's eligibility and coverage as a Covered Employee will terminate (i.e. he will no longer be an Eligible Employee or a Covered Employee) as of 12:01 a.m. on the earliest of the following days:

(1) The first day of the calendar month in which he does not have enough contributions in his Dollar Bank to pay the Monthly Premium and he does not self-pay the difference between the amount of contributions in his Dollar Bank and the Monthly Premium in accordance with Section 1.03;

(2) The first day of the calendar month following the month that he has received coverage in accordance with the Complete Self-Pay provisions of Section 1.03(b) for 12 consecutive months;

(3) The effective date of his Retiree coverage under the Plan;

(4) The date that he enters the Uniformed Services on active duty, except he will have the right to extend his coverage under the USERRA provisions or other applicable law;

(5) The date his Dollar Bank is forfeited in accordance with Section 1.14(a)(1);

(6) The date his Dollar Bank is frozen in accordance with Section 1.14(a)(2); or

(7) The first day of the month following his death.

If an Employee's eligibility and coverage are terminated in accordance with this Section 1.13(a), the Employee will only regain eligibility and coverage as a Covered Employee if his eligibility and coverage are reinstated in accordance with Section 1.15(a) (other than under any continuation rules required by applicable law).

(b) Termination of Eligibility and Coverage for Retirees

A Retiree's eligibility and coverage under the Plan will terminate as of 12:01 a.m. on the earliest of the following days:

(1) the first day of the calendar month in which he does not have enough contributions in his Dollar Bank to pay the Retiree Premium and he does not self-pay the difference between the amount of contributions in his Dollar Bank and the Retiree Premium in accordance with Section 1.09;

(2) the date that he enters the Uniformed Services on active duty, except he will have the right to extend his coverage under the USERRA provisions or other applicable law;

(3) the first day of the month that he no longer meets the definition of Retiree;

(4) the date that his Dollar Bank is forfeited in accordance with Section 1.14(b);

(5) the first day of the month following his death; or

(6) if the Retiree has not yet attained age 55 and he is receiving coverage due to a Total and Permanent Disability in accordance with Section 1.07, the first day of the second month after he no longer meets at least one of the criteria required to be considered Totally and Permanently Disabled in accordance with Section 1.07.

If a Retiree's eligibility and coverage are terminated in accordance with this Section 1.13(b), he may only regain coverage as a Retiree if his eligibility and coverage are reinstated in accordance with Section 1.16 (other than under any continuation rules required by applicable law).

Section 1.14 – Forfeiture of Dollar Bank and Termination of Eligibility for Employees and Retirees

(a) Forfeiture of Dollar Bank and Termination of Eligibility for Employees
An Employee's Dollar Bank will be forfeited and he will no longer be eligible for coverage (i.e. he will not be an Eligible Employee and he will not be allowed to self-pay) if (1), (2), or (3) occurs:

(1) If an Employee or former Employee becomes employed in the electrical industry by an employer having no obligation to contribute to this Plan, the Employee (or former Employee) will permanently forfeit all of the contributions in his Dollar Bank on the first day of the month following the month during which the work for the non-contributing employer was first performed;

(2) If an Employee or former Employee becomes employed in a non-bargaining unit position for an Employer on or after January 1, 2011, and he no longer has contributions remitted to the Plan on his behalf, he can use the contributions in his Dollar Bank to pay the Monthly Premium for a maximum of three months. After three months, the Employee's (or former Employee's) Dollar Bank will be frozen (i.e. his Dollar Bank will be frozen on the first day of the fourth month after he begins working in a non-bargaining unit position for an Employer). After seven years, the Employee will permanently forfeit the contributions in his Dollar Bank unless he re-establishes eligibility under the Plan in accordance with Section 1.15(a); or

(3) If an Employee or former Employee is not covered under the Plan for seven years and he does not have any contributions credited to his Dollar Bank during these seven years (i.e. he is not covered under the Plan for 84 consecutive months and he does not have any contributions credited to his Dollar Bank during those 84 months), he will permanently forfeit all of the contributions in his Dollar Bank.

(b) Forfeiture of Dollar Bank and Termination of Eligibility for Retirees
A Retiree's Dollar Bank will be forfeited and he will no longer be eligible for coverage (i.e. he will not be allowed to self-pay) if he becomes employed in the electrical industry by an employer having no obligation to contribute to this Plan. If a Retiree becomes employed in the electrical industry by an employer having no obligation to contribute to this Plan, the Retiree will permanently forfeit all of the contributions in his Dollar Bank on the first day of the month following the month during which the work for the non-contributing employer was first performed.

Section 1.15 – Reinstatement of Eligibility and Coverage as a Covered Employee

(a) Reinstatement of Eligibility and Coverage as a Covered Employee if your Coverage was Terminated in Accordance with Section 1.13(a)
If an Employee's eligibility and coverage are terminated in accordance with Section 1.13(a), he is required to work in Covered Employment for a minimum of 120 hours before his eligibility is reinstated and he becomes an Eligible Employee. An Employee will regain eligibility (i.e. become an Eligible Employee) on the first day of the third month after he has completed 120 hours of Covered Employment. Hours

worked by an Employee prior to the time that he lost eligibility and coverage from the Plan do not count towards these 120 hours. Once an Employee regains eligibility (i.e. becomes an Eligible Employee), his coverage will begin (i.e. he will become a Covered Employee), only if he has sufficient contributions in his Dollar Bank to pay the Monthly Premium or he self-pays the difference between the amount of contributions in his Dollar Bank and the Monthly Premium on the first day of the third month after he has completed 120 hours. If the Employee does not become a Covered Employee (i.e. he does not pay the Monthly Premium) on the first day of the third month after he has worked 120 hours the contributions he has earned will remain in his Dollar Bank; however, his coverage will not be reinstated and he will lose eligibility (i.e. he will no longer be an Eligible Employee).

If an Employee's coverage is not reinstated and he loses eligibility because he did not become a Covered Employee on the first day of the third month after he worked 120 hours in Covered Employment, the Employee will be required to work at least one hour in Covered Employment before his eligibility is reinstated (i.e. before he becomes an Eligible Employee). An Employee's eligibility will be reinstated (i.e. he will become an Eligible Employee) on the first day of the third month after he has completed one hour of Covered Employment. Once an Employee regains eligibility (i.e. becomes an Eligible Employee), his coverage will begin (i.e. he will become a Covered Employee), only if he has sufficient contributions in his Dollar Bank to pay the Monthly Premium or he self-pays the difference between the amount of contributions in his Dollar Bank and the Monthly Premium on the first day of the third month after he has completed one additional hour of Covered Employment. In other words, to become a Covered Employee in accordance with this Section 1.15(a), an Employee must work in Covered Employment for 120 hours after the date that his eligibility and coverage from the Plan were terminated and he must become a Covered Employee on the first day of the third month after he has completed those 120 hours. If an Eligible Employee does not become a Covered Employee on the first day of the third month after he completed 120 hours, he can re-establish eligibility and become a Covered Employee if he works one additional hour in Covered Employment and he becomes a Covered Employee (i.e. he pays the Monthly Premium) on the first day of the third month after he works the additional hour of Covered Employment.

(b) Restatement of Eligibility and Coverage as a Covered Employee if your coverage was Terminated in Accordance with Section 1.13(b)

If a Retiree's eligibility and coverage are terminated in accordance with Section 1.13(b), he is required to work a minimum of 120 hours within three consecutive months before his eligibility is reinstated and he becomes an Eligible Employee. An Employee will regain eligibility (i.e. become an Eligible Employee) on the first day of the third month after he has completed 120 hours of Covered Employment. Hours worked by an Employee while he was covered under the Plan as a Retiree count towards these 120 hours. Once an Employee regains eligibility (i.e. becomes an Eligible Employee), his coverage will begin (i.e. he will become a Covered Employee), only if he has sufficient contributions in his Dollar Bank to pay the Monthly Premium or he self-pays the difference between the amount of contributions in his Dollar Bank and the Monthly Premium on the first day of the third month after he has completed 120 hours. If an Employee does not become a Covered Employee (i.e. he does not pay the Monthly Premium) on the first day of the third month after he has worked 120 hours the contributions he has earned will remain in his Dollar Bank; however, his coverage will not be reinstated and he will lose eligibility.

If an Employee's coverage is not reinstated and he loses eligibility because he did not become a Covered Employee on the first day of the third month after he worked 120 hours in Covered Employment, the Employee will be required to work at least one hour in Covered Employment before his eligibility is reinstated (i.e. before he becomes an Eligible Employee). An Employee's eligibility will be reinstated on the first day of the third month after he has completed one hour of Covered Employment. Once an Employee regains eligibility (i.e. he becomes an Eligible Employee), his coverage will begin (i.e. he will become a Covered Employee), only if he has sufficient contributions in his Dollar Bank to pay the Monthly Premium or he self-pays the difference between the amount of contributions in his Dollar Bank

and the Monthly Premium on the first day of the third month after he has completed one additional hour of Covered Employment. In other words, to become a Covered Employee in accordance with this Section 1.15(b), an Employee must work 120 hours in three consecutive months and he must become a Covered Employee on the first day of the third month after he has completed 120 hours. If an Eligible Employee does not become a Covered Employee on the first day of the third month after he has completed 120 hours, he can re-establish eligibility and become a Covered Employee if he works one additional hour in Covered Employment and he becomes a Covered Employee (i.e. he pays the Monthly Premium) on the first day of the third month after he works the additional hour of Covered Employment.

The following examples illustrate how Sections 1.15(a) and (b) work. The contribution rates, Monthly Premium, and Retiree Premium amounts listed in these examples are hypothetical numbers used solely for the purpose of illustrating how these sections work. The numbers listed in the examples do not reflect the actual contribution rates, Monthly Premium or Retiree Premium amounts. For information concerning the actual contribution rate, Monthly Premium, or Retiree Premium contact the Fund Office.

Example 1

In December 2010, Phillip is covered under the Plan as a Covered Employee and does not work in any type of employment. In January 2011, Phillip's Dollar Bank becomes zero. On February 1, 2011, Phillip does not self-pay the Monthly Premium and his eligibility and coverage are terminated. In March 2011, Phillip returns to Covered Employment. The Collective Bargaining Agreement in effect from January 1, 2011 through December 31, 2011 requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In March 2011, Phillip works 120 hours in Covered Employment. In April and May 2011, Phillip does not work in Covered Employment. On June 1, 2011 Phillip becomes an Eligible Employee. On June 1, 2011, Phillip has $120 in his Dollar Bank. The Monthly Premium in June 2011 is $200. On June 1, 2011, Phillip self-pays the remaining $80 (i.e. the difference between the Monthly Premium of $200 and the $120 of contributions in his Dollar Bank). The $120 of contributions for Phillip's March 2011 hours are drawn from his Dollar Bank and Phillip is a Covered Employee in June 2011.

Example 2

In December 2010, Phillip is covered under the Plan as a Covered Employee and does not work in any type of employment. In January 2011, Phillip's Dollar Bank becomes zero. On February 1, 2011, Phillip does not self-pay the Monthly Premium and his eligibility and coverage are terminated. In March 2011, Phillip returns to Covered Employment. The Collective Bargaining Agreement in effect from January 1, 2011 through December 31, 2011 requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In March 2011, Phillip works 120 hours in Covered Employment. In April and May 2011, Phillip does not work in Covered Employment. On June 1, 2011, Phillip becomes an Eligible Employee. On June 1, 2011, Phillip has $120 in his Dollar Bank. The Monthly Premium in June 2011 is $200. Phillip does not self-pay the remaining $80 (i.e. the difference between the Monthly Premium of $200 and the $120 of contributions in his Dollar Bank). Phillip is not a Covered Employee in June 2011. Because Phillip does not become a Covered Employee on June 1, 2011, he loses eligibility (i.e. he is no longer an Eligible Employee). The $120 in contributions for Phillip's March 2011 hours will remain in his Dollar Bank.

The Monthly Premium in July 2011 is $110. Because Phillip is not an Eligible Employee, the Plan Administrator will not take the contributions from Phillip's Dollar Bank, Phillip will not be allowed to self-pay the Monthly Premium, and Phillip cannot become a Covered Employee in July 2011.

In August 2011, Phillip works 10 hours in Covered Employment. On November 1, 2011, Phillip's eligibility is reinstated (i.e. he becomes an Eligible Employee). On November 1, 2011, Phillip has $130 in his Dollar Bank. The Monthly Premium in November 2011 is $120. The Plan Administrator will automatically take $120 out of Phillip's Dollar Bank and Phillip will become a Covered Employee on November 1, 2011.

Example 3

In December 2010, Phillip is covered under the Plan as a Covered Employee and does not work in any type of employment. In January 2011, Phillip's Dollar Bank becomes zero. On February 1, 2011, Phillip self-pays the Monthly Premium and remains a Covered Employee. From February 1, 2011 through January 31, 2012, Phillip self-pays the Monthly Premium. On February 1, 2012, Phillip's eligibility and coverage are terminated because it is the first day of the calendar month following the month that Phillip has received coverage for 12 consecutive months in accordance with the Complete Self-Pay provisions of Section 1.03(b).

In October 2012, Phillip returns to Covered Employment. The Collective Bargaining Agreement in effect from January 1, 2012 through December 31, 2012 requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. Phillip works 40 hours in Covered Employment each month in October, November and December 2012. Phillip does not work in Covered Employment in January 2013 or February 2013. On March 1, 2013, Phillip becomes an Eligible Employee. On March 1, 2013, Phillip has $120 in his Dollar Bank. The Monthly Premium in March 2013 is $220. On March 1, 2013, Phillip self-pays the remaining $100 (i.e. the difference between the Monthly Premium of $220 and the $120 of contributions in his Dollar Bank). The $120 of contributions for Phillip's October, November, and December 2012 hours are drawn from his Dollar Bank and Phillip is a Covered Employee on March 1, 2013.

Example 4

In December 2010, Phillip is covered under the Plan as a Covered Employee and does not work in any type of employment. In January 2011, Phillip has $50 in his Dollar Bank. The Monthly Premium in February 2011 is $100. Phillip does not self-pay the remaining $50. On February 1, 2011, Phillip's eligibility and coverage are terminated from the Plan. In April 2011, Phillip returns to Covered Employment. The Collective Bargaining Agreement in effect from January 1, 2011 through December 31, 2011 requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. Phillip works 40 hours each month in April, May and June 2011. Phillip does not work in Covered Employment in July or August 2011. On September 1, 2011, Phillip becomes an Eligible Employee. On September 1, Phillip has $170 in his Dollar Bank (the $50 that was in his Dollar Bank in January 2011 plus $40 per month for April, May and June 2011). The Monthly Premium in September 2011 is $150. The Plan Administrator will automatically take $150 out of Phillip's Dollar Bank and Phillip will become a Covered Employee on September 1, 2011. The extra $20 in contributions will remain in Phillip's Dollar Bank.

Example 5

In October 2010, Phillip loses his job in Covered Employment. From October 2010 through January 31, 2011, Phillip does not work in any type of employment and remains covered under the Plan through the contributions that were previously credited to his Dollar Bank. On January 31, 2011, Phillip has $700 in his Dollar Bank. The Monthly Premium for February 2011 is $500. On February 1, 2011, $500 is drawn from Phillip's Dollar Bank and Phillip remains covered under the Plan. In February 2011, Phillip returns to work in Covered Employment. The Collective Bargaining Agreement in effect from January 1, 2011 through December 31, 2011 requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In February 2011, Phillip works 40 hours in Covered Employment.

In March 2011, Phillip has $200 in his Dollar Bank. The Monthly Premium for March 2011 is $400. Phillip does not self-pay the remaining $200 and his coverage is terminated on March 1, 2011 in accordance with Section 1.13(a). In March 2011, Phillip works 80 hours in Covered Employment. In April and May 2011, Phillip does not work in any type of employment. On June 1, 2011, Phillip has $320 in his Dollar Bank (the $200 that was in his Dollar Bank in March 2011, plus $40 in contributions for hours worked in February 2011 and $80 in contributions for hours worked in March 2011). The Monthly Premium for June 2011 is $220. On June 1, 2011, even though Phillip has enough contributions in his Dollar Bank to pay the Monthly Premium, he is not eligible for coverage from the Plan (i.e. he is not an Eligible Employee) because the 40 hours that he worked in February 2011 (i.e. before time he lost eligibility and coverage) do not count toward the 120 hours required to reinstate eligibility and coverage in accordance with Section 1.15(a).

In June 2011, Phillip returns to Covered Employment and he works 50 hours. On September 1, 2011 Phillip becomes an Eligible Employee (because of the 80 hours he worked in March and the 50 hours he worked in June). On September 1, 2011, Phillip has $370 of contributions in his Dollar Bank (the $200 that was in his Dollar Bank in March 2011, plus $40 in contributions for hours worked in February 2011, plus $80 in contributions for hours worked in March 2011 and $50 in contributions for hours worked in June 2011). The Monthly Premium in September 2011 is $250. On September 1, 2011, the Plan Administrator will automatically take $250 out of Phillip's Dollar Bank and Phillip will become a Covered Employee. The extra $120 in contributions will remain in Phillip's Dollar Bank.

Example 6

On January 1, 2011, Phillip is 55 years old, he is covered under the Plan as a Retiree, he has $0 in his Dollar Bank, and he does not work in any type of employment. Phillip does not have any Dependents, he receives Plan A Coverage and he pays the Retiree Premium in accordance with Section 1.09.

In May 2011, Phillip returns to Covered Employment. The Collective Bargaining Agreement in effect from January 1, 2011 through December 31, 2011 requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In May 2011, Phillip works 40 hours in Covered Employment. In June 2011, Phillip works 60 hours in Covered Employment. In July 2011, Phillip works 20 hours in Covered Employment. On October 1, 2011, Phillip no longer meets the definition of Retiree and his eligibility and coverage under the Plan as a Retiree are terminated in accordance with Section 1.13(b)(3).

On that same date (i.e. October 1, 2011) Phillip's eligibility as an Employee is reinstated in accordance with Section 1.15(b) (i.e. he became an Eligible Employee at the same time that he no longer met the definition of Retiree). On October 1, 2011, Phillip has $120 in his Dollar Bank. In October 2011, the Monthly Premium is $110 and the Retiree Premium for a Retiree with Plan A Coverage and no Dependents is $55. Because Phillip is now an Eligible Employee instead of a Retiree, the Plan Administrator will automatically take $110 (i.e. the Monthly Premium) out of Phillip's Dollar Bank and he will become a Covered Employee on October 1, 2011.

Phillip is not permitted to receive coverage from the Plan as a Retiree until October 2012. On October 1, 2012, Phillip's eligibility and coverage as a Retiree may be reinstated if he fulfills the requirements of Section 1.16.

Example 7

On January 1, 2011, Phillip is 55 years old, he is covered under the Plan as a Retiree, he has $0 in his Dollar Bank and he does not work in any type of employment. Phillip does not have any Dependents, he receives Plan A Coverage and he pays the Retiree Premium in accordance with Section 1.09.

In May 2011, the Monthly Premium is $250 and the Retiree Premium for a Retiree with Plan A Coverage and no Dependents is $125. On May 1, 2011, Phillip self-pays $125 and remains covered under the Plan as a Retiree.

On May 15, 2011, Phillip returns to Covered Employment. The Collective Bargaining Agreement in effect from January 1, 2011 through December 31, 2012 requires Employers to contribute $1 per hour to the Plan on behalf of each Employee. In May 2011, Phillip works 120 hours in Covered Employment. In June and July 2011, Phillip does not work in Covered Employment. On August 1, 2011, Phillip no longer meets the definition of Retiree and his eligibility and coverage under the Plan as a Retiree are terminated in accordance with Section 1.13(b)(3).

On that same date (i.e. August 1, 2011) Phillip's eligibility as an Employee is reinstated in accordance with Section 1.15(b) (i.e. he became an Eligible Employee at the same time that he no longer met the definition of Retiree). On August 1, 2011, Phillip has $120 in his Dollar Bank. In August 2011, the Monthly Premium is $200 and the Retiree Premium for a Retiree with Plan A coverage and no Dependents is $100. Because Phillip is now an Eligible Employee instead of a Retiree, he will only be covered under the Plan if he self-pays $80 (i.e. the difference between the Monthly Premium of $200 and the $120 of contributions in his Dollar Bank) in August 2011. Phillip does not self-pay the remaining $80 and he is not a Covered Employee in August 2011. Because

Phillip does not become a Covered Employee on August 1, 2011, he loses eligibility (i.e. he is no longer an Eligible Employee). The $120 in contributions for Phillip's May 2011 hours will remain in his Dollar Bank.

The Monthly Premium in September 2011 is $120 and the Retiree Premium for a Retiree with Plan A Coverage and no Dependents is $60. Because Phillip is not eligible for coverage as an Employee (i.e. he is not an Eligible Employee) or a Retiree, the Plan Administrator will not take the contributions from his Dollar Bank, Phillip will not be allowed to self-pay the Monthly Premium or the Retiree Premium and Phillip cannot become a Covered Employee or a Retiree in September 2011.

From August 2011 through March 2012, Phillip is not covered under the Plan and he does not work in any type of employment. In April 2012, Philip returns to Covered Employment. In April, Phillip works 10 hours in Covered Employment. In May and June 2012, Phillip does not work in Covered Employment. On July 1, 2012, Phillip's eligibility as an Employee is reinstated (i.e. he becomes an Eligible Employee). On July 1, 2012, Phillip has $130 in his Dollar Bank. The Monthly Premium in July 2012 is $120. The Plan Administrator will automatically take $120 out of Phillip's Dollar Bank and Phillip will become a Covered Employee on July 1, 2012.

On August 1, 2012 (i.e. 12 months after the date his eligibility and coverage were terminated in accordance with Section 1.13(b)(3)), Phillip's eligibility and coverage as a Retiree may be reinstated if he fulfills the requirements of Section 1.16.

Section 1.16 – Reinstatement of Eligibility and Coverage as a Retiree

If a Retiree's eligibility and coverage are terminated in accordance with Section 1.13(b), he is required to meet all of the requirements of Section 1.06 or Section 1.07 before his eligibility and coverage as a Retiree are reinstated. A Retiree's eligibility and coverage will be reinstated at 12:01 a.m. 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.

Section 1.17 – Qualification as an Eligible Dependent

(a) Spouse

The spouse of a Covered Employee or Retiree is covered under this Plan only if the parties' marriage is recognized in their State of domicile, and they are not legally separated or subject to a decree of separate maintenance, regardless of the terms used to describe any legal separation or separate maintenance.

(b) Child

The child of a Covered Employee or Retiree will be covered under this Plan as a Dependent of the Covered Employee or Retiree if the child meets the criteria of (1) and (2) below.

(1) He has one of the following relationships to the Covered Employee or Retiree:

i. Is a son, daughter, stepson or stepdaughter;

ii. Is an eligible foster child*;

iii. Is legally adopted or lawfully placed with the Covered Employee or Retiree for legal adoption so long as the child is adopted or placed with the Covered Employee or Retiree for legal adoption prior to his 18th birthday; or

iv. Is a child for whom the Covered Employee or Retiree has legal responsibility by virtue of a court order for custody and support or maintenance (including a legal guardianship), or who is the subject of a Qualified Medical Child Support Order (QMCSO)**.

(2) He meets one of the following conditions:

i. Is under the age of 19;

ii. Is under the age of 26 and does not have health care coverage available through his employer, or spouse's employer if married;

iii. Is a full-time student who has not reached age 24; or

iv. Is permanently and totally disabled and the disability began before the child would have lost coverage under the Plan if not for this provision.

* A foster child means an individual who is placed with the Covered Employee or Retiree by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction. In order for a foster child to be covered under the Plan, no parent can claim the child as a "qualifying child" under the tax code and the non-parent Covered Employee or Retiree must have a higher adjusted gross income (AGI) than any parent of the child.

** A child who does not meet the eligibility criteria under this Plan may still be covered as a Dependent if the Plan receives a Qualified Medical Child Support Order (QMCSO) from the court ordering the Plan to provide coverage to the child as the Alternate Recipient under the QMCSO. A National Medical Support Notice received by the Plan by a state agency regarding coverage for a child will also be treated as a QMCSO. The Plan will review the QMCSO and determine whether it is qualified in accordance with the Plan's written procedures for handling medical child support orders. The Plan's procedures for handling medical child support orders will be provided to a Participant or Beneficiary upon request and free of charge.

Section 1.18 – Date of Coverage for Dependents of Covered Employees

If you are a Covered Employee, coverage for your spouse will become effective at the same time as your coverage so long as an enrollment form for your spouse was postmarked or otherwise positively received by the Fund Office on such date. If you get married after the date your coverage begins, coverage for your spouse will be effective at 12:01 a.m. on the date of marriage as long as an enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office within 90 days of marriage. If an enrollment form for your spouse is not postmarked or otherwise positively received by the Fund Office at the same time as your coverage begins or within 90 days of marriage, your spouse will become eligible for coverage for claims incurred the first day of the month after an enrollment form for your spouse is postmarked or otherwise positively received by the Fund Office.

If you are a Covered Employee, coverage for your Dependent children will become effective at the same time as your coverage so long as the Dependent child's enrollment form was postmarked or otherwise positively received by the Fund Office on such date. If the Dependent child's enrollment form was not postmarked or otherwise positively received by the Fund Office on such date, the Dependent child will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

A newly acquired Dependent child of a Covered Employee will be covered effective 12:01 a.m. on the date of birth, adoption, placement for adoption, the effective date of a court order establishing the Covered Employee's or spouse's financial responsibility for a child, or the effective date of a Qualified Medical Child Support Order, as applicable, so long as the Dependent child's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of such event. If the Dependent child's enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days of birth, adoption, placement for adoption, the effective date of a court order establishing the Covered Employee's or spouse's financial responsibility for a child, or the effective date of a Qualified Medical Child Support Order, as applicable, the Dependent child will become eligible for coverage for claims incurred the first day of the month after the enrollment form is postmarked or otherwise positively received by the Fund Office.

If you acquire a Dependent you should immediately contact the Fund Office. Claims for a Dependent will not be paid if a current enrollment form is not on file with the Fund Office for that Dependent.

Section 1.19 – Date of Coverage for Dependents of Retirees

If you are a Retiree and you elect coverage under this Plan, you may also elect coverage for your Dependents. An additional premium amount may apply to coverage of Dependents of Retirees. A Retiree may not select coverage for his Dependents if he declines Retiree coverage for himself. Once a Retiree has declined Retiree coverage, he may not later seek to enroll himself or his Dependents.

If you are a Retiree and you elect coverage for yourself, but decline coverage for your Dependents, you may not subsequently obtain coverage for any Dependents who could have been enrolled at the time of your retirement. A Retiree's Dependents are not entitled to receive any benefits from this Plan unless the Retiree makes an affirmative election at the time that he provides the Fund Office with a form requesting Retiree health coverage in accordance with Section 1.06(d) or Section 1.07(a)(5) as applicable or during a special enrollment period with respect to that Dependent.

A special enrollment period is provided with respect to a Dependent of a Retiree under the following circumstances:

(a) Newly Acquired Dependents:

If a person becomes a Dependent of a covered Retiree through marriage, birth, adoption, placement for adoption or a court order (including a QMCSO) that Dependent will be entitled to a 90 day special enrollment period beginning on the date of marriage, birth, adoption, placement for adoption or date a court order is entered. This means that if the Dependent's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of the marriage, birth, adoption, placement for adoption or date a court order is entered, the Dependent will be covered effective 12:01 a.m. on the date of the marriage, birth, adoption, placement for adoption or effective date of the court order. If the Dependent's enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days of the marriage, birth, adoption, placement for adoption or the date a court order is entered the Retiree may not subsequently obtain coverage for the Dependent.

(b) Spouse who has other Coverage:

If the spouse of a Retiree has coverage under an employer-sponsored health plan, and the Retiree declines coverage under this Plan for his spouse because of the other coverage, the spouse will be entitled to a 90 day special enrollment period beginning on the date that the spouse loses such other coverage or any replacement coverage provided the following requirements are met:

(1) The Retiree or spouse must provide the Plan Administrator with proof of other coverage (for example a certificate of creditable coverage) upon declining this Plan's coverage, along with notice that she is declining coverage under this Plan because of the other coverage; and

(2) The spouse's enrollment form must be postmarked or otherwise positively received by the Fund Office within 90 days of losing such other coverage or replacement coverage. If the spouse's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of losing such other coverage, the spouse will be covered effective 12:01 a.m. on the date her other coverage was terminated.

A spouse using other coverage will not be treated as having a lapse in coverage for purposes of Section 1.23 by reason of the other coverage.

Section 1.20 – Termination of Dependent Spouse Eligibility and Coverage

A Dependent spouse's eligibility and coverage will terminate when the Covered Employee or Retiree's coverage terminates for any reason, subject to the spouse's right to continue coverage as a surviving spouse as

discussed in Sections 1.22 and 1.23 as applicable. A Dependent spouse's eligibility and coverage will also terminate the first day of the month following the month in which a decree of divorce, dissolution of marriage, legal separation or separate maintenance (regardless of the terms used to describe the divorce or legal separation) is entered.

All Covered Persons are responsible for promptly notifying the Plan Administrator if they have a change in marital status. This means a Covered Person must notify the Plan Administrator immediately in the event of divorce, dissolution of marriage, legal separation or separate maintenance. Failure to notify the Fund Office of divorce, dissolution of marriage, legal separation or separate maintenance will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a Covered Employee or Retiree does not notify the Plan Administrator of his divorce, dissolution of marriage, legal separation or separate maintenance the Plan may recover any payments made for claims incurred by the former spouse after the divorce, dissolution or marriage, legal separation or separate maintenance in accordance with Section 13.18.

Section 1.21 – Termination of Dependent Child Eligibility and Coverage

A Dependent child's eligibility and coverage will terminate when the Covered Employee or Retiree's coverage terminates for any reason, except as provided in Sections 1.22 and 1.23 as applicable. A Dependent child's eligibility and coverage will also terminate in accordance with Sections 1.21(a), (b) and (c) below.

(a) A Dependent child will automatically remain covered through the end of the month containing his 26th birthday unless he has employer-sponsored health care coverage available through his employer, or spouse's employer if married, in which case his coverage will cease in the month following the month such other coverage becomes available (regardless of whether the Dependent child elects such other available employer-sponsored health care coverage), unless the Dependent child is eligible under Section 1.17(b)(2)(i), 1.17(b)(2)(iii), or 1.17(b)(2)(iv) above.

(b) A Dependent child may continue to be covered as a Dependent under this Plan from age 19 until age 24, even if he has employer-sponsored health care coverage available through his employer, or spouse's employer if married, provided he is a full-time student at a school with a regular teaching staff, curriculum and student body. If the Dependent child is a full-time student and has other health care coverage available through his employer, or spouse's employer if married, his coverage shall automatically terminate on the earlier of:

(1) the end of the month containing the last day of the enrollment period for which proof of enrollment has been submitted to the Plan Administrator; or

(2) the end of the month containing his 24th birthday.

A Dependent child age 19 through 24 may remain continuously covered under this Plan between enrollment periods, even if he has employer-sponsored health care coverage available through his employer, or spouse's employer if married, as long as he enrolls in the next regular enrollment period following the date on which coverage would otherwise terminate. (For example, a college student whose spring semester ends during May may receive benefits under this Plan over the summer if he enrolls for the following fall semester, even if the fall semester does not begin until August or September). Such interim coverage will be provided only if the Fund Office receives proof of enrollment. If the proof of enrollment is not available prior to the date coverage would otherwise terminate, coverage will be provided retroactively upon the Fund Office's receipt of proof of enrollment.

The internet is considered as a method of attending school as long as the classes attended through the internet are from a state accredited school, the Dependent child is enrolled in enough credits to be

considered a full-time student and the credits earned count towards a degree or certification. In order to determine if a Dependent child taking classes on the internet is considered a full-time student, all of the following items must be provided to the Fund Office:

- the name and location of the school;
- the number of hours the Dependent child is enrolled in via the internet;
- the number of hours, if any, the Dependent child is enrolled in on-campus (if the Dependent child is enrolled in a combination of internet and on-campus classes both must be provided);
- the start and end date of the internet classes;
- the projected graduation date; and
- the degree and/or certification program that the internet classes apply towards earning.

Notwithstanding the rule that a Dependent child over age 18 who has other health coverage available through his employer, or spouse's employer if married, is not eligible for coverage under this Plan unless the child is a full-time student between the ages of 19 and 24, a Dependent child who is covered past the age of 19 due to enrollment in post-secondary education (i.e. college students between the ages of 19 and 24), will remain covered for up to a year, unless the child's coverage would end earlier for another reason (such as a parent's termination of employment or the child's exceeding age 24), during a Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is one which begins while a Dependent child is suffering from a serious Sickness or Injury, is Medically Necessary, and causes the child to lose student status for purposes of the Plan (i.e. the child is unable to attend school on a full-time basis due to the serious Sickness or Injury). In order to receive coverage during a Medically Necessary Leave of Absence, you must provide the Fund Office with written certification by a treating Physician of the child which states that the child is suffering from a serious Sickness or Injury and that the leave of absence (or other change of enrollment) is Medically Necessary. A Dependent child whose benefits are continued under this section will receive the same benefits as if the child continued to be a covered full-time student at the institution of higher education and was not on a Medically Necessary Leave of Absence.

(c) Notwithstanding the age limits above, a permanently and totally disabled Dependent child may remain eligible for coverage despite his age, provided the other criteria are met. A Dependent child will be considered permanently and totally disabled for purposes of receiving continued eligibility for benefits under the Plan if he is unable (because of a physical or mental condition) to support himself financially, as long as the disability began before the child's coverage would have otherwise terminated. The Plan may require proof of the disability in order to continue coverage past the age of 25, and may continue to require this proof from time to time. The Covered Employee, Retiree or Dependent must inform the Plan Administrator if a disabled Dependent child is entitled to Medicare. For the rules regarding the Plan's coordination of benefits with Medicare, see Section 10.04.

All Covered Persons are responsible for promptly notifying the Plan Administrator when a Dependent child no longer meets the Plan's definition of Dependent. This means a Covered Person must notify the Plan Administrator immediately if a Dependent child has other coverage available through his employer or spouse's employer if married, is no longer a full-time student or is no longer permanently and totally disabled (as applicable). Failure to notify the Fund Office that a child has other coverage available through his employer or spouse's employer if married, is no longer a full-time student or is no longer permanently and totally disabled, as applicable, will be considered an omission that constitutes fraud and an intentional misrepresentation of a material fact that is prohibited by the terms of the Plan. If a Covered Employee or Retiree does not notify the Plan Administrator that a child has other coverage available through his employer or spouse's employer if married, is no longer a full-time student or is no longer permanently and totally disabled, as

applicable, the Plan may recover any payments made for claims incurred by the child after the date of such event (i.e. after the child was no longer eligible for coverage from the Plan as a Dependent child) in accordance with Section 13.18.

Section 1.22 – Surviving Spouse of a Covered Employee

The surviving spouse of a Covered Employee may continue coverage under the Plan as follows:

(a) The surviving spouse must have been covered as a Dependent under this Plan on the date of the Covered Employee's death.

(b) The surviving spouse's Dependents, who were also Dependents of the deceased Covered Employee on the date of his death, may remain covered as long as the spouse remains covered under this Section 1.22, so long as they continue to meet the definition of Dependent. Coverage is not available for any Dependent of a surviving spouse who was not a covered Dependent of the Covered Employee on the date of his death. However, if the surviving spouse was pregnant at the time of the Covered Employee's death, the child born to the surviving spouse will be treated as if he was a Dependent of the Covered Employee at the time of his death.

(c) The surviving spouse and the surviving spouse's Dependents who are covered under the Plan in accordance with Section 1.22(b) above, will receive two free years of coverage from the Plan following a Covered Employee's death. This means that the surviving spouse will not have to pay a Monthly Premium or a Retiree Premium for coverage for 24 months after the Covered Employee's death. The two year period will begin the first day of the month following the Covered Employee's death. After the two years of free coverage, the surviving spouse and the surviving spouse's Dependents who are covered under the Plan in accordance with Section 1.22(b) above will be required to pay the Monthly Premium or Retiree Premium (as applicable) to be covered under the Plan as follows:

(1) Beginning on the first day of the 25th month following the Employee's death, the Monthly Premium or Retiree Premium (as applicable), will be automatically drawn from the deceased Employee's Dollar Bank to pay for coverage for the surviving spouse and her Dependents who are covered under the Plan in accordance with Section 1.22(b). This will continue until there are no longer sufficient contributions in the deceased Employee's Dollar Bank to pay the Monthly Premium or Retiree Premium as applicable.

(2) The first month that the deceased Employee's Dollar Bank does not have sufficient contributions to cover the Plan's Monthly Premium or Retiree Premium (as applicable) 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 Employee's Dollar Bank and the Monthly Premium or Retiree Premium, as applicable. The self-pay amount is due on the first day of the month for which the surviving spouse intends to receive coverage. Coverage for the surviving spouse and her Dependents who are covered under the Plan in accordance with Section 1.22(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. A surviving spouse may make unlimited consecutive self-payments under this section (even when the amount in the deceased Employee's Dollar Bank is zero) 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.

(d) Neither a surviving spouse nor any Dependents of a surviving spouse shall be entitled to the Death Benefit or the Short-Term Disability Benefit.

(e) A surviving spouse and her Dependents may not regain coverage following a lapse in coverage.

(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 will be required to pay the Retiree Premium for Plan A Coverage beginning the first day of the month following the surviving spouse's 55th birthday and ending the first day of the month following the surviving spouse's 60th birthday.

(3) A surviving spouse may elect to pay the Retiree Premium for Plan A Coverage or Plan B Coverage once the surviving spouse has attained 60 years of age (i.e. the month after the surviving spouse's 60th 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.

(g) For purposes of COBRA continuation coverage, the surviving spouse's (and her Dependent(s)) qualifying event (i.e. losing coverage due to the death of the Covered Employee) occurs when the surviving spouse coverage terminates.

Section 1.23 – Surviving Spouse of a Retiree

The surviving spouse of a Retiree may continue coverage under the Plan as follows:

(a) The surviving spouse must have been covered as a Dependent under this Plan on the date of the Retiree's death. A surviving spouse who is using other coverage in accordance with the special enrollment period rules in Section 1.19(b) shall be treated as a Dependent for purposes of this provision so long as all other requirements are met and the surviving spouse elects coverage under this Plan within 90 days of losing such other coverage.

(b) The surviving spouse's Dependents who were also Dependents of the deceased Retiree on the date of his death may remain covered as long as the spouse remains covered under this Section 1.23, so long as they continue to meet the definition of Dependent. Coverage is not available for any Dependent of a surviving spouse who was not a covered Dependent of the Retiree on the date of his death. However, if the surviving spouse was pregnant at the time of the Retiree's death, the child born to the surviving spouse will be treated as if he was a Dependent of the Retiree at the time of his death.

(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 self-pay

amount is 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. A surviving spouse may make unlimited consecutive self-payments under this Section 1.23 (even when the amount in the deceased Retiree's Dollar Bank is zero) 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.

(d) Whether the surviving spouse and her Dependents will have Plan A Coverage or Plan B Coverage will be determined as follows:

(1) If the Retiree had Plan A Coverage on the date of his death, the surviving spouse will be required to have Plan A Coverage until the first day of the month following the surviving spouse's 60th birthday.

(2) If the Retiree had Plan A Coverage on the date of his death, a surviving spouse may elect to change to Plan B Coverage, so long as the surviving spouse is at least 60 years old. **Once a surviving spouse elects Plan B Coverage, she may not subsequently elect Plan A Coverage.**

(3) If the Retiree had Plan B Coverage on the date of his death, the surviving spouse will have Plan B Coverage. The surviving spouse will not be permitted to change from Plan B Coverage to Plan A Coverage.

(e) Neither a surviving spouse nor any Dependents of a surviving spouse shall be entitled to the Death Benefit or the Short-Term Disability Benefit.

(f) A surviving spouse and her Dependents may not regain coverage following a lapse of coverage. A surviving spouse who elects to use other coverage in accordance with Section 1.19(b) shall not be treated as having a lapse in coverage.

(g) For purposes of COBRA continuation coverage, the surviving spouse spouse's (and her Dependent(s)) qualifying event (i.e. losing coverage due to the death of the Retiree) occurs when the surviving spouse coverage terminates.

Section 1.24 – COBRA Continuation Coverage

Notice of COBRA Continuation of Coverage Rights
IBEW Local 347 Electrical Workers Health and Welfare Plan

****Continuation Coverage Rights Under COBRA****

Introduction: This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). **This notice generally explains COBRA continuation coverage, when it may be available to you and your family, and what you need to do to protect your right to receive it.**

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the

Plan when they would otherwise lose their group health coverage. This Summary Plan Description contains additional information about your rights and obligations under the Plan and under federal law. For more information regarding COBRA contact the Plan Administrator.

COBRA Continuation Coverage: COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, you, your spouse and your Dependent children could become qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The coverage provided under COBRA continuation coverage is identical to the medical coverage provided under the Plan to similarly situated beneficiaries with respect to whom a qualifying event has not occurred. Ancillary welfare benefits, such as the Death Benefit and Short-Term Disability Benefit may not be continued under COBRA.

Qualifying Events: If you lose coverage because one of the following events happens, you are considered a "qualified beneficiary" who has suffered a "qualifying event" and will be eligible for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced (such as, you do not work sufficient hours to maintain the contributions required for coverage); or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee or Retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse (i.e. the Employee or Retiree) dies;
- Your spouse's hours of employment are reduced (that is, if the Employee does not work sufficient hours to maintain the contributions required for coverage);
- Your spouse's employment ends for any reason other than his gross misconduct;
- Your spouse becomes entitled to Medicare (Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following events happens:

- The parent-employee (meaning Employee or Retiree) dies;
- The parent-employee's hours of employment are reduced (that is, if the parent-employee does not work sufficient hours to maintain contributions required for coverage);
- The parent-employee's employment ends for any reason other than his gross misconduct;
- The parent-employee (meaning Employee or Retiree) becomes entitled to Medicare (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Plan Administrator is responsible for determining that you are eligible for COBRA continuation coverage when the qualifying event is the end of employment,

reduction of hours of employment, death of the Employee or Retiree or the Employee or Retiree becoming entitled to Medicare (Part A, Part B or both).

For any other qualifying events (divorce or legal separation of the Employee or Retiree and spouse or a Dependent child losing eligibility for coverage as a Dependent child), **YOU must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator, Wilson-McShane Corporation, IBEW Local 347 Electrical Workers Health and Welfare Fund, 4200 University Avenue, Suite 320, West Des Moines, IA 50266. Your notice to the Plan Administrator must be made in writing and must be accompanied by a copy of any legal documentation (such as a divorce decree or order granting legal separation) relating to the qualifying event.**

How is COBRA Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days after receiving such notice. If you submit notice of a qualifying event, and the Plan Administrator determines that you are not eligible for COBRA continuation coverage, the Plan Administrator will send you written notice of the unavailability of such coverage.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Employees and Retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects it, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee or Retiree, the Employee or Retiree becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if an Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts up to 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

- **Disability extension of 18 month period of continuation coverage**
  If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional eleven months of COBRA continuation coverage, for a total maximum 29 months. You must provide the notice to the Plan Administrator within the first 60 days of COBRA continuation coverage, or if later, within 60 days from the Social Security Administration's determination of disability and before the end of the 18 month period of COBRA continuation coverage. Additionally, such notice must be accompanied with a copy of the Social Security Administration's determination letter. This notice must be sent to the Fund Office.

- **Second qualifying event extension of 18 month period of continuation coverage**
  If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension is available to the spouse and Dependent children if the Employee or Retiree dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Office and must be accompanied by any appropriate documentation.

If You Have Questions
If you have questions concerning your COBRA continuation rights, you should contact the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Termination of COBRA Continuation Coverage
Your COBRA continuation coverage will terminate on the earliest of the following events:

- The end of the 18, 29 or 36 month maximum period as described in the section above. Because this Plan does not provide for a conversion option from group coverage under the Plan to an individual policy, you will not receive any notice prior to the termination of your COBRA continuation coverage due to exhaustion of the maximum period;

- The date on which the IBEW Local 347 Electrical Workers Health and Welfare Fund no longer provides any group health coverage to any individual;

- The first day of the month for which you do not pay your applicable premium on time;

- The date on which you become covered by another group health plan (after the date of your election of COBRA continuation coverage) that does not contain any exclusion or limitation with respect to any pre-existing condition which you may have;

- The date on which you become entitled to Medicare after your election of COBRA continuation coverage; or

- If your coverage was extended up to 29 months due to a disability, the first day of the month following the month in which the Social Security Administration determines that the qualified beneficiary is not disabled.

If your COBRA continuation coverage terminates earlier than the maximum coverage period (18, 29 or 36 months as described above), the Plan Administrator will send you a notice of such termination.

You do not have to show that you are insurable to receive continuation coverage. Eligibility for COBRA continuation coverage is subject only to the general eligibility rules stated in this notice.

COBRA Continuation Procedures

General
An Employee or Dependent with respect to whom a qualifying event has occurred shall be a qualified beneficiary entitled to elect COBRA continuation coverage. Any person who has properly elected continuation coverage shall remain a qualified beneficiary until continuation coverage is terminated.

Notice of Qualifying Events
Employers are not required to provide notice of qualifying events to the Plan Administrator. The Plan Administrator shall determine whether a qualifying event has occurred due to the Employee's termination of employment or reduction of hours of employment, the Employee or Retiree becoming entitled to Medicare (Part A, Part B or both), or the Employee or Retiree's death.

In order to make a determination whether a qualifying event has occurred as a result of termination of employment or reduction of hours of employment, the Plan Administrator shall review the monthly Employer contribution reports to determine the amount of contributions to be credited to the Employee based on the number of hours worked and whether full contributions are received for all hours worked. If Employer contribution reports are submitted timely, the Plan Administrator will generally have sufficient information to determine whether an Employee will lose coverage as a result of a termination of employment or reduction of hours of employment within 45 days after the last day of the month in which the Employee does not have sufficient contributions credited to maintain coverage for the following month. The Plan Administrator shall send notice of the qualifying event and the qualified beneficiaries' right to elect COBRA continuation coverage within 14 days after determining that a qualifying event has occurred.

If the qualifying event is the Employee or Retiree's death, the Plan Administrator shall send notice of the qualifying event and all qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after determining that a qualifying event has occurred.

The Plan Administrator shall determine whether an Employee or Retiree has become entitled to Medicare and whether such entitlement constitutes a qualifying event within 30 days following the qualifying event. If the Plan Administrator determines that a qualifying event has occurred, the Plan Administrator shall send notice of the qualifying event and all qualified beneficiaries rights to elect COBRA continuation coverage within 14 days of the determination.

An Employee or Retiree must give written notice to the Plan Administrator within 60 days after the occurrence of a qualifying event that is divorce or legal separation of the Employee or Retiree and spouse or a Dependent child's ceasing to meet the Plan requirements for an eligible Dependent. The notice shall be provided in writing and should be mailed, faxed or delivered to the Fund Office. The Plan will provide forms to Participants and Beneficiaries which may be used to provide this notice. Use of the Plan's form is not required as long as the written notice of the qualifying event contains all of the necessary information and is accompanied by documentation of the qualifying event, if applicable. The Plan Administrator will then send notice of the qualified beneficiaries' rights to elect COBRA continuation coverage, or the unavailability of COBRA continuation coverage within 14 days after receiving such notice.

Second Qualifying Event and Disability
If a qualified beneficiary experiences a second qualifying event while on COBRA continuation coverage that is subject to a maximum period of 18 or 29 months, the qualified beneficiary must provide written notice to the Plan Administrator within 60 days of the second qualifying event in order to extend the maximum COBRA continuation coverage period to 36 months.

If a qualified beneficiary or any member of the qualified beneficiary's family is disabled, as determined by the Social Security Administration, at any time within the first 60 days of COBRA continuation coverage, the qualified beneficiary must provide written notice of such disability to the Plan Administrator within the first 60 days of COBRA continuation coverage or, if later, within 60 days from the Social Security Administrator's determination that the qualified beneficiary or family member is disabled. The notice must be accompanied by a copy of the Social Security Administration's determination letter. A qualified beneficiary may, but is not required to, use a form provided by the Fund Office to provide this notice. If the Social Security Administration determines that the person's disability has ended while the person is on COBRA continuation coverage, the qualified beneficiary must provide a copy of the Social Security Administration's letter stating that the person is no longer disabled, to the Plan Administrator within 30 days after the Social Security Administration's determination.

The Plan Administrator shall send notice of the right to elect an extended period of continuation coverage, or notice of the unavailability of an extension of continuation of coverage, within 14 days after receiving notice from the qualified beneficiary.

Applicable Premium for COBRA Continuation Coverage

COBRA premiums are payable monthly, and are due on the first day of the month for the month of coverage. You will have 60 days in which to elect COBRA continuation coverage, and you have 45 days from the date you elect COBRA continuation coverage to submit your initial premium payment. Payments must be submitted to the Fund Office, as explained more fully in the notice you will receive when you become eligible for COBRA continuation coverage.

The applicable premium is an amount determined by the Board of Trustees to be a fair and appropriate amount to cover the cost of the coverage provided to you, but will never exceed 102% of the total cost to the Plan for your coverage, except as provided for in this paragraph regarding disability. The total cost to the Plan for your coverage is calculated on an actuarial basis by making a reasonable estimate of the cost of providing coverage for similarly situated Participants and Beneficiaries. This amount may be recalculated annually. The Plan reserves the right to charge an additional premium for qualified beneficiaries who take advantage of the eleven month extension of COBRA continuation coverage for totally disabled qualified beneficiaries and family members of such qualified beneficiaries described on page 42 of this Summary Plan Description. If you are eligible for the eleven month extension (to a maximum 29 months of continuation coverage), the maximum applicable premium for those additional eleven months is 150% of the total Plan cost of your coverage.

Unavailability of COBRA Continuation Coverage

When the Plan Administrator receives a notice from an Employee, or Beneficiary relating to a qualifying event, second qualifying event or determination of disability by the Social Security Administration regarding a covered Employee, qualified beneficiary or other individual, and the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage or an extension of COBRA continuation coverage, the Plan Administrator shall provide a notice to the person sending the notice explaining why the individual is not entitled to COBRA continuation coverage. The unavailability notice shall be sent within 14 days from receipt of the notice from the Employee, Beneficiary or other individual.

Early Termination of COBRA Continuation Coverage

Whenever COBRA continuation coverage is terminated prior to the latest date shown on the Election Notice (that is prior to the 18, 29 or 36 month maximum period), notice must be sent to all affected qualified beneficiaries explaining the reason for the termination, the date of termination and any rights the qualified beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage. The termination notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage shall terminate.

Premium Rate Increase

In the event COBRA premiums increase, the Plan Administrator shall send notice of such increase to all qualified beneficiaries at least one month prior to the effective date of the increase.

Deficient Premium Payment

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is less than the full premium amount due, and the deficiency is not more than $50, or the deficiency is not more than 10% of the applicable premium amount, if 10% of the premium is less than $50, the Plan Administrator shall provide notice of deficiency to the qualified beneficiary, demanding payment of the deficiency in full within 30 days from the date of the notice of deficiency. The deficient premium will be considered full payment until the end of the 30 day period. If the Plan Administrator fails to provide notice of the deficiency to the qualified beneficiary within 30 days after receipt of the payment, the amount paid will be deemed to constitute full payment of the applicable premium.

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is significantly less than the full amount due (that is, the deficiency exceeds the lesser of $50 or 10% of the applicable premium), no additional time will be granted to make up the deficiency. If the deficiency is not paid within the initial 30 day grace period, coverage will be retroactively terminated as of the first day of the month for which full payment was not made.

Section 1.25 – Certificate of Creditable Coverage

The Plan will issue a Certificate of Creditable Group Health Plan Coverage to an individual (including Employees, Retirees and Dependents) who loses coverage from the Plan. These Certificates provide the necessary documentation of prior coverage and/or waiting periods that individuals need to reduce pre-existing condition exclusions when enrolling in a new health benefit plan. Certificates are provided free of charge by this Plan automatically when an individual loses coverage under this Plan. If the Covered Person elects COBRA Continuation Coverage, another Certificate will be provided after the COBRA Continuation Coverage ends. In addition, a Certificate will be provided upon a request made to the Plan Administrator by a Covered Person before he loses coverage or within 24 months after he loses coverage. To request a Certificate or to obtain additional information contact:

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266
Telephone: (515) 224-4308
Toll Free: (877) 224-4308
www.ibew347benefits.com

ARTICLE II – COMPREHENSIVE MEDICAL BENEFITS

The following topics are discussed under this Article on Comprehensive Medical Benefits:

COMPREHENSIVE MEDICAL BENEFITS		
PLAN LIMITS, DEDUCTIBLES AND MAXIMUMS		
Calendar Year Maximum Payment Limit ..... $2,000,000* *There is no calendar year maximum payment limit as of January 1, 2014.		
	PPO PROVIDER	**NON-PPO PROVIDER**
Deductible • **Individual** • **Family**	 $ 200 $ 600	 $ 200 $ 600
When the family maximum is satisfied for a calendar year, Comprehensive Medical Benefits will be payable as if the individual Deductibles had been satisfied for each person in your family.		
Annual Out-of-Pocket Maximum • **Individual** The Annual Out-of-Pocket Maximum is applied on an individual basis. There is no family level Annual Out-of-Pocket Maximum.	Once you have incurred $3,000 of eligible Covered Charges in a calendar year, you have met your Annual Out-of-Pocket Maximum and for the rest of that calendar year the Plan will pay 100% of Covered Charges for most Comprehensive Medical Benefits provided by a PPO Provider and 80% of Covered Charges for most Comprehensive Medical Benefits provided by a non-PPO provider. Refer to Section 2.03 for more details.	

COMPREHENSIVE MEDICAL BENEFITS		
COVERAGE (PLAN PAYS)		
SERVICE	**PPO PROVIDER**	**NON-PPO PROVIDER**
AMBULANCE SERVICES	80% after Deductible	80% after Deductible
CHIROPRACTIC SERVICES	100% after $20 Copay - Deductible Waived	80% after Deductible
COLONOSCOPY SERVICES		
• **ROUTINE (limited to one every five years)**	100% - Deductible Waived	100% - Deductible Waived
• **NON-ROUTINE (must be Medically Necessary)**	80% after Deductible	60% after Deductible
DENTAL SERVICES – ACCIDENT RELATED	80% after Deductible*	80% after Deductible*
* Deductible is waived if treatment is completed within six months of the accident.		
DENTAL SERVICES – IMPACTED TEETH	80% after Deductible	80% after Deductible
DENTAL SERVICES – IMPLANTS FOR CONGENITAL DEFECTS	80% after Deductible	80% after Deductible
Limited to $5,000 per Covered Person per lifetime.		
DENTAL SERVICES – ORAL SURGERY	80% after Deductible	60% after Deductible
DIAGNOSTIC RADIOLOGY AND LABORATORY SERVICES		
• **OUTPATIENT HOSPITAL OR FACILITY**	80% after Deductible	60% after Deductible
• **PHYSICIAN'S OFFICE**	100% - Deductible Waived	60% after Deductible
DURABLE MEDICAL EQUIPMENT	80% after Deductible	80% after Deductible
HOME HEALTH CARE SERVICES	80% after Deductible	80% after Deductible
The Plan covers 40 home health care visits per calendar year. A home health care visit is a visit that lasts up to four hours. A visit that lasts more than four hours is considered two visits.		
HOSPICE CARE SERVICES	80% after Deductible	80% after Deductible
HOSPITAL – EMERGENCY ROOM SERVICES	100% after $50 Copay and Deductible	80% after $50 Copay and Deductible
* Hospital emergency room Copay is waived if admitted.		
HOSPITAL AND FACILITY – INPATIENT SERVICES	80% after Deductible	60% after Deductible
HOSPITAL AND FACILITY – OUTPATIENT SERVICES	80% after Deductible	60% after Deductible
INFERTILITY SERVICES		
• **OUTPATIENT HOSPITAL OR FACILITY**	80% after Deductible	60% after Deductible
• **PHYSICIAN'S OFFICE**	100% Deductible Waived	60% after Deductible
Limited to $4,000 per Covered Person per lifetime. Not available to Dependent children.		

COMPREHENSIVE MEDICAL BENEFITS (CONTINUED)		
COVERAGE (PLAN PAYS)		
SERVICE	**PPO PROVIDER**	**NON-PPO PROVIDER**
MAMMOGRAM SERVICES • **ROUTINE (limited to one per calendar year)** • **NON-ROUTINE (must be Medically Necessary)**	100% - Deductible Waived 80% after Deductible	100% - Deductible Waived 60% after Deductible
MATERNITY SERVICES	80% after Deductible	60% after Deductible
Not available to Retirees with Plan B Coverage and their Dependents.		
NURSE PRACTITIONER RETAIL CLINIC VISIT	100% after $10 Copay - Deductible Waived	60% after Deductible
PHYSICIAN OFFICE VISITS	100% after $20 Copay - Deductible Waived	60% after Deductible
ROUTINE PHYSICAL EXAMS	100% after $20 Copay - Deductible Waived	60% after Deductible
SECOND SURGICAL OPINION	100% - Deductible Waived	100% - Deductible Waived
SKILLED NURSING FACILITY SERVICES	80% after Deductible	80% after Deductible
Limited to 120 days per Sickness or Injury.		
SURGICAL SERVICES	80% after Deductible	60% after Deductible
THERAPY SERVICES	80% after Deductible	60% after Deductible
TRANSPLANT SERVICES	80% after Deductible	60% after Deductible
WELL CHILD CARE	100% - Deductible and Copay waived	60% - Deductible and Copay waived
Limited to: • Seven visits from the time a child is born until the child is one year old; • Two visits while the child is one year old; • One visit per year while the child is two, three, four, five, and six years old; and • Zero visits per year after the child's seventh birthday. Visits in addition to this allowed schedule may be available under the Routine Physical Exam benefit.		
WIGS AND HAIR PROSTHESES	80% after Deductible	80% after Deductible
Limited to $300 per Covered Person per lifetime.		

Section 2.01 – General Information

The Fund offers the UnitedHealthcare network of Physicians, Hospitals, Facilities and other health care providers. UnitedHealthcare contracts with these providers to offer medical services to Participants and Dependents at reduced rates. This network of providers is called a Preferred Provider Organization (PPO) and the providers in the network are referred to as "PPO Providers."

You are not required to use a PPO Provider to receive benefits from the Plan. However, by using a PPO Provider, you benefit from these important advantages:

- You will pay a lower percentage of the Covered Charges for most treatments; and

- You will not have to pay charges that exceed the Prevailing Charge. The Plan specifically excludes payment for any part of a charge for treatment that exceeds Prevailing Charges. When you receive treatment from a PPO Provider, you will not be billed for more than the total Prevailing Charge. If you do not use a PPO Provider, that provider could bill for more than the total Prevailing Charge.

Section 2.02 – Deductible

For most services and treatment, you must pay a certain amount of Covered Charges each calendar year before the Plan will start paying benefits. This amount is referred to as the "Deductible." The calendar year Deductible is $200 per Covered Person or $600 per family. Any Copay amounts that you pay do not count towards your Deductible. The amount of Covered Charges that you pay at both PPO Providers and non-PPO providers are applied to the Deductible.

Section 2.03 – Annual Out-of-Pocket Maximum

Once you have incurred $3,000 of eligible Covered Charges in a calendar year, you have met your Annual Out-of-Pocket Maximum and for the rest of that calendar year, the Plan will pay 100% of Covered Charges for most Comprehensive Medical Benefits provided by a PPO Provider and 80% of Covered Charges for most Comprehensive Medical Benefits provided by a non-PPO provider. If you utilize a benefit that requires a Copay, you will continue to be responsible for the required Copay even after you have met your Annual Out-of-Pocket Maximum.

The following Covered Charges do <u>not</u> count towards your Annual Out-of-Pocket Maximum:

- The portion of Covered Charges that you pay as a Deductible;
- Covered Charges for services and treatment when you are only responsible for a Copay (e.g. Covered Charges for a Physician Office Visit at a PPO Provider);
- Covered Charges for services and treatment when you are not responsible for any portion of the cost for the services or treatment (e.g. Covered Charges for a routine colonoscopy); and
- Covered Charges paid for treatment and services in Article III – Prescription Drug Benefits, Article IV – Dental Benefits, and Article V – Vision Benefits.

The Annual Out-of-Pocket Maximum is applied on an individual basis. There is no family level Annual Out-of-Pocket Maximum.

Section 2.04 – Calendar Year Maximum Payment Limit

The maximum amount payable under the Plan for each Covered Person is $2,000,000 in any calendar year. There is no calendar year maximum payment limit on claims incurred on and after January 1, 2014.

Section 2.05 – Covered Services

The Plan provides benefits to help cover the cost for a wide range of Medically Necessary treatment, including Physician, Hospital and Facility charges, diagnostic testing and surgery. The Plan also provides benefits for some preventative care services that are specifically listed as covered by the Plan (e.g. mammograms, routine physical exams). The Comprehensive Medical Benefits covered by the Plan are listed in Section 2.06 through Section 2.32 below.

Section 2.06 – Ambulance Services

The Plan covers licensed ambulance service for ground transportation to or from a Hospital. The Plan will also cover a licensed air ambulance if the location and nature of the Sickness or Injury make air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Ambulance Services regardless of whether the services are provided by a PPO Provider or a non-PPO provider. After a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Ambulance

Services provided by a PPO Provider and 80% of Covered Charges for Ambulance Services provided by a non-PPO provider.

Section 2.07 – Chiropractic Services

The Plan covers services provided by a licensed Physician or chiropractor for the treatment or correction of structural imbalance, subluxation, or misalignment of the spine. The Plan will pay the following percentages for Chiropractic Services:

- For Chiropractic Services provided by a PPO Provider, the Plan will pay 100% of Covered Charges after a Covered Person has paid a $20 Copay (Deductibles do not apply).

- For Chiropractic Services provided by a non-PPO provider, the Plan will pay 80% of Covered Charges after a Covered Person has met his Deductible.

Section 2.08 – Colonoscopy Services

The Plan covers one routine colonoscopy every five years. A colonoscopy is considered a routine colonoscopy if it is obtained as a diagnostic screening procedure (in other words, the Covered Person does not have any diagnosis or symptoms). The Plan will pay 100% of Covered Charges for a routine colonoscopy regardless of whether the colonoscopy is provided by a PPO Provider or a non-PPO provider (Deductibles do not apply).

The Plan also covers Medically Necessary (i.e. non-routine) colonoscopies. A colonoscopy is considered Medically Necessary if a Covered Person has any diagnosis other than screening, such as an abnormality or symptom. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Medically Necessary colonoscopies provided by a PPO Provider and 60% of Covered Charges for Medically Necessary colonoscopies provided by a non-PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Medically Necessary colonoscopies provided by a PPO Provider and 80% of Covered Charges for Medically Necessary colonoscopies provided by a non-PPO provider.

Section 2.09 – Dental Services – Accident Related

The Plan covers services provided by a Dentist or Physician for the treatment of the jaw or natural teeth that is required because of an accidental Injury and is received within 12 months of the accident. Injuries resulting from eating, chewing, or biting are not considered accidental Injuries for purposes of this Section. The Plan will pay the following percentages for dental services resulting from an accidental Injury:

- For dental services received within 6 months of the accident, the Plan will pay 80% of Covered Charges regardless of whether the services are provided by a PPO Provider, non-PPO provider, Participating Dentist, or non-participating Dentist (Deductibles do not apply).

- For dental services received between 6 and 12 months after the accident, the Plan will pay 80% of Covered Charges after a Covered Person has met his Deductible regardless of whether the services are provided by a PPO Provider, non-PPO provider, Participating Dentist, or non-participating Dentist.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for dental services provided by a PPO Provider or Participating Dentist. The Plan will continue to pay 80% of Covered Charges for dental services provided by a non-PPO provider or non-participating Dentist.

NOTE: For dental services that are not accident related, refer to Sections 2.10, 2.11, 2.12 and Article IV – Dental Benefits.

Section 2.10 – Dental Services – Impacted Teeth

The Plan covers services provided by a Dentist or Physician for the treatment of impacted teeth. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for dental services for the treatment of impacted teeth regardless of whether the services are provided by a PPO Provider, non-PPO provider, Participating Dentist, or non-participating Dentist. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for dental services provided by a PPO Provider or Participating Dentist. The Plan will continue to pay 80% of Covered Charges for dental services provided by a non-PPO provider or non-participating Dentist.

NOTE: Extraction of teeth for reasons other than treatment of impacted teeth is not covered under this Section. Refer to Section 4.03 for a description of coverage for other oral surgical treatment.

Section 2.11 – Dental Services – Implants for Congenital Defect

The Plan covers services provided by a Dentist or Physician for dental implants that are required to correct or improve a congenital defect that cannot be corrected or improved by an alternative treatment. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for dental services for dental implants regardless of whether the services are provided by a PPO Provider, non-PPO provider, Participating Dentist, or non-participating Dentist. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for dental services provided by a PPO Provider or Participating Dentist. The Plan will continue to pay 80% of Covered Charges for dental services provided by a non-PPO provider or non-participating Dentist.

The benefits in this Section are subject to a lifetime maximum of $5,000 per Covered Person.

NOTE: Refer to Section 4.04 for a description of coverage for dental implants that are required for a reason other than a congenital defect. The benefits provided under Section 4.04 are in addition to the benefits provided in this Section and will not count toward this Section's $5,000 lifetime maximum.

Section 2.12 – Dental Services – Oral Surgery

The Plan covers oral surgery provided by a Dentist or Physician for the treatment of diseases of the teeth, jaw or gums. The Plan also covers oral surgery provided by a Dentist or Physician for the treatment of fractures and dislocation of the jaw. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for oral surgery provided by a PPO Provider or Participating Dentist and 60% of Covered Charges for oral surgery provided by a non-PPO provider or non-participating Dentist. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for oral surgery provided by a PPO Provider or Participating Dentist and 80% of Covered Charges for oral surgery provided by a non-PPO provider or non-participating Dentist.

NOTE: Refer to Section 4.03 for a description of coverage for oral surgery that is required for a reason other than diseases of the teeth, jaw or gums.

Section 2.13 – Diagnostic Radiology and Laboratory Services

The Plan covers diagnostic radiology and laboratory services that are prescribed by a Physician. The Plan will pay the following percentages for Diagnostic Radiology and Laboratory Services:

- For Diagnostic Radiology and Laboratory Services provided by a PPO Provider during a Physician's Office Visit, the Plan will pay 100% of Covered Charges (Deductibles do not apply);
- For Diagnostic Radiology and Laboratory Services provided by a PPO Provider at a Hospital or Facility, the Plan will pay 80% of Covered Charges after a Covered Person has met his Deductible; and

- For Diagnostic Radiology and Laboratory Services provided by a non-PPO provider, the Plan will pay 60% of Covered Charges after a Covered Person has met his Deductible regardless of whether the services are provided during a Physician's Office Visit, at a Hospital, or at a Facility.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Diagnostic Radiology and Laboratory Services provided by a PPO Provider and 80% of Covered Charges for Diagnostic Radiology and Laboratory Services provided by a non-PPO provider regardless of whether the services are provided during a Physician's Office Visit, at a Hospital, or at a Facility.

Section 2.14 – Durable Medical Equipment

The Plan covers the rental or purchase (whichever costs less) of durable medical equipment. The Plan also covers batteries for covered durable medical equipment. Durable Medical Equipment means equipment and supplies that are prescribed by a Physician and meet all of the following criteria:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose that is related to the Covered Person's physical disorder;
- is generally not useful to a person who is not sick or injured, and is not used by anyone other than the Covered Person for whom it was prescribed; and
- is appropriate for home use.

Examples of Durable Medical Equipment include prosthetic devices, orthopedic braces, crutches and wheelchairs.

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Durable Medical Equipment regardless of whether the equipment is provided by a PPO Provider or a non-PPO provider. After a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Durable Medical Equipment provided by a PPO Provider. The Plan will continue to pay 80% of Covered Charges for Durable Medical Equipment provided by a non-PPO provider.

The Plan does not cover equipment that serves as a convenience item. Examples of equipment that is not covered includes, but is not limited to, sporting equipment, athletic equipment, posture chairs, whirlpool tubs, elevators, and dehumidifiers.

The Plan also does not cover maintenance fees (i.e. warranties); shipping or sales tax; or charges in excess of the lesser of the cost for renting or purchasing the durable medical equipment.

Section 2.15 – Home Health Care Services

The Plan covers 40 home health care visits per calendar year for Home Health Care Services provided by a home health agency. A home health agency is a home health care provider that meets the conditions that a home health agency must meet in order to participate in Medicare. A home health care visit is a visit that lasts up to four hours. A visit that lasts more than four hours is considered two visits.

Home Health Care Services means services prescribed by a Physician and provided by a home health agency while the Covered Person is under the medical supervision of the Physician who prescribed the services. Home Health Care Services include:

- Services provided by a licensed registered nurse;

- Services provided by a home health aide who is employed by (or contracted with) a home health agency so long as the services are ordered and supervised by a registered nurse employed by the home health agency;
- Services provided by a licensed therapist for physical therapy, occupational therapy, speech therapy or respiratory therapy;
- Services provided by a registered dietician or social worker;
- Supplies and prescription drugs provided by the home health agency; and
- Laboratory services provided by the home health agency.

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Home Health Care Services regardless of whether the services are provided by a PPO Provider or a non-PPO provider. After a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Home Health Care Services provided by a PPO Provider. The Plan will continue to pay 80% of Covered Charges for Home Health Care Services provided by a non-PPO provider.

The Plan does not cover Custodial Care, transportation services or services provided by household members.

NOTE: Although not required, the Trustees encourage you to have your provider contact UnitedHealthcare to request prior authorization before you receive Home Health Care Services. Refer to Section 2.33 for instructions on how to obtain prior authorization.

Section 2.16 – Hospice Care Services

The Plan covers Hospice Care Services that a terminally ill Covered Person receives at home, in a hospice Facility, or in a Hospital. The Plan also covers Hospice Care Services provided to a Covered Person's family as explained in greater detail below.

For purposes of this Section, a Covered Person is considered terminally ill if a Physician certifies that the Covered Person is terminally ill and has a life expectancy of six months or less if his Sickness runs its normal course.

Hospice Care Services means services for pain control, symptom relief, and emotional support that are provided by an approved hospice program. An approved hospice program is a hospice program that meets the state licensure requirements as a hospice (in states with licensure requirements) and is Medicare-certified.

Hospice Care Services include:

- Treatment, room and board at a hospice Facility or Hospital;
- Physician services;
- Nursing care provided by or under the supervision of a registered nurse;
- Home health aide services;
- Medical social services;
- Nutritional supplements, guidance and support provided by a registered nutritionist;
- Counseling treatment provided by a licensed social worker or a licensed pastoral counselor; and
- Bereavement counseling provided to the Participant or their Dependent in the case of a death of a Covered Person, within 12 months of the patient's death.

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Hospice Care Services regardless of whether the services are provided by a PPO Provider or a non-PPO provider. After a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Hospice Care Services provided by a PPO Provider. The Plan will continue to pay 80% of Covered Charges for Hospice Care Services provided by a non-PPO provider.

Treatment for any medical condition other than the life threatening Sickness is not covered under this Section.

The Plan does not cover Custodial Care, services provided by household members, or care beyond what is considered reasonable and customary hospice care (for example, the Plan will not cover the cost of a pet).

NOTE: Although not required, the Trustees encourage you to have your provider contact UnitedHealthcare to request prior authorization before you receive Hospice Care Services. Refer to Section 2.33 for instructions on how to obtain prior authorization.

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 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.

Section 2.18 – Hospital and Facility – Inpatient Services

The Plan covers treatment and services that a Covered Person receives while he is an inpatient at a Hospital. The treatment and services covered under this Section include treatment for mental health and substance abuse. The Plan also covers the following charges for room and board at a Hospital or Facility:

- If intensive care or other specialized unit confinement is Medically Necessary, the Prevailing Charge for room and board in such unit;
- If confinement in a private room is Medically Necessary, the Prevailing Charge for room and board in such private room; or
- In all other cases, the Prevailing Charge for a semi-private room.

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Hospital – Inpatient Services provided by a PPO Provider and 60% of Covered Charges for Hospital – Inpatient Services provided by a non-PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Hospital – Inpatient Services provided by a PPO Provider and 80% of Covered Charges for Hospital – Inpatient Services provided by a non-PPO provider.

NOTE: Inpatient Hospital and Facility treatment and services provided to a Covered Person while he is receiving hospice care are not covered under this Section. Refer to Section 2.16 for a description of coverage for inpatient Hospital and Facility services provided in connection with hospice care.

Section 2.19 – Hospital and Facility – Outpatient Services

The Plan covers treatment and services that a Covered Person receives while he is at a Hospital or Facility on an outpatient basis. The treatment and services covered under this Section includes treatment for mental health and substance abuse. It also includes Specialty Drugs (including IV infusion therapy) that are administered at the Hospital or Facility.

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Hospital and Facility – Outpatient Services provided by a PPO Provider and 60% of Covered Charges for Hospital and Facility – Outpatient Services provided by a non-PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Hospital and Facility – Outpatient Services provided by a PPO Provider and 80% of Covered Charges for Hospital and Facility – Outpatient Services provided by a non-PPO provider.

Section 2.20 – Infertility Services

The Plan covers infertility services received by a Participant or Dependent spouse (but not for a Dependent child). Examples of Infertility Services include artificial insemination, In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), Blastocyst Culture and transfer, and Transmyometrial Embryo Transfer (Towako).

The Plan will pay the following percentages for Infertility Services:

- For Infertility Services provided by a PPO Provider during a Physician's Office Visit, the Plan will pay 100% of Covered Charges (Deductibles do not apply).
- For Infertility Services provided by a PPO Provider at a Hospital or Facility, the Plan will pay 80% of Covered Charges after a Covered Person has met his Deductible.
- For Infertility Services provided by a non-PPO provider, the Plan will pay 60% of Covered Charges after a Covered Person has met his Deductible regardless of whether the services are provided during a Physician's Office Visit, at a Hospital, or at a Facility.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Infertility Services provided by a PPO Provider and 80% of Covered Charges for Infertility Services provided by a non-PPO provider regardless of whether the services are provided during a Physician's Office Visit, at a Hospital, or at a Facility.

The benefits in this Section are subject to a lifetime maximum of $4,000 per Covered Person.

The Plan does not cover reversals of voluntary sterilization. The Plan also does not cover Infertility Services for Dependent children.

Section 2.21 – Mammogram Services

The Plan covers one routine mammogram each calendar year. A mammogram is considered a routine mammogram if it is obtained as a diagnostic screening procedure (in other words, the Covered Person does not have any diagnosis or symptoms). The Plan will pay 100% of Covered Charges for a routine mammogram regardless of whether the mammogram is provided by a PPO Provider or a non-PPO provider.

The Plan also covers Medically Necessary (i.e. non-routine) mammograms. A mammogram is considered Medically Necessary if a Covered Person has any diagnosis other than screening, such as breast mass or nodes, tender or painful breasts, nipple discharge, or changes in the color, surface size and/or shape of the breast, skin, or nipple. After a Covered Person has met her Deductible, the Plan will pay 80% of Covered Charges for Medically Necessary mammograms provided by a PPO Provider and 60% of Covered Charges for Medically Necessary mammograms provided by a non-PPO provider. Once a Covered Person has met her Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Medically Necessary mammograms provided by a PPO Provider and 80% of Covered Charges for Medically Necessary mammograms provided by a non-PPO provider.

Section 2.22 – Maternity Services

The Plan covers maternity services received by a Covered Employee, a Retiree with Plan A Coverage, or a Dependent of a Covered Employee or a Retiree with Plan A Coverage (but not for a Retiree with Plan B Coverage or a Dependent of a Retiree with Plan B Coverage).

Maternity Services are services provided by a Physician in connection with pregnancy and childbirth, including treatment during the prenatal, delivery and post-partum periods. Services provided by a certified nurse midwife for obstetrical care are considered Maternity Services when the midwife is practicing under the direction and supervision of a Physician.

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

After a Covered Person has met her Deductible, the Plan will pay 80% of Covered Charges for Maternity Services provided by a PPO Provider and 60% of Covered Charges for Maternity Services provided by a non-PPO provider. Once a Covered Person has met her Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Maternity Services provided by a PPO Provider and 80% of Covered Charges for Maternity Services provided by a non-PPO provider.

Health Pregnancy Program

The Plan provides a free program to assist pregnant mothers throughout their pregnancy. This free program is called the Health Pregnancy Program and is available to Covered Employees, Retirees with Plan A Coverage, and Dependent's of Covered Employee's and Retiree's with Plan A Coverage (but not Retirees with Plan B Coverage and their Dependents). The Healthy Pregnancy Program provides education, assistance, and prenatal vitamins to pregnant mothers to help them have a healthy pregnancy which results in a healthy baby. To enroll in the program, please contact UnitedHealthcare at (800) 411-7984. You can enroll up to week 34 of your pregnancy. Information is also available at www.healthy-pregnancy.com.

The Plan does not cover Maternity Services for Retirees with Plan B Coverage and their Dependents. The Plan also does not provide the Healthy Pregnancy Program to Retirees with Plan B Coverage and their Dependents.

Section 2.23 – Nurse Practitioner Retail Clinic Visit

The Plan covers services and treatment received during a Nurse Practitioner Retail Clinic Visit (e.g. CVS MinuteClinics, Walgreens Take Care Clinics, Mercy Quick Clinics). The treatment and services covered under this Section includes exams, laboratory tests, and immunizations provided during the Nurse Practitioner Retail Clinic Visit.

The Plan will pay the following percentages for Nurse Practitioner Retail Clinic Visits:

- For Nurse Practitioner Retail Clinic Visits to a PPO Provider, the Plan will pay 100% of Covered Charges after a Covered Person has paid a $10 Copay (Deductibles do not apply).
- For Nurse Practitioner Retail Clinic Visits to a non-PPO provider, the Plan will pay 60% of Covered Charges after a Covered Person has met his Deductible.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will continue to pay 100% of Covered Charges after the $10 Copay for Nurse Practitioner Retail Clinic Visits to PPO Providers. The Plan will begin to pay 80% of Covered Charges for Nurse Practitioner Retail Clinic Visits to non-PPO providers.

Section 2.24 – Physician Office Visits

The Plan covers services and treatment (including diagnostic treatment but not including surgical treatment) received during a Physician Office Visit. The treatment and services covered under this Section includes treatment for mental health and substance abuse. It also includes Specialty Drugs (including IV infusion therapy) that are administered during the Physician Office Visit.

The Plan will pay the following percentages for Physician Office Visits:

- For Physician Office Visits to a PPO Provider, the Plan will pay 100% of Covered Charges after a Covered Person has paid a $20 Copay (Deductibles do not apply).
- For Physician Office Visits to a non-PPO provider, the Plan will pay 60% of Covered Charges after a Covered Person has met his Deductible.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will continue to pay 100% of Covered Charges after the $20 Copay for Physician Office Visits to PPO Providers. The Plan will begin to pay 80% of Covered Charges for Physician Office Visits to non-PPO providers.

NOTE: Surgical Services provided at a Physician's office are not covered under this Section. Refer to Section 2.28 for a description of coverage for surgical services.

Section 2.25 – Routine Physical Exams

The Plan covers Routine Physical Exams and services performed at and related to the Routine Physical Exam including routine immunizations, routine diagnostic tests, routine laboratory tests, routine radiology, routine pap smears, and routine Prostate Specific Antigen ("PSA") tests. The Plan will pay the following percentages for Routine Physical Examinations:

- For Routine Physical Examinations provided by a PPO Provider, the Plan will pay 100% of Covered Charges after a Covered Person has paid a $20 Copay (Deductibles do not apply).
- For Routine Physical Examinations provided by a non-PPO provider, the Plan will pay 60% of Covered Charges after a Covered Person has met his Deductible.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will continue to pay 100% of Covered Charges after the $20 Copay for Routine Physical Examinations provided by PPO Provider. The Plan will begin to pay 80% of Covered Charges for Routine Physical Examinations provided by a non-PPO provider.

Section 2.26 – Second Surgical Opinion

The Plan covers a second surgical opinion that is provided by a Physician to determine whether a proposed surgery is appropriate for the Covered Person's Sickness or Injury. The Plan will pay 100% of Covered Charges for a Second Surgical Opinion regardless of whether the opinion is provided by a PPO Provider or a non-PPO provider. An opinion from a Physician that performs the Covered Person's surgery is not considered a Second Surgical Opinion and is not covered under this Section.

Section 2.27 – Skilled Nursing Facility Services

The Plan covers treatment, room, and board at a Skilled Nursing Facility for up to 120 days per Sickness or Injury if all of the following criteria are met:

(a) A Physician certifies that the Skilled Nursing Facility Services are necessary for recovery from a Sickness or Injury;

(b) The confinement at the Skilled Nursing Facility begins within 14 days after a Hospital admission of at least three consecutive days; and

(c) The confinement at the Skilled Nursing Facility is for the Sickness or Injury that caused the Hospital admission.

For purposes of this Section's 120 day limit, any subsequent Sickness or Injury that results from or relates to the original Sickness or Injury is considered the same Sickness or Injury.

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Skilled Nursing Facility Services regardless of whether the services are provided by a PPO Provider or a non-PPO provider. After a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Skilled Nursing Facility Services provided by a PPO Provider. The Plan will continue to pay 80% of Covered Charges for Skilled Nursing Facility Services provided by a non-PPO provider.

NOTE: Although not required, the Trustees encourage you to have your provider contact UnitedHealthcare to request prior authorization before you receive Skilled Nursing Facility Services. Refer to Section 2.33 for instructions on how to obtain prior authorization.

Section 2.28 – Surgical Services

The Plan covers inpatient and outpatient surgical procedures provided by a Physician at a Physician's office, Facility, or Hospital. The Plan also covers services performed in connection with and related to covered surgical procedures including preoperative care, postoperative care and anesthesia.

The following covered Surgical Services are subject to special terms and conditions:

(a) Bariatric Surgery:

The Plan covers bariatric surgery when a Covered Person meets all of the following criteria:

- He is at least 18 years old;
- He has completed a six month Physician-supervised weight loss program;
- He has passed a pre-surgical psychological evaluation; and

He is morbidly obese. A Covered Person is considered morbidly obese if he has either (1) or (2) below:

(1) Class III obesity, (Body Mass Index (BMI) greater than 40 kg/m2); or

(2) Class II obesity (BMI of 35 to 39 kg/m2) in the presence of one or more of the following co-morbidities:

i. Type 2 diabetes;

ii. Cardiovascular disease (e.g. stroke, myocardial infarction, stable or unstable angina pectoris, hypertension or coronary artery bypass); or

iii. Life-threatening cardiopulmonary problems (e.g. severe sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy).

The Plan provides a free program to assist Covered Persons in determining whether they meet the criteria listed above. This free program is called the UnitedHealthcare Bariatric Program and is available to all Covered Persons. To utilize the program, please contact UnitedHealthcare at (888) 936-7246.

(b) Mastectomy Surgery:

The Plan covers mastectomies and related services in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA). If a Covered Person who is receiving benefits from the Plan in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, the Plan will provide coverage for the following treatments in a manner determined in consultation with the attending Physician and the patient:

(1) Reconstruction of a breast on which a mastectomy has been performed;

(2) Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance in a manner determined between the patient and the attending Physician; and

(3) Coverage for prostheses and physical complications of all states of mastectomy (including lymph edemas).

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Surgical Services provided by a PPO Provider and 60% of Covered Charges for Surgical Services provided by a non-PPO provider regardless of whether the services are provided during a Physician's Office Visit, at a Hospital, or at a Facility. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for surgical services provided by a PPO Provider and 80% of Covered Charges for surgical services provided by a non-PPO provider regardless of whether the services are provided during a Physician's Office Visit, at a Hospital, or at a Facility.

Section 2.29 – Therapy Services

The Plan covers physical therapy, occupational therapy, speech therapy, aquatic therapy, and massage therapy so long as the therapy is administered by a properly licensed or certified health care provider, is prescribed by a Physician, is Medically Necessary, is generally recognized as an appropriate and reasonable treatment by Physicians specializing in the area of medicine implicated by the treatment, and is designed and adapted to promote the restoration of a useful physical function that has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time.

After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for Therapy Services provided by a PPO Provider and 60% of Covered Charges for Therapy Services provided by a non-

PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Therapy Services provided by a PPO Provider and 80% of Covered Charges for Therapy Services provided by a non-PPO provider.

The Plan does not cover therapy provided for the treatment of developmental delay.

NOTE: Therapy services provided at a Covered Person's home in connection with home health care are not covered under this Section. Refer to Section 2.15 for a description of coverage for therapy services provided in connection with home health care.

Section 2.30 – Transplant Services

The Plan covers the following human-to-human organ or bone marrow transplant procedures and the services related to or resulting from such procedures:

- Heart;
- Heart/lung (simultaneous);
- Single and double lung;
- Liver;
- Kidney;
- Pancreas;
- Kidney/pancreas (simultaneous);
- Small bowel;
- Cornea;
- Skin; and
- Bone marrow transplant or peripheral stem cell infusion, including high dose chemotherapy, when a positive response to standard medical treatment or chemotherapy has been documented.

(a) Transplant Services covered under this Section include:

(1) Organ and tissue procurement consisting of the removal from a cadaver, preservation, storage, and transporting of the organ;

(2) Medically Necessary cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy;

(3) Charges incurred by the organ donor, if the charges are not covered by any other medical expense coverage;

(4) Travel and lodging expenses for the Covered Person and the Covered Person's travel companion if the transplant procedure is provided by a PPO Provider that is greater than 100 miles away from the Covered Person's home;

(5) One listing with the United Network of Organ Sharing (UNOS);

(6) Transplant consultations from two Physicians. A transplant consultation means a consultation provided by a transplant Physician to determine whether a Covered Person's condition is such that he qualifies for further evaluation; and

(7) Transplant evaluations. A transplant evaluation means services provided for the evaluation of organs and tissue, including but not limited to, the determination of tissue matches. These services include tests, labs, x-rays, and scans.

The Plan will pay the following percentages for Transplant Services:

- For travel and lodging expenses described in Section 2.30(a)(4) above, the Plan will pay 100% of Covered Charges (Deductibles do not apply).
- For Transplant Services described in Section 2.30(a)(6) above that are performed during a Physician Office Visit, the Plan will cover such services under Section 2.24.
- For all other Transplant Services covered under this Section, the Plan will pay 80% of Covered Charges for Transplant Services provided by a PPO Provider and 60% of Covered Charges for Transplant Services provided by a non-PPO provider after a Covered Person has met his Deductible.

Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for Transplant Services provided by a PPO Provider and 80% of Covered Charges for Transplant Services provided by a non-PPO provider.

(b) In addition to the items listed in Article VIII – Benefit Exclusions and Limitations, the Plan does not cover the following transplant-related services:

(1) Cryopreservation and storage, transportation and lodging, transplant consultations, and listings with the United Network of Organ Sharing (UNOS) except as specifically provided in Section 2.30(a) above;

(2) Transplant procedures (including the services related to such procedures) that are not listed at the beginning of this Section as well as complications arising from such procedures; and

(3) Animal organ or artificial organ transplants.

Section 2.31 – Well Child Care

The Plan covers well child care services including, physical examinations, immunizations, laboratory tests, pediatric preventative services, and hearing screening in accordance with the following schedule (i.e. these services are subject to the following frequency limitations):

- The Plan will cover seven Well Child Care visits from the time a child is born until the child's first birthday;
- The Plan will cover two Well Child Care visits from the day after the child's first birthday through the child's second birthday (i.e. the Plan will cover two visits while the child is one year old);
- The Plan will cover one Well Child Care visit per year from the day after the child's second birthday through the child's seventh birthday (i.e. the Plan will cover one visit per year while the child is two, three, four, five and six years old); and
- The Plan does not cover Well Child Care visits after the child's seventh birthday.

The Plan will pay 100% of Covered Charges for Well Child Care provided by a PPO Provider and 60% of Covered Charges for Well Child Care provided by a non-PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will continue to pay 100% of Covered Charges for Well Child Care provided by a PPO Provider and will begin to pay 80% of Covered Charges for Well Child Care provided by a non-PPO provider.

NOTE: Well child care services that exceed the frequency limitations listed above may be covered as a Routine Physical Exam. Refer to Section 2.25 for a description of coverage for Routine Physical Exams.

Section 2.32 – Wigs and Hair Prostheses

The Plan covers wigs and hair prostheses that are purchased for hair loss caused by cancer treatment. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for wigs and hair prostheses regardless of whether they are provided by a PPO Provider or a non-PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will begin to pay 100% of Covered Charges for wigs and hair prostheses provided by a PPO Provider. The Plan will continue to pay 80% of Covered Charges for wigs and hair prostheses provided by a non-PPO provider.

The benefits in this Section are subject to a lifetime maximum of $300 per Covered Person.

Section 2.33 – Prior Authorization

Prior Authorization is the process whereby your provider calls the Plan's case management vendor to get authorization to proceed with the intended medical treatment. This process assures that treatments are Medically Necessary and appropriate for your condition. The Plan has contracted with UnitedHealthcare to provide this service. **The phone number is (877) 440-8263 and can be found on the back of your identification card.**

While Prior Authorization is not required for medical treatment, the Trustees encourage you to have your provider contact UnitedHealthcare before you are admitted to the Hospital, undergo surgery, rent or purchase Durable Medical Equipment, or receive Therapy Services, Transplant Services, Home Health Care Services, Hospice Care Services or Skilled Nursing Facility Services. For Hospital admissions (other than a Medical Emergency), a Prior Authorization should be requested by your Physician prior to the day of admission to a Hospital.

The Trustees strongly encourage you to seek Prior Authorization for the following treatment and services:

- Cholecystectomy
- Bariatric Surgery
- Hysterectomy
- Laminectomy
- Marshall-Marchetti-Krantz
- Home Health Care Services
- Hospice Care Services
- Mastectomy
- Prostate Surgery
- Thyroidectomy
- Tonsillectomy
- Varicose Vein Surgery
- Transplant Services
- Durable Medical Equipment
- Skilled Nursing Facility Services
- Therapy Services

It is important to remember that Prior Authorization is not a prerequisite for receiving treatment. It is a service provided by the Plan to enable you to obtain an evaluation of whether a particular treatment will be covered by the Plan. If your provider requests prior authorization and is informed that the Plan will not pay for the treatment, you are still free to obtain the treatment and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted in your provider's request for Prior Authorization.

Section 2.34 – Exclusions and Limitations

In addition to any exclusions and limitations listed within this Article, Comprehensive Medical Benefits will not be payable for any items listed in Article VIII – Benefit Exclusions and Limitations.

Section 2.35 – Filing a Claim

Comprehensive Medical Benefit claims must be filed with UnitedHealthcare at the address shown on your identification card. PPO Providers and many other Hospitals, Facilities and Physicians will submit a claim to UnitedHealthcare on your behalf. If your health care provider does not submit a claim on your behalf, you must submit a claim form to UnitedHealthcare. You can submit the claim form in paper format using either your provider's form or a standard health claim form. Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com.

If this Plan is secondary, you or your provider should still file Comprehensive Medical Benefit claims with UnitedHealthcare at the address shown on your identification card. This includes any Medicare related claims that must be filed with this Plan.

ARTICLE III – PRESCRIPTION DRUG BENEFITS

The following topics are discussed under this Article on Prescription Drug Benefits:

PRESCRIPTION DRUG BENEFITS		
COVERAGE (PLAN PAYS)		
PRESCRIPTION DRUG TYPE	**WALK-IN RETAIL PHARMACY** (Up to a 34 Day Supply)	**MAIL ORDER PHARMACY** (Up to a 90 Day Supply)
GENERIC	100% after the greater of: 20% or $7 Copay	100% after $10 Copay
PREFERRED BRAND	100% after the greater of: 20% or $15 Copay *	100% after $10 Copay *
* If a generic equivalent is available, only the generic drug may be dispensed unless your Physician has indicated "Dispense as Written" on your prescription. In such cases you will be required to pay the applicable Copay plus the price difference between the generic drug and the preferred brand name drug.		
NON-PREFERRED BRAND	100% after the greater of: 25% or $30 Copay*	100% after $70 Copay *
* If a generic equivalent is available, only the generic drug may be dispensed unless your Physician has indicated "Dispense as Written" on your prescription. In such cases you will be required to pay the applicable Copay plus the price difference between the generic drug and the non-preferred brand name drug.		
SPECIALTY	100% after a $50 Copay *	100% after $50 Copay *
* Specialty drugs are limited to a 30 day supply.		

Section 3.01 – General Information

LDI is the pharmacy benefit manager that administers the prescription drug benefits. LDI provides a network of participating retail pharmacies and the mail order and specialty pharmacy program.

When a non-occupational Injury or Sickness causes a Covered Person to need prescription drugs, the Plan will pay benefits according to the above chart. Prescription drugs can be legally obtained only by the written prescription of a Physician. The Plan does not cover prescriptions filled at Wal-Mart and Sam's Club pharmacies.

Each prescription and each refill will be filled with a generic prescription drug if there is a generic equivalent available. If a generic equivalent is available, only the generic drug may be dispensed unless your Physician has indicated "Dispense as Written" on your prescription. In such cases you will be required to pay the

applicable Copay plus the price difference between the generic drug and the preferred or non-preferred brand name drug.

Section 3.02 – No Deductible and No Annual Out-of-Pocket Maximum

You do not have to meet a Deductible prior to receiving Prescription Drug Benefits, instead you will pay a Copay for each prescription. The Prescription Drug Benefits are separate from the Comprehensive Medical Benefits so the Covered Charges that you incur for prescription drugs do not count towards your Annual Out-of-Pocket Maximum.

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; and

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

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.

Section 3.04 – Specialty Drugs

Specialty Drugs are, in general, more expensive than non-specialty medications due to the cost of the ingredients to develop them. They are dispensed in 30-day (or less) quantities depending on FDA guidelines and are often not carried in stock at retail pharmacies.

Specialty Drugs include oral, injectable, infused or inhaled medications that are either self-administered or administered by a healthcare provider, and used or obtained in either an outpatient or home setting.

Injectable drugs including specialty oral medications shall encompass all medications, and biological, human or animal derived products or biosynthetic agents, including preparations that are sterile and pyrogen-free including, inhalation or implantation.

Specialty Drugs have the following key characteristics:

- More expensive than non-specialty medications;
- Need frequent dosage adjustments;
- Cause more severe side effects than traditional drugs;
- Need special storage, handling and/or administration;
- Have a narrow therapeutic range; and
- Require periodic laboratory or diagnostic testing.

Specialty Drugs are limited to a 30-day supply due to the nature of the drug and the need for dosage adjustments.

LDI provides a list of Specialty Drugs on their website. If you have questions regarding Specialty Drugs you can call LDI at (866) 516-4121 or visit www.LDIRx.com.

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, immunization agents 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;

(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; and

(r) Services and treatment excluded under Article VIII – Benefit Exclusions and Limitations.

Section 3.06 – Filing a Prescription Claim

The Plan provides a retail pharmacy program and a mail order pharmacy program. When you need a medication for a short time, for example an antibiotic, you should fill your prescription at a retail pharmacy. The Plan will provide up to a 34 day supply of medication per prescription through the retail pharmacy program.

The mail order pharmacy program is only available for medication that is necessary to treat a chronic or long-term Sickness or Injury, for example, medication to control blood pressure or cholesterol. The Plan will provide up to a 90 day supply of medication (except for Specialty Drugs which are limited to a 30 day supply) per prescription through the mail order pharmacy program.

(a) Retail Participating Pharmacy Purchases:

Participating retail pharmacies will submit a claim to LDI on your behalf.

If you buy your prescription drugs from a Participating Pharmacy, you should:

- Present your identification card to the pharmacist with your prescription each time you need to have a prescription filled or refilled;
- Sign the pharmacy claims voucher (the pharmacist will have this voucher); and
- pay the pharmacist only the Copay amount as described in the chart at the beginning of this Article.

To view a complete list of Participating Pharmacies, you may either visit the LDI website at: www.LDIRx.com or call LDI directly at (866) 516-3121.

(b) Retail Non-Participating Pharmacy Purchases:

If you buy your prescription drugs from a retail pharmacy that is not a Participating Pharmacy, you should:

- Pay the pharmacist the entire cost of the prescription;
- Get a special claim form for prescription drugs from Wilson-McShane Corporation or at the website www.ibew347benefits.com;
- Complete your portion of the claim form and ask the pharmacist to complete the pharmacist portion; and
- Mail the completed form to LDI at the address shown on page 1 of this Summary Plan Description.

If you buy your prescription drugs at a non-participating retail pharmacy, the Plan will only reimburse you the amount that the Plan would have paid for the prescription if it was filled at a Participating Pharmacy, minus your Copay. This means you will likely pay a higher amount because you will no longer have the advantage of the discounts available through Participating Pharmacies. No benefits will be paid for prescriptions purchased at Wal-Mart or Sam's Club.

(c) Mail Service Purchases

If you order your prescription using the mail order program your initial order consists of three parts: 1) the written prescription from your Physician; 2) a claim form; and 3) a Copay. You should allow 14 days for your order to be completed and shipped to you. All orders are mailed either by express mail or First Class U.S. Mail. If you wish to have your order shipped by express mail, you will need to pay the extra cost.

Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com. If you have a question concerning medication or a particular order, you can call the pharmacy customer service toll free at (866) 516-3121. You can also visit the LDI website at www.LDIRx.com.

(d) Specialty Drug Purchases

If you order your prescription using the specialty drug service your initial order consists of three parts: 1) the written prescription from your Physician; 2) a claim form; and 3) a Copay. You should allow 14 days for your order to be completed and shipped to you. All orders are mailed either by express mail or First Class U.S. Mail. If you wish to have your order shipped by express mail, you will need to pay the extra cost.

Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com. A list of Specialty Drugs is available at the website www.LDIRx.com. If you have questions regarding Specialty Drugs you can call the specialty services at LDI at (866) 516-4121 or visit www.LDIRx.com. Providers can fax your prescription directly to (314) 652-1126.

ARTICLE IV – DENTAL BENEFITS

The following topics are discussed under this Article on Dental Benefits:

DENTAL BENEFITS	
SERVICE	**COVERAGE (PLAN PAYS)**
Preventive – Dental Care Unit 1 **Basic – Dental Care Unit 2** **Major – Dental Care Unit 3** **Amelogenesis Imperfecta**	100% up to Maximum Plan Payment Limit, after $10 Copay
Dental Implants (not due to a congenital defect)	50% up to Maximum Plan Payment Limit
Maximum Plan Payment Limit: ▪ Dental Care Units 1, 2, 3 and Amelogenesis Imperfecta (combined) ..... $ 2,500 per calendar year ▪ Amelogenesis Imperfecta (on permanent teeth) ..... $ 15,000 per lifetime ▪ Dental Implants (not due to a congenital defect) ..... $ 5,000 per lifetime	
Maximum Payment Limits for Dental Care Units 1, 2 and 3 and for Amelogenesis Imperfecta do not apply to Covered Persons under age 19. The Maximum Payment Limit for Dental Implants applies to all Covered Persons regardless of age.	

Section 4.01 – Eligibility for Dental Benefits

The Dental Benefits in this Article IV are available for Covered Employees, Retirees with Plan A Coverage, Dependents of Covered Employees and Dependents of Retirees with Plan A Coverage. The Dental Benefits in this Article IV are not available for Retirees with Plan B Coverage or their Dependents.

Section 4.02 – General Information

The Fund offers the Delta Dental of Iowa network of Dentists. Delta Dental of Iowa contracts with these Dentists to offer Dental services to you at reduced rates. The Dentists in this network are called Participating Dentists. You are not required to use a Participating Dentist. However, if you use a Participating Dentist, you will not have to pay charges that exceed the Prevailing Charge.

The Plan specifically excludes payment for any part of a charge for treatment that exceeds the Prevailing Charge. When you receive services from a Participating Dentist, you will not be billed for more than the total Prevailing Charge. If you do not use a Participating Dentist, that Dentist could bill for more than the total Prevailing Charge. This means that if you do not use a Participating Dentist, you will have to pay the amount that exceeds the Prevailing Charge in addition to the Copay.

Whether you use a Participating Dentist or a non-participating Dentist, Covered Charges will be the actual cost submitted by your Dentist for treatment, but not more than the Prevailing Charge and not more than the cost of

an alternative procedure that is equally effective. For example, if you prefer a porcelain crown or a white filling when a silver crown or filling would be equally effective, the Plan will pay up to the cost for the silver crown or filling and you would be responsible for the difference. If you receive treatment which is more costly than those equally effective for the treatment or maintenance of your teeth and supporting structures, you are responsible for paying the difference.

When charges for a period of dental treatment (other than emergency treatment) are expected to exceed $200, you may file a dental treatment plan with Delta Dental of Iowa before treatment begins. A period of dental treatment means all sessions of dental care that result from the same initial diagnosis and any related complications. Delta Dental of Iowa will provide you and your Dentist with a form for this purpose. Delta Dental of Iowa will indicate the benefits payable for the proposed treatment and return the form to the attending Dentist. It is important to remember that filing a dental treatment plan is not a prerequisite for receiving Dental Benefits. It is a service provided by the Plan to enable you to obtain an evaluation whether a particular benefit will be covered by the Plan. If you are informed that benefits will not be payable for the proposed treatment, you are still free to obtain the treatment and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted with the dental treatment plan.

You do not have to meet a Deductible prior to receiving Dental Benefits. The Dental Benefits are separate from the Comprehensive Medical Benefits so the Covered Charges that you incur for Dental Benefits do not count towards your Annual Out-of-Pocket Maximum.

Section 4.03 – Covered Dental Services

The Plan pays for the Covered Dental Services listed in this Section at 100% after satisfaction of the $10 Copay per visit. For Covered Persons age 19 and older, the maximum amount payable in any calendar year for Preventive Procedures (i.e. Dental Care Unit 1), Basic Procedures (i.e. Dental Care Unit 2), Major Procedures (i.e. Dental Care Unit 3) and Amelogenesis Imperfecta combined is $2,500. The $2,500 benefit limit does not apply to Covered Persons under age 19.

(a) Preventive Procedures - Dental Care Unit 1

(1) Examinations
Oral Examinations - Only one oral examination (other than an emergency examination) will be covered each six month period.

(2) Radiographs

- *Intraoral X-Rays:*
    - Complete series or panoramic - Covered once each three year period;
    - Bitewing - Only one set will be covered each six month period (limited to four films per set);
    - Occlusal; and
    - Periapical

- *Extraoral X-Rays – Only one of the extraoral procedures listed below will be covered each six month period:*
    - Sialography;
    - Cephalometric film;
    - Temporomandibular Disease (TMD) (to diagnose condition only; treatment related to TMD is not a Covered Charge);

- Posterior/anterior and lateral skull and facial bone survey; or
- Other extraoral

(3) Other Services

- Prophylaxis (cleaning of teeth) - Two cleanings per calendar year combined with cleanings under Periodontic Services
- Topical application of fluoride - Applicable only to Dependent children. Only one application will be covered each 12 month period
- Space maintainers - Applicable only to Dependent children under age 14
- Topical application of sealants - Applicable only to Dependent children under age 14; covered once each quadrant in each four year period
- Biopsy of oral tissue
- Palliative treatment - Covered as a separate procedure only if no other treatment (except x-rays) is provided during the visit
- Bacteriologic culture
- Histopathologic examination
- Pulp vitality test
- Diagnostic cast - Covered once each two year period

(b) Basic Procedures - Dental Care Unit 2

(1) Restorations

- Fillings (amalgam, silicate, plastic or composite, including pin retention when necessary)
- Stainless steel crown
- Gold foil
- Gold inlays and onlays - Gold restorations are covered only if the tooth cannot be restored by a silver filling and (for replacements) at least five years have elapsed since the last placement
- Porcelain inlay
- Crowns (single restorations only) - Crowns are covered only if the tooth cannot be restored by a filling and (for replacement) at least five years have elapsed since the last replacement. Crowns for the primary purpose of periodontal splinting, altering vertical dimension, and restoring occlusion or due to erosion, abrasion, attrition and abfraction are not covered.
  - Plastic (acrylic)
  - Plastic, prefabricated
  - Plastic with non-precious metal
  - Plastic with semi-precious metal
  - Plastic with gold
  - Porcelain

- Porcelain with non-precious metal
- Porcelain with semi-precious metal
- Porcelain with gold
- Gold (3/4 cast)
- Gold (full cast)
- Nonprecious metal (full cast)
- Semiprecious metal (full cast)

- Cast post and core - Covered only for teeth that have had root canal therapy
- Steel post and composite or amalgam

(2) Oral Surgery

- Extraction of teeth
- Alveoloplasty
- Removal of dental cysts and tumors
- Surgical incision and drainage of dental abscess

NOTE: Oral surgery that is required for the treatment of diseases of the teeth, jaw, or gums is not covered under this Section. Refer to Section 2.12 for a description of coverage for oral surgery that is required for the treatment of diseases of the teeth, jaw or gums.

(3) Periodontic Services

- Surgical procedures - Only one of the listed periodontic surgical procedures is covered for each quadrant in a 12 month period:
  - Gingivectomy
  - Osseous surgery
  - Gingival curettage
  - Osseous graft
- Scaling and root planing (each quadrant) - Once each quadrant each six month period.
- Periodontal appliance - One appliance each three year period.
- Periodontal prophylaxis - Two cleanings per calendar year combined with cleanings under Preventive Procedures.

(4) Endodontic Services

- Pulp cap
- Vital pulpotomy
- Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures and follow-up care.
- Apexification
- Apicoectomy*

- Retrograde filling*
- Apical curettage
- Root resection
- Hemisection

* Apicoectomy and retrograde filling covered as a separate procedure only if performed more than one year after the root canal therapy is completed.

(5) Anesthesia

General anesthesia – Covered Charges for Medically Necessary treatment provided by a professional anesthetist or anesthesiologist are payable when the treatment is provided at a medical or dental Facility or Hospital and is supervised by a Physician or Dentist in connection with Dental services that are covered by the Plan.

(c) Major Procedures - Dental Care Unit 3

(1) Prosthodontics – Fixed

Fixed bridges - initial placement or replacement

The Plan covers the initial placement of fixed bridges that are required to replace missing teeth. The Plan also covers the replacement of fixed bridges if the original bridge cannot be made serviceable and five years have elapsed since the last placement.

(2) Prosthodontics – Removable

Full or partial dentures - initial placement or replacement

The Plan covers the initial placement of full or partial removable dentures that are required to replace missing teeth. The Plan also covers the replacement of full or partial removable dentures if the existing denture cannot be made serviceable and five years have elapsed since the last placement. The Plan does not cover charges for overdentures or for precision or semi-precision attachments.

Section 4.04 – Dental Implants

The Plan pays 50% of the Prevailing Charge for dental implants that are required for a reason other than a congenital defect up to a maximum of $5,000 per Covered Person per lifetime. You are responsible for the remaining 50% of the Prevailing Charge as well as any charges that exceed $5,000. Dental Implants are not considered Preventive Procedures, Basic Procedures or Major Procedures as described above. Accordingly, the charges incurred for dental implants do not count towards your $2,500 maximum per year.

NOTE: Refer to Section 2.11 for a description of coverage for dental implants that are required to correct or improve a congenital defect that cannot be corrected or improved by an alternative treatment. The benefits provided under Section 2.11 are in addition to the benefits provided in this Section and will not count towards this Section's $5,000 lifetime maximum.

Section 4.05 – Amelogenesis Imperfecta

The Plan pays for Amelogenesis Imperfecta at 100% after satisfaction of the $10 Copay per visit. The maximum payable per Covered Person per lifetime is $15,000. For Covered Persons age 19 and older, the maximum payable in any calendar year for Preventive Procedures (i.e. Dental Care Unit 1), Basic Procedures (i.e. Dental Care Unit 2), Major Procedures (i.e. Dental Care Unit 3) and Amelogenesis Imperfecta combined is $2,500. The benefit limits do not apply to Covered Persons under age 19.

Section 4.06 – Dental Benefit Exclusions and Limitations
Dental Benefits will not be payable for:

(a) Treatment by any person who is not a Dentist or dental hygienist except as specifically provided in this Article;

(b) Any treatment that is primarily Cosmetic, including personalization of dentures or crowns and teeth whitening;

(c) Any procedure that does not have uniform professional endorsement;

(d) Bite registration or occlusal analysis;

(e) Treatment to alter vertical dimension or restore occlusion;

(f) Treatment for the purpose of duplicating a prosthetic device or appliance or replacing any such device that is lost or stolen;

(g) Orthodontic treatment;

(h) Treatment covered under Article II – Comprehensive Medical Benefits;

(i) Charges in excess of the Maximum Plan Payment Limits listed in the chart at the beginning of this Article;

(j) Charges for treatment that exceeds the least expensive equally effective treatment; and

(k) Services and treatment excluded under Article VIII – Benefit Exclusions and Limitations.

Section 4.07 – Filing a Claim
Dental Benefit claims must be filed with Delta Dental of Iowa at the address listed below. Participating Dentists and many other Dentists will submit a claim to Delta Dental on your behalf. If your Dentist does not submit a claim on your behalf, you must submit a claim form to Delta Dental of Iowa within 12 months from the date of service. The claim form must contain the following information: the Participant's name, the Participant's ID number, the patient's name and date of birth, the date of service, the name and address of the provider who performed the treatment and an itemized list of the treatment received. You must file Dental Benefit claims on Delta Dental's claim forms which are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com. The completed claim form and receipt should be mailed to the following address:

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000

For more information or to locate a Participating Dentist please visit Delta Dental's website at www.deltadentalia.com or call Delta Dental directly at (800) 544-0718.

ARTICLE V – VISION BENEFITS

The following topics are discussed under this Article on Vision Benefits:

VISION BENEFITS			
COVERAGE (PLAN PAYS)			
BENEFIT	**FREQUENCY ALLOWED**	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Examination	Once Per Calendar Year	100% after $10 Copay	100% after $10 Copay to a maximum of $50
Single Vision Lenses (pair)	Once Every Other Calendar Year	100% after $20 Copay	100% after $20 Copay to a maximum of $50
Lined Bifocal Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $75
Lined Trifocal Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $100
Lined Lenticular Lenses (pair)		100% after $20 Copay	100% after $20 Copay to a maximum of $125
Frames	Once Every Other Calendar Year	100% after $20 Copay to a maximum of $120 plus 20% off any out-of-pocket expense	100% after $20 Copay to a maximum of $70
Elective Contact Lenses/Evaluation/ Fitting	Once Every Other Calendar Year as a substitute for all other lens and frames benefits	100% to a maximum of $120	100% to a maximum of $105
Medically Necessary Contact Lenses/Evaluation/Fitting	Once Every Other Calendar Year as a substitute for all other lens and frames benefits	100% after $20 Copay	100% after $20 Copay to a maximum of $210

Section 5.01 – Vision Benefits

The Fund offers the Vision Service Plan ("VSP") network of vision care providers. The doctors in this network are called Preferred Providers. If your doctor is a Preferred Provider and you inform him that you are a VSP member before your appointment, you will receive Vision Benefits in accordance with the column in the chart above titled, "PREFERRED PROVIDER". If your doctor is a non-preferred provider or you do not inform your doctor that you are a VSP member prior to your appointment, you will receive Vision Benefits in accordance with the column in the chart above titled, "NON-PREFERRED PROVIDER."

BE SURE YOUR VISION PROVIDER KNOWS YOU PARTICIPATE IN THE VSP NETWORK WHEN YOU CALL TO MAKE AN APPOINTMENT.

IN ORDER TO RECEIVE PREFERRED PROVIDER BENEFITS, YOUR PROVIDER MUST BE AWARE OF YOUR VISION NETWORK PRIOR TO RENDERING SERVICES.

Section 5.02 – Covered Vision Services

The Plan will pay for the following services and supplies subject to the maximum amounts indicated on the chart at the beginning of this Article:

- Eye Exams – available once every calendar year.
- Lenses – including single, bifocal, trifocal or lenticular lenses, available once every other calendar year.
- Frames – available once every other calendar year. If you choose frames that exceed the benefit maximum indicated on the chart at the beginning of this Article, you will be responsible for the additional amount. If you have Laser Vision Correction, you may be allowed to purchase sunglasses from a Preferred Provider as a substitute for all other frames.
- Elective Contact Lenses – available once every other calendar year as a substitute for all other lenses and frames (i.e. if you obtain contact lenses you will not be eligible for spectacle lenses or frames again for two years). If you choose contact lenses for any purpose other than the Medically Necessary circumstances described below, they are considered elective contact lenses. Elective contact lenses must contain a prescription to be covered under the Plan (i.e. contact lenses used solely for the purpose of changing your eye color are not covered by the Plan). If you choose lenses that exceed the benefit maximum indicated on the chart at the beginning of this Article, you will be responsible for the additional amount.
- Medically Necessary Contact Lenses – available once every other calendar year as a substitute for all other lenses and frames (i.e. if you obtain contact lenses you will not be eligible for spectacle lenses or frames again for two years). If you must wear contact lenses to correct vision problems that cannot be corrected with prescription glasses, they are considered Medically Necessary.

Low Vision Benefit

In addition to the above treatments, low vision benefits are available for severe visual problems that are not correctable with regular lenses. The Plan will pay 100% of Covered Charges for supplementary testing from a Preferred Provider and 100% of Covered Charges up to a maximum of $125 from a non-preferred provider. The Plan will pay 75% of Covered Charges for supplemental care aids up to a maximum of $1,000 per Covered Person every two years.

Section 5.03 – Discounts Available from Preferred Providers

When you use a Preferred Provider, you will receive discounts on the following items that are not covered by the Plan:

(a) 20% off charges for frames that exceed the $120 frame allowance;

(b) Average 35-40% savings on all non-covered lens options;

(c) 30% off additional prescription glasses and sunglasses, including lens options, from the same Preferred Provider on the same day as your exam. Or get 20% off from any Preferred Provider within 12 months of your last exam;

(d) 15% off the cost of a contact lens exam (fitting and evaluation); and

(e) 15% off the regular price of Laser Vision Correction or 5% off the promotional price. Discounts are only available from contracted VSP Facilities. Please contact VSP at (800) 877-7195 to learn more prior to making an appointment. The discount for Laser Vision Correction is only available for a Participant or his Dependent spouse and is not available for Dependent children.

Section 5.04 – Vision Benefit Exclusions and Limitations

Vision Benefits will not be payable for:

(a) Special/unusual procedures, including but not limited to orthoptics or vision training and any associated supplemental testing, plano lenses (less than a ± .50 diopter power) or two pairs of glasses in lieu of bifocals;

(b) Extra charges for glasses with special lenses, including but not limited to tinted lenses, coated lenses, UV protected lenses, and Cosmetic lenses, unless they are prescribed by an optometrist or ophthalmologist as Medically Necessary;

(c) Replacement of lenses and frames which are lost or broken except at the normal intervals as described in the chart at the beginning of this Article;

(d) Medical or surgical treatment of the eyes;

(e) Charges in excess of the benefit maximums listed in the chart at the beginning of this Article; and

(f) Services and treatment excluded under Article VIII – Benefit Exclusions and Limitations.

Section 5.05 – Filing a Claim

If your doctor is a Preferred Provider, it is important that you inform his office that you are a VSP member before your appointment. When you go to your doctor's appointment, you will need to pay the Preferred Provider your $10 examination Copay and your $20 Copay for supplies (e.g. frames, lenses), if applicable. VSP will pay the Preferred Provider directly for the balance of the Covered Charges. If you receive any treatment that is not covered by the Plan, you will need to arrange for payment of the treatment with your doctor, and the cost of the treatment will be your responsibility.

If your doctor is a non-preferred provider, you will need to pay for all services and supplies at the time you receive them and submit a claim form with the following information within 12 months from the date treatment was provided:

- An itemized paid receipt listing the treatment received;
- The name, address and phone number of the non-preferred provider;
- The Participant's I.D. number;
- The Participant's name, phone number and address;
- The name of the organization that provides your VSP coverage;
- The patient's name, date of birth, phone number and address; and
- The patient's relationship to the Participant (such as "self," "spouse," "child").

VSP will deduct your Copay from your reimbursement request prior to applying the Covered Charges for the treatment. Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com. The mailing address for VSP claim forms is:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

To locate a Preferred Provider, you can visit VSP's website at www.vsp.com. If you should have questions regarding vision benefits, please contact VSP directly at (800) 877-7195.

ARTICLE VI – DEATH BENEFIT

The following topic is discussed under this Article on the Plan's Death Benefit:

6.01. Death Benefit

DEATH BENEFIT
The Designated Beneficiary of the Death Benefit Participant may receive a Death Benefit in the amount of $25,000.

Section 6.01 – Death Benefit

The Death Benefits in this Article are only available for the death of a Death Benefit Participant. The Death Benefits in this Article are not available for the death of a Dependent, qualified beneficiary (i.e. individual covered by COBRA), or surviving spouse.

If a Death Benefit Participant dies after March 1, 2007, the Designated Beneficiary of the Death Benefit Participant may receive a Death Benefit in the amount of $25,000 in accordance with the following rules:

(a) Death Benefit Participant means any of the following individuals:

(1) A Participant (i.e. a Covered Employee or Retiree); or

(2) An Employee or former Employee who is not a Participant in the Plan and meets all of the following criteria:

i. He was participating in the IBEW Local 347 Death Benefit Plan on a self-pay basis on February 28, 2007;

ii. He was not participating in this Plan on February 28, 2007;

iii. He has not been eligible for coverage from this Plan (either as an Eligible Employee or Retiree) at any time since March 1, 2007;

iv. He has been a Death Benefit Participant at all times since March 1, 2007 (i.e. his status as a Death Benefit Participant has not ever been terminated); and

v. He self-pays the Death Benefit Premium in accordance with Section 6.01(b).

(b) If you are a Death Benefit Participant in accordance with Section 6.01(a)(2) above (i.e. you are a Death Benefit Participant but you are not a Participant in the Plan), you must pay the death benefit premium each month. The dollar amount of the death benefit premium is established by the Board of Trustees. The Board of Trustees has the authority to establish and change the death benefit premium as it may deem appropriate in its sole and exclusive discretion.

The death benefit premium is due on the first day of each month. Unless there are extenuating circumstances as determined solely by the Plan Administrator and/or the Board of Trustees, your status as a Death Benefit Participant will be terminated if the death benefit premium is not received by the Fund Office by the fifth business day of the month. If your status as a Death Benefit Participant is

terminated because you failed to pay the death benefit premium on time, your status as a Death Benefit Participant may not be reinstated unless you become covered under the Plan as a Covered Employee in accordance with Section 1.02 or Section 1.15, as applicable.

(c) If you are a Death Benefit Participant, you may designate a Beneficiary in writing on the Plan's Beneficiary Designation Form and you may change or revoke the Beneficiary designation at any time prior to your death. A Beneficiary Designation Form shall be effective only when filed (that is, received by) the Plan Administrator prior to the death of the Death Benefit Participant. If you are a Death Benefit Participant who was participating in the IBEW Local 347 Death Benefit Plan on February 28, 2007, and you designated a Beneficiary in writing on the IBEW Local 347 Death Benefit Plan's Beneficiary Designation Form, the Beneficiary designation made for the IBEW Local 347 Death Benefit Plan will remain in effect under this Plan. **Notwithstanding the foregoing, if you are a Death Benefit Participant and you designate your spouse as your Beneficiary, the Beneficiary designation shall automatically become null and void upon divorce. If you get divorced and you want your ex-spouse to remain your Designated Beneficiary, you must file a new Beneficiary Designation Form with the Plan Administrator after your divorce.** In the event you designate your spouse and another individual as your Designated Beneficiaries, only the portion of the Beneficiary Designation that relates to your spouse will automatically become null and void upon divorce. For example, if your Beneficiary Designation Form lists both your spouse and your son as your primary Designated Beneficiaries, and you die while you are still married, they will each receive $12,500 (50% of the Death Benefit). If you get divorced, you do not file a new Beneficiary Designation Form with the Plan Administrator, and then you die, your son will receive $25,000 (100% of the Death Benefit).

(d) In any circumstance in which a representative of the Plan reasonably questions the validity of a Beneficiary designation, including all circumstances when a Beneficiary Designation Form is presented to the Plan Administrator by any person other than the Death Benefit Participant, the Plan Administrator may request additional information to prove the validity of the Beneficiary designation, and may refuse to recognize the Beneficiary designation until satisfactory proof of validity has been provided. In the event no satisfactory proof of validity is provided within the time designated by the Plan Administrator (which shall be no less than 45 days), or in any instance in which the Plan Administrator reasonably determines within 30 days after receiving a Beneficiary Designation Form or revocation thereof, that a Beneficiary designation is unclear or impractical to apply, the Plan Administrator may reject such Beneficiary Designation Form or revocation.

(e) If you are a Death Benefit Participant and you die without having validly designated a Beneficiary to receive your Death Benefit, or if your Designated Beneficiary predeceases you, the first of the following who survives you shall be the Designated Beneficiary:

(1) Your spouse;

(2) Your descendants, per stirpes;

(3) Your parents, in equal shares;

(4) Your siblings, in equal shares; or

(5) Your estate.

If you designate your spouse as your sole Beneficiary, and the Beneficiary designation becomes null and void in accordance with Section 6.01(c) above, you will be treated as though you died without having validly designated a Beneficiary unless you file a new Beneficiary Designation Form with the Plan Administrator before your death.

(f) If a Death Benefit Participant designates more than one Beneficiary without specifying their respective interests, the Death Benefit will be paid in equal shares.

ARTICLE VII – SHORT-TERM DISABILITY BENEFITS

The following topic is discussed under this Article on Short-Term Disability Benefits:

7.01. Short-Term Disability Benefits

SHORT-TERM DISABILITY BENEFITS
Covered Employees may receive Short-Term Disability Benefits during any period that the Covered Employee is not retired and is unable to work for at least one week due to an Injury or Sickness. The maximum Short-Term Disability Benefit is $500 gross amount per week for a maximum of 26 weeks.

Section 7.01 – Short-Term Disability Benefits

The Short-Term Disability Benefits in this Article are only available for Covered Employees. The Short-Term Disability Benefits in this Article are not available for Retirees, Dependents, qualified beneficiaries (i.e. individuals covered by COBRA), or surviving spouses.

Covered Employees may receive Short-Term Disability Benefits during any period that the Covered Employee is not retired and is unable to work for at least one week due to an Injury or Sickness in accordance with the following rules:

(a) The maximum Short-Term Disability Benefit you may receive is $500 gross amount per week for a maximum of 26 weeks. The weekly benefit is calculated on a seven calendar day period beginning with the first day of a "Period of Disability" (in other words, beginning with the first day that you are unable to work due to a covered Injury or Sickness). The first day of any Period of Disability will never be considered to be more than three calendar days prior to the date on which the Covered Employee was first seen by a Physician for the Injury or Sickness causing the disability. If a Period of Disability lasts less than 26 weeks, but ends with a partial week (for example, if your Period of Disability lasts for 20 days), you will receive a partial week's credit for the number of days you were unable to work in the final week based on the weekly rate divided by seven. For example, if you are unable to work for 20 days, you will get $500 per week for each of the first two weeks and then will be paid $428.57 ($71.43 per day) for the final partial week (the final six days).

(b) A Period of Disability is the total amount of time that you are completely unable to perform any work in your own occupation due to an Injury or Sickness. If you are unable to work after your initial Period of Disability, any subsequent Short-Term Disability Benefits will be paid as follows:

    (1) Reoccurring Disability: If the subsequent disability is a "reoccurring disability," you will be treated as if your initial Period of Disability had not ended (except that you will not be entitled to any Short-Term Disability Benefits for the time between the date you stopped receiving Short-Term Disability Benefits and the date that you are subsequently unable to work due to an Injury or Sickness). This means that if you already received Short-Term Disability Benefits for 26 weeks, you will not be entitled to any additional Short-Term Disability Benefits. If you have not already received Short-Term Disability Benefits for 26 weeks, you may receive Short-Term Disability Benefits for a maximum period of time equal to 26 weeks minus the number of weeks that you have already received Short-Term Disability Benefits.

For purposes of this Section 7.01, your disability will be considered a reoccurring disability if both of the following conditions are met:

i. You are completely unable to perform any work in your own occupation due to an Injury or Sickness that is the same as or related to the Injury or Sickness that rendered you unable to work during your initial Period of Disability; and

ii. You have not worked in Covered Employment for at least 40 hours after your initial Period of Disability.

(2) Separate Disability: If the subsequent disability is a "separate disability," a second separate Period of Disability will begin and you may receive a maximum of 26 additional weeks of Short-Term Disability Benefits (provided all of the criteria of this Section 7.01 are met). This means that you may receive Short-Term Disability Benefits for a maximum of 26 weeks, regardless of the duration of your initial Period of Disability. For purposes of this Section 7.01, your disability will be considered a separate disability if one of the following conditions is met:

i. You are completely unable to perform any work in your own occupation due to an Injury or Sickness that is unrelated to the Injury or Sickness that rendered you unable to work during your initial Period of Disability; or

ii. You have returned to and actually worked in Covered Employment for at least 40 hours after your initial Period of Disability.

(c) No Short-Term Disability Benefits will be paid under this Plan for:

(1) Any period during which you are disabled as a direct result of an intentionally self-inflicted Injury, unless such Injury or disability was the result of any physical or mental health condition;

(2) Any Period of Disability caused by an Injury or Sickness that was contracted, suffered or incurred while you were engaged in, or that results from your engagement in, a felonious act or enterprise;

(3) Any Period of Disability caused by an Injury or Sickness for which you have received or are entitled to receive compensation under any program of Workers Compensation, occupational disease law or related program;

(4) Any Period of Disability that lasts less than seven consecutive days;

(5) Any period during which you are engaged in any gainful employment;

(6) Any period during which you are receiving unemployment insurance and/or compensation payments;

(7) Any period during which you are receiving Social Security Disability Benefits;

(8) Any period during which you are receiving benefits from the National Electrical Benefit Fund;

(9) Any period during which you are not under the regular care of a Physician; or

(10) Any Period of Disability that lasts longer than 26 weeks (i.e. the Plan will only pay Short-Term Disability Benefits for a maximum of 26 weeks for a Period of Disability).

(d) To become eligible to receive Short-Term Disability Benefits, you must provide the Plan Administrator proof that you are unable to work due to an Injury or Sickness. You may also be required to periodically submit proof that you are still unable to work due to an Injury or Sickness throughout your Period of Disability. If you are receiving Short-Term Disability Benefits in accordance with this Section 7.01, you must notify the Fund Office prior to or immediately upon the occurrence of one of the events listed in (1), (2), (3), (4), or (5) below as follows:

(1) You must provide written notice to the Fund Office before engaging in any employment;

(2) You must provide written notice to the Fund Office prior to the date you receive unemployment insurance and/or compensation payments;

(3) You must provide written notice to the Fund Office prior to the date you receive Social Security Disability Benefits;

(4) You must provide written notice to the Fund Office prior to the date you receive benefits from the National Electrical Benefit Fund; or

(5) You must provide written notice to the Fund Office on the date a Physician determines that you are no longer unable to work because of an Injury or Sickness.

Failure to provide notification in accordance with this Section 7.01(d) could result in an overpayment of benefits that you will be required to repay in accordance with Section 13.18. You may also be responsible for additional costs incurred by the Plan to recover the overpayment.

(e) If you are a Covered Employee, you will receive one Monthly Premium credit per month for each month that you meet the following requirements:

(1) You are absent from work for at least two consecutive weeks because you are totally unable to work due to an Injury or Sickness; and

(2) You are receiving Short-Term Disability Benefits from this Plan or you are receiving benefits under Workers Compensation (or similar law or program) during the period that you are unable to work.

The Monthly Premium credit will equal the Monthly Premium in effect for the third month following the month that you were unable to work. The Monthly Premium credit will be applied on the first day of the third month following the month that you were unable to work. This means that you will be covered under the Plan during the third month following the month that you were unable to work regardless of the amount of contributions in your Dollar Bank.

Benefits paid based on any type of partial disability will not qualify you for the Monthly Premium credit.

ARTICLE VIII – BENEFIT EXCLUSIONS AND LIMITATIONS

The following topic is discussed under this Article on Benefit Exclusions and Limitations:

8.01. Benefit Exclusions and Limitations

Section 8.01 – Benefit Exclusions and Limitations

In addition to any other exclusions and limitations set forth in the Plan, benefits are **NOT** payable for any charge incurred for or resulting from:

(a) Treatment that is not Medically Necessary except as specifically provided for in the Plan;

(b) Any part of a charge for treatment that exceeds Prevailing Charges;

(c) Treatment that is Experimental, Investigational or does not meet accepted standards of medical practice;

(d) Dental services, except as specifically provided for in Article II – Comprehensive Medical Benefits and Article IV – Dental Benefits;

(e) Vision services, except when provided for the treatment of a disease, or as specifically provided for in Article V – Vision Benefits;

(f) Hearing aids and hearing aid batteries;

(g) Acupuncture or acupressure treatment;

(h) Equipment and supplies that serves as a convenience item such as sporting equipment, athletic equipment, posture chairs, whirlpool tubs, elevators, and dehumidifiers;

(i) Cosmetic treatment or complications arising from cosmetic treatment except:

1) As specifically provided for under Article III - Prescription Drug Benefits; or

2) When the treatment results from a Sickness or Injury, and the treatment is completed within 12 months after the date of such Sickness or Injury;

(j) Treatment due to any form of temporomandibular joint disorder (malfunction, degeneration or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances or surgery of any type;

(k) Kerato-Refractive eye treatment;

(l) Treatment for educational or training problems, learning disorders, developmental delays, marital counseling, family counseling or social counseling except as specifically provided for under Section 2.15, Section 2.16, or Section 2.29;

(m) Treatment for which a Covered Person has no financial liability or that would be provided at no charge in the absence of coverage;

(n) Treatment that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law);

(o) Charges for telephone calls, telephone consultations, emails and/or email consultations;

(p) Treatment that results from war or an act of war or from participation in criminal activities;

(q) Treatment that results from an Injury or Sickness arising out of or in the course of any employment for wage or profit, or from an Injury or Sickness covered by a Workers' Compensation Act or other similar law except as specifically provided in Section 11.04;

(r) Treatment related to the reversal of voluntary sterilization;

(s) For Retirees with Plan B Coverage and Dependents of Retirees with Plan B Coverage, treatment that results from pregnancy;

(t) Barrier-free home modifications whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, railing or standing frames;

(u) Sexual disorder therapy, except as specifically provided for in Article III – Prescription Drug Benefits;

(v) Treatment for insertion, removal or revision of breast implants, including any Sickness or condition for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the treatment is post-mastectomy;

(w) Charges or fees for missed appointments;

(x) Non-implantable communicator-assist devices, including but not limited to, communication boards and computers;

(y) Vocational rehabilitation programs;

(z) Treatment leading to, in connection with, or resulting from sexual transformation or intersex surgery;

(aa) Treatment by any type of health care practitioner not otherwise provided for in the Plan;

(bb) Treatment for Custodial Care;

(cc) Treatment for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained, except as specifically provided for in Section 2.15, Section 2.16, or Section 2.29;

(dd) Cryopreservation or storage, except for as specifically provided for in Section 2.30;

(ee) Organ transplants and complications arising from organ transplants except as specifically provided in Section 2.30;

(ff) Charges for Physician overhead, including but not limited to surgical suites or rooms, or equipment used to perform the particular treatment (e.g. laser equipment);

(gg) Treatment for non-synostotic plagiocephaly (positional head deformity);

(hh) Charges for heating pads, heating and cooling units, ice bags or cold therapy units;

(ii) Treatment for unattended home sleep studies;

(jj) Charges for travel and lodging, except for as specifically provided for in Article II – Comprehensive Medical Benefits;

(kk) Molecular genetic testing (specific gene identification) for the purposes of health screening or if not part of a treatment regimen for a specific Sickness;

(ll) Treatment for standby services;

(mm) Charges for motorized carts, scooters or strollers, except as specifically provided for in Article II – Comprehensive Medical Benefits;

(nn) Treatment for gynecomastia (abnormal breast enlargement in males);

(oo) Treatment arising from elective abortions, except in the case of rape, incest or to save the life of the Participant or Dependent;

(pp) Treatment not provided by a licensed Physician or Dentist accept as specifically provided for in the Plan;

(qq) Maternity charges incurred by a Participant or Dependent acting as a surrogate mother;

(rr) Treatment required as a result of complications from a treatment not covered by the Plan;

(ss) Treatment provided by a provider or institution acting outside the scope of his license;

(tt) Claims for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits and Vision Benefits filed more than 12 months after the date of treatment;

(uu) Immunizations necessary for travel purposes; and

(vv) Costs associated with breast pumps, mastectomy bras, and compression stockings.

ARTICLE IX – CLAIMS AND APPEALS PROCEDURES

The following topics are discussed under this Article on Claims and Appeals Procedures:

This Article describes the procedures for filing claims and the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. Throughout this Article, "you" and "your" may refer to you, your Dependent(s), and/or your authorized representative, as applicable.

The Claims and Appeals procedures in this Article only apply to a request for benefits that is considered a claim. A request for Plan benefits is considered a claim if it is made in accordance with Section 9.02 below. For example, if you want to fill a prescription by mail order and you submit a claim form to LDI in accordance with Section 9.02(b) below, that request is considered a claim.

A casual inquiry about benefits or the circumstances under which benefits might be paid is not considered a claim. In addition, a request for prior approval of a benefit or treatment is not considered a claim. For example, if prior to providing a benefit your provider contacts the Plan to obtain an advance determination that the benefit will be covered by the Plan, that request is not considered a claim.

A request for a determination of whether you are eligible for benefits from the Plan is not considered a claim. However, if you file a request for a specific benefit in accordance with Section 9.02, that request will be considered a claim. If that claim is denied because you are not eligible for benefits from the Plan (i.e. it is denied because you are not a Covered Person), you may file an appeal by using the procedures in this Article. For example, if your coverage as a Retiree is terminated and you submit a request to the Plan Administrator to have your coverage reinstated, that request is not considered a claim. However, if your coverage as a Retiree is terminated and then you go to the doctor and submit a claim form and itemized bill from the doctor to UnitedHealthcare in accordance with Section 9.02, that request is considered a claim. If the Plan denies your claim because you are not covered by the Plan, you may appeal the denial in accordance with this Article.

Section 9.01 – Use of an Authorized Representative or other Individual to File a Claim or Appeal on your Behalf

A claim may be filed by the person who incurred the health care expense, his authorized representative, his personal representative or his provider (i.e. the person who provided the treatment). In the event a claim is filed by a provider, the provider will not automatically be considered a Covered Person's authorized representative.

An individual is considered your personal representative, if under applicable law, he has the authority to act on your behalf in making decisions related to health care. For example, a parent may be the personal representative of a minor child.

An individual is considered your authorized representative if you have designated the individual to act on your behalf through a Designation of Authorized Representative Form available at the Fund Office or at the website, www.ibew347benefits.com.

An appeal may be filed by the person who incurred the health care expense, his authorized representative or his personal representative. An appeal may not be filed by a provider unless the provider is also the Covered Person's authorized representative.

Section 9.02 – Filing a Claim

A request for benefits will be considered a claim only if you submit a completed claim form along with an itemized bill to the correct entity as described in this Section 9.02.

(a) Comprehensive Medical Benefit Claims

Comprehensive Medical Benefit claims must be filed with UnitedHealthcare at the address shown on your identification card. PPO Providers and many other Hospitals, Facilities and Physicians will submit a claim to UnitedHealthcare on your behalf. If your health care provider does not submit a claim on your behalf, you must submit a claim form to UnitedHealthcare. You can submit the claim form in paper format using either your provider's form or a standard health claim form. Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com.

If this Plan is secondary, you or your provider should still file Comprehensive Medical Benefit claims with UnitedHealthcare at the address shown on your identification card. This includes any Medicare related claims that must be filed with this Plan.

(b) Prescription Drug Benefit Claims

Prescription Drug Benefit claims must be filed with LDI at the address shown on page 1 of this Summary Plan Description. Participating retail pharmacies will submit a claim to LDI on your behalf. If you purchase your prescription at a non-participating retail pharmacy, you must pay the full retail price of the prescription and submit a claim for reimbursement to LDI. No benefits will be paid for prescriptions filled at Wal-Mart or Sam's Club. To fill your prescription by mail order, you must submit a claim form, payment and the prescription from your doctor to LDI. Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com.

If this Plan is secondary, you must pay your primary plan's copay for the prescription and submit a claim for reimbursement to Wilson-McShane Corporation.

The presentation of a prescription at a pharmacy does not constitute a claim. If a pharmacy refuses to fill your prescription unless you pay the entire cost, you must pay the full retail price of the prescription and submit a claim for reimbursement to LDI. In this case, your request for reimbursement will be considered a claim, and if it is denied you may appeal in accordance with this Article.

(c) Dental Benefit Claims

Dental Benefit claims must be filed with Delta Dental of Iowa at the address shown on your identification card. Participating Dentists and many other Dentists may submit a claim to Delta Dental on your behalf. If your Dentist does not submit a claim on your behalf, you must submit a claim form to Delta Dental of Iowa. You must file Dental Benefit claims on Delta Dental's claim forms which are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com.

If this Plan is secondary, you or your provider should submit Dental Benefit claims along with a copy of the primary plan or carrier's explanation of benefits to Delta Dental of Iowa at the address shown on your identification card.

(d) Vision Benefit Claims

When you schedule an appointment with your eye doctor, you should inform your doctor's office that you are a VSP member. If your doctor is a Preferred Provider and you inform his office that you are a VSP member before your appointment, your doctor's office will submit a claim to VSP on your behalf. If your doctor is a non-preferred provider, you must pay the full price of all services and supplies at the time you receive them and submit a claim for reimbursement to VSP at the address shown on page 1 of this Summary Plan Description. Claim forms are available at Wilson-McShane Corporation or at the website www.ibew347benefits.com.

If this Plan is secondary, you or your provider should still file Vision Benefit claims with VSP at the address shown on page 1 of this Summary Plan Description.

(e) Death Benefit Claims and Short-Term Disability Benefit Claims

Death Benefit claims and Short-Term Disability Benefit claims must be filed with Wilson-McShane Corporation at the address shown on page 1 of this Summary Plan Description. Claim forms are available from Wilson-McShane Corporation or at the website www.ibew347benefits.com. To submit a claim for a Death Benefit, you must submit proof of death (such as a death certificate) with the claim.

Section 9.03 – Deadline for Filing a Claim

Claims for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits and Vision Benefits must be filed within 12 months after the date of treatment.

Claims for Short-Term Disability Benefits must be filed within 12 months after the end of the Period of Disability.

Claims for Death Benefits must be filed within 12 months from the date of death.

You can only file claims after the periods described above with the express approval of the Trustees. If you cannot file your claim within this period, you must send a written request to file a late claim to the Trustees that includes an explanation of the circumstances preventing timely filing.

Section 9.04 – Timing of Notification of Benefit Determination

The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with Section 9.02, regardless of whether the Plan has all of the information necessary to decide the claim.

(a) Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits and Vision Benefits

Claims for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits and Vision Benefits will be decided and notice of the benefit determination will be sent to you within a reasonable period of time, but not later than 30 days after your claim is received by the Plan. The Plan may extend this period one time by up to 15 days if the Plan:

(1) determines that an extension of time is necessary due to matters beyond the control of the Plan; and

(2) sends you a written notice of the extension within the initial 30 day period, explaining the circumstances requiring the extension of time and the date that the Plan expects to render a decision.

If the extension is necessary because the Plan needs additional information, the notice of the extension will specifically describe the required information and you will be allowed at least 45 days from receipt of

the notice to provide the specified information. The time period for deciding the claim will be suspended (tolled) from the date on which the notice requesting additional information is sent until the date the Plan receives your response, or until 45 days have passed since the date the notice was sent, whichever happens first. The Plan will grant you additional time to supply the requested information upon written request. When the Plan receives your response (or 45 days have passed and you have not provided a response), the Plan will make a decision on the claim within 15 days.

(b) Short-Term Disability Benefits

Claims for Short-Term Disability Benefits will be decided and notice of the benefit determination will be sent to you within a reasonable period of time, but not later than 45 days after your claim is received by the Plan. The Plan may extend this period for up to 30 days if the Plan:

(1) determines that an extension of time is necessary due to matters beyond the control of the Plan; and

(2) sends you a written notice of the extension within the initial 45 day period, explaining the circumstances requiring the extension of time and the date that the Plan expects to render a decision.

If circumstances beyond the control of the Plan cause the Plan to be unable to decide the claim within the additional 30 days, the Plan may extend the time for deciding the claim for an additional 30 days. If another extension is required, you will get another written notice from the Plan prior to the expiration of the first 30 day extension period that tells you the reason for the extension, the date the Plan expects to render a decision, the standards you must meet to be entitled to the benefit, the unresolved issues that prevent a decision on your claim, and the additional information required to resolve those issues. You will be allowed at least 45 days from receipt of the notice to provide the specified information. The time period for deciding the claim will be suspended (tolled) from the date on which the notice is sent until the date the Plan receives your response, or until 45 days have passed since the date the notice was sent, whichever happens first. The Plan will grant you additional time to supply the requested information upon written request. When the Plan receives your response (or 45 days have passed and you have not provided a response), the Plan will make a decision within 30 days.

(c) Death Benefits

Claims for Death Benefits will be decided and notice of the benefit determination will be sent to you within 90 days after your claim is received by the Plan. The Plan may extend this period for up to 90 days if the Plan:

(1) determines that special circumstances require an extension of time for processing the claim; and

(2) sends you a written notice of the extension within the initial 90 day period, explaining the special circumstances requiring the extension of time and the date the Plan expects to render a decision.

Section 9.05 – Content of Benefit Notification

You will receive notice of all claim determinations. If the Plan pays 100% of the total billed amount of your claim, you will receive a written notice that contains sufficient information to fully apprise you of the Plan's decision to approve the requested benefit.

If your claim is denied, in whole or in part, or the Plan pays less than the total amount charged, you will receive a written notice that includes:

(a) The specific reason or reasons for the adverse benefit determination;

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

(c) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review (appeals) procedures and the time limits applicable to those procedures, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse benefit determination on review;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the notice will either set forth the specific rule, guideline, protocol or other similar criterion in full, or it will contain a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request; and

(f) If the adverse benefit determination is based on Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of the claim, or it will contain a statement that such an explanation will be provided free of charge upon request.

ONLY A FORMAL NOTICE OF A BENEFIT DETERMINATION, AS DESCRIBED IN THIS SECTION, SHALL CONSITUTE AN OFFICIAL PLAN DECISION AS TO WHETHER BENEFITS ARE AVAILABLE, SUBJECT ONLY TO APPEAL AS SET FORTH BELOW. NO OTHER COMMUNICATION, WHETHER WRITTEN OR ORAL, SHALL CONSTITUTE A PROMISE TO PAY OR A GUARANTEE OF BENEFITS UNDER THIS PLAN.

Section 9.06 – Filing an Appeal

If a claim for benefits is denied, in whole or in part, or if the amount approved or paid varies in any other way from the total amount claimed, you may appeal the determination by filing a written request for review to the Board of Trustees at the following Fund Office address:

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266

Section 9.07 – Deadline for Filing an Appeal

A request for review of claims (i.e. an appeal) for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits and Short-Term Disability Benefits must be made within 180 days after you receive notice of the adverse benefit determination.

A request for review of claims (i.e. an appeal) for Death Benefits must be made within 60 days after you receive notice of the adverse benefit determination.

Section 9.08 – Right to Request a Hearing

You may request a hearing where you may appear in person to present your appeal to the Trustees. To request a hearing you must file a written request to the Board of Trustees at the following Fund Office address:

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266

If you request a hearing, you will be notified in writing of the date, time, and place of the hearing. You will have the right to present any additional information that was not previously submitted. If you request a hearing and do not appear (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written comments, documents, records and other information submitted.

If you do not request a hearing, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written comments, documents, records and other information submitted.

Section 9.09 – Full and Fair Review of Appeals

You may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. If you request such information, it will be provided to you free of charge.

The Trustees will provide a full and fair review of the claim and the adverse benefit determination, and will not give deference to the initial determination. The Trustees' decision will be based on all comments, records and other information that you submit, regardless of whether such information was submitted or considered in the initial benefit determination.

In deciding an appeal of any benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental or Investigational or not Medically Necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be any individual who was consulted previously with respect to the claim for benefits, nor the subordinate of any such individual.

Section 9.10 – Timing of Notification of Benefit Determination on Appeal

The Board of Trustees shall render a determination on your appeal no later than the date of the regularly scheduled quarterly meeting immediately following the Plan's receipt of your request for review. If your request for review is received within 30 days preceding the date of the next regularly scheduled meeting, the Trustee's review and determination will be made no later than the second meeting following the Plan's receipt of your request for review.

The Plan may extend this period until the third meeting following the Plan's receipt of your request for review if the Plan:

(a) determines that special circumstances (such as the need to hold a hearing) require a further extension of time; and

(b) sends you a written notice of the extension prior to the commencement of the extension, explaining the special circumstances requiring the extension of time and the date that the Trustees will render a determination on your appeal.

The Plan Administrator will provide you written notice of the decision on review (i.e. the appeal) as soon as possible, and in no event later than five days after the decision is made.

Section 9.11 – Content of Notification of Benefit Determination on Appeal

If your appeal is granted, you will receive a written notice that contains sufficient information to fully apprise you of the Plan's decision to grant your appeal.

If your appeal is denied, you will receive a written notice that includes:

(a) The specific reason or reasons for the adverse benefit determination;

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

(c) 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 for benefits;

(d) A statement of your right to bring a lawsuit under Section 502(a) of ERISA;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the notice will either set forth the specific rule guideline, protocol or other similar criterion in full, or it will contain a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request; and

(f) If the adverse benefit determination is based on Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, the notice will either include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of the claim, or the notice will contain a statement that such an explanation will be provided free of charge upon request.

The Trustees have the sole and exclusive power and discretion to rule on all appeals and their determination shall be final and binding upon all parties. If you are dissatisfied with the Board of Trustees determination on appeal and you have exhausted all of the claims and appeals procedures in this Article, you may file a lawsuit. For any lawsuit filed, the determination of the Trustees is subject to judicial review only for abuse of discretion.

Section 9.12 – Pre-Service Claims and Urgent Care Claims

Federal law provides that a request for prior approval of a benefit is not considered a Pre-Service Claim or an Urgent Care Claim unless the terms of a plan condition receipt of the benefit (in whole or in part) on approval of the benefit in advance of obtaining medical care. This Plan does not require prior approval of any benefit or treatment. This means it is not possible for a request for benefits from this Plan to be considered a Pre-Service Claim or an Urgent Care Claim.

Although the Plan does not require prior approval of any benefit or treatment, it does provide the opportunity for your provider to request an advance determination. This information is explained in greater detail below.

(a) Definitions:

(1) **Pre-Service Claim** means a claim for a benefit for which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(2) **Urgent Care Claim** means a Pre-Service Claim with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(b) Request for Pre-Service Determination

As indicated above, this Plan does not require prior approval of any benefit or treatment offered under the Plan. This means it is not possible to have a Pre-Service Claim or an Urgent Care Claim as those terms are defined by Section 9.12(a) above and 29 C.F.R. Section 2560.503-1.

If you would like to receive prior approval for a specific Comprehensive Medical Benefit, your provider may request an advance determination by contacting UnitedHealthcare at (866) 596-8447. Only a provider may request an advance determination (in other words, a Covered Person may not request an advance determination).

It is important to remember that an advance determination is not a prerequisite for receiving benefits. It is a service provided by the Plan to enable you to obtain an evaluation whether a particular benefit will be covered by the Plan. If the advance determination is negative (i.e. you are informed that the Plan will not pay for the benefit), you are still free to obtain the benefit and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted for the advance determination.

ARTICLE X – COORDINATION OF BENEFITS

The following topics are discussed under this Article on Coordination of Benefits:

The coordination of benefits rules explained in this Article limit the duplication of benefits when a Covered Person has coverage under more than one health plan. If you or your Dependents have health care coverage available under this Plan and "Another Plan," your benefits will be coordinated in accordance with this Article.

To understand the Plan's coordination of benefits rules, there are two definitions you need to know about. You need to know (1) the definition of "Primary Plan"; and (2) the definition of "Secondary Plan."

The plan that pays benefits first is called the "Primary Plan." The "Primary Plan" must pay benefits without regard to the possibility that another plan may cover some expenses.

The "Secondary Plan" may reduce the benefits it pays so that no more than 100% of the "Allowable Expense" is paid through the combined coverage of the plans.

The rules that determine which plan is primary and which is secondary are explained in greater detail below.

Section 10.01 – Definitions for this Article X Only

The following terms will have a specific meaning when they are used within this Article:

(a) **"Another Plan"** means any form of coverage with which coordination is allowed.

(1) "Another Plan" shall include, but not be limited to, any of the following that provides benefits or services for medical, prescription, dental or vision care or treatment:

i. Group and nongroup insurance contracts and subscriber contracts;

ii. Uninsured arrangements of group or group-type coverage;

iii. Health Maintenance Organization (HMO) contracts;

iv. Group and nongroup coverage through "Closed Panel Plans";

v. "Group-Type Contracts";

vi. The medical care component of long-term care contracts, such as skilled nursing care;

vii. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" contracts; and

viii. Medicare or other governmental benefits as permitted by law (this does not include Medicaid).

(2) "Another Plan" does not include:

i. Hospital indemnity coverage benefits or other fixed indemnity coverage;

ii. Accident-only coverage;

iii. Specified disease or specified accident coverage;

iv. Limited benefit health insurance coverage as defined by the laws of the State of Iowa;

v. School accident-type coverage;

vi. Benefits for non-medical components of long-term care policies;

vii. Medicare supplement policies;

viii. Medicaid policies; or

ix. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

(3) The term "Another Plan" shall be construed separately as to each policy, contract or other arrangement for benefits or services. If "Another Plan" has two parts and the coordination of benefits rules only apply to one of the two, each of the parts shall be treated separately.

(4) In the event a husband and wife are both covered under this Plan as Participants, the IBEW Local 347 Electrical Workers Health and Welfare Plan shall be considered "Another Plan."

(b) **"Allowable Expense"** means any health care expense, including deductibles, coinsurance or copays that is covered at least in part under any of the health plans covering the Covered Person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an "Allowable Expense" and a benefit paid. An expense that is not covered by any plan covering the Covered Person is not an "Allowable Expense." In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an "Allowable Expense." The following are examples of expenses that are not "Allowable Expenses."

(1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an "Allowable Expense" unless one of the plans provides coverage for private Hospital room expenses.

(2) When benefits are reduced by both the "Primary Plan" and the "Secondary Plan" due to negotiated reductions with a PPO, any amount in excess of the lowest reimbursement amount for a specific service is not an "Allowable Expense." However, if the Covered Person receives a balance billing from the provider after both the "Primary Plan" and the "Secondary Plan" have paid and this Plan is the "Secondary Plan," the additional benefits this Plan would have paid in the absence of "Another Plan" will be considered an "Allowable Expense."

(3) When benefits are reduced by the "Primary Plan" because a Covered Person does not comply with the plan provisions, the amount of this reduction is not an "Allowable Expense." Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements (e.g. if benefits are reduced by the "Primary Plan" because a Covered Person did not obtain a second surgical opinion or obtain a required pre-certification, the extra amount the Covered Person is required to pay will not be considered an "Allowable Expense").

(c) **"Closed Panel Plan"** means a plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(d) **"Custodial Parent"** means the parent awarded custody of a child by a court decree, or in the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

(e) **"Group-Type Contract"** means a contract that is not available to the general public and is obtained only because of membership in or a connection with a particular organization or group, including blanket coverage. "Group-Type Contract" does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(f) **"Primary Plan"** means a plan whose benefits for a Covered Person's health care coverage must be determined without taking the existence of any other plan into consideration. Whether a plan is the "Primary Plan" shall be determined in accordance with the Order of Benefit Determination rules in Section 10.02 and the Coordination of Benefits with Medicare rules in Section 10.04, as applicable.

(g) **"Secondary Plan"** means any plan that is not a "Primary Plan" and whose benefits are determined after those of another plan and are reduced so that all plan benefits do not exceed 100% of the total "Allowable Expense."

Section 10.02 – Rules for Coordination of Benefits

When a Covered Person is also covered by "Another Plan," the following rules shall apply:

(a) If this Plan is the "Primary Plan," it shall determine benefits as if the "Secondary Plan" or plans do not exist.

(b) If this Plan is the "Secondary Plan," and a "Closed Panel Plan" is the "Primary Plan," this Plan shall pay or provide benefits as if it were the "Primary Plan" when a Covered Person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the "Primary Plan."

(c) If this Plan is the "Secondary Plan," it will calculate the benefits it would have paid on a claim in the absence of other health care coverage and will apply that calculated amount to any "Allowable Expense" under the Plan that is unpaid by the "Primary Plan." This Plan may reduce its payment by an amount so that, when combined with the amount paid by the "Primary Plan," the total benefits paid or provided by all plans for the claim do not exceed 100% of the total "Allowable Expense" for that claim. In addition, this Plan shall credit to its Plan Deductible any amounts that it would have credited to its Deductible in the absence of other health care coverage.

(d) If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(i), (ii), (iii), (iv), (v), (vi), or (vii) (i.e. the Covered Person is covered by this Plan and "Another Plan" and the other plan is not Medicare), this Plan will coordinate benefits with "Another Plan" or the portion of "Another Plan," that provides the same type of benefits that are the subject of the claim. For example, in the case of a general medical claim, this Plan will coordinate with "Another Plan(s)" providing general medical benefits to the Covered Person.

(e) If "Another Plan's" coordination of benefits provisions are inconsistent with the provisions in this Article, the following rules shall apply:

(1) Except as provided in Section 10.02(e)(2) below, a plan that does not contain a coordination of benefits provision that is consistent with applicable laws and regulations is always the "Primary Plan" unless the provisions of both plans state that the plan that does comply with all applicable laws and regulations is the "Primary Plan."

(2) Coverage that is obtained by virtue of membership in a group and is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of such supplementary coverage are major medical coverage that is superimposed over base plan Hospital and surgical benefits and insurance-type coverage written in connection with a "Closed Panel Plan" to provide out-of-network benefits.

Section 10.03 – Order of Benefit Determination

If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(viii) (i.e. the Covered Person is also covered by Medicare), the Plan will determine whether it is the "Primary Plan" or the "Secondary Plan" in accordance with Section 10.04.

If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(i), (ii), (iii), (iv), (v), (vi), or (vii) (i.e. the Covered Person is covered by this Plan and "Another Plan" and the other plan is not Medicare), the Plan will determine whether it is the "Primary Plan" or the "Secondary Plan" using the first of the following rules that applies:

(a) Dependent/Nondependent

(1) Except as provided in Section 10.03(a)(3) below, if a Participant is covered under "Another Plan" as a dependent, this Plan shall be the "Primary Plan" and "Another Plan" shall be the "Secondary Plan."

(2) Except as provided in Section 10.03(a)(3) below, if a Dependent is covered under "Another Plan" other than as a dependent (for example, as an employee, member, policyholder, subscriber, or retiree), this Plan shall be the "Secondary Plan" and "Another Plan" shall be the "Primary Plan."

(3) Notwithstanding Sections 10.03(a)(1) and (2), if the Covered Person is a Medicare beneficiary and as a result of Federal law, Medicare is secondary to the plan covering the Covered Person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Covered Person as a dependent is the "Primary Plan" and the other plan is the "Secondary Plan."

(b) Dependent Child Covered Under More Than One Plan

If a Dependent child is covered under more than one plan, and there is no court decree stating otherwise, the order of benefits is determined as follows:

(1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the "Primary Plan"; or if both parents have the same birthday, the plan that has covered one of the parents the longest is the "Primary Plan."

(2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the "Primary Plan." If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does have health care coverage, that parent's spouse's plan is the "Primary Plan." This rule shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the plan of the parent whose birthday falls earlier in the calendar year is the "Primary Plan;" or if both parents have the same birthday, the plan that has covered one of the parents the longest is the "Primary Plan."

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the plan of the parent whose birthday falls earlier in the calendar year is the "Primary Plan"; or if both parents have the same birthday, the plan that has covered one of the parents the longest is the "Primary Plan."

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child is as follows:

(A) The plan covering the "Custodial Parent";

(B) The plan covering the "Custodial Parent's" spouse;

(C) The plan covering the noncustodial parent; and then

(D) The plan covering the noncustodial parent's spouse.

(3) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable under Section 10.03(b)(1) or (2) as if those individuals were the parents of the child.

(c) Active Employee or Retired or Laid-Off Employee

If the rules in Section 10.03(a) do not determine the order of benefits, the following rules apply:

(1) If a Covered Employee uses his Dollar Bank to pay the Monthly Premium (i.e. he does not self-pay the entire Monthly Premium amount in accordance with Section 1.03(b)), and he is covered under "Another Plan" as a laid-off or retired employee, this Plan shall be the "Primary Plan" for the Covered Employee and his Dependents and "Another Plan" shall be the "Secondary Plan."

(2) If a Covered Employee self-pays the entire Monthly Premium amount in accordance with Section 1.03(b) and he is covered under "Another Plan" as an active employee (i.e. an employee who is neither laid off nor retired), this Plan shall be the "Secondary Plan" for the Covered Employee and his Dependents and "Another Plan" shall be the "Primary Plan."

(3) If a Retiree is covered under "Another Plan" as an active employee (i.e. an employee who is neither laid off nor retired), this Plan shall be the "Secondary Plan" for the Retiree and his Dependents and "Another Plan" shall be the "Primary Plan."

(4) If "Another Plan" does not have the rules provided in this Section 10.03(c), and as a result, the plans do not agree on the order of benefits, the rules in this Section 10.03(c) shall be ignored and the order of benefits shall be determined in accordance with Section 10.03(e) or (f) as applicable.

(d) COBRA or State Continuation Coverage

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other Federal law is covered under "Another Plan," the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the "Primary Plan" and the COBRA or state or other federal continuation coverage is the "Secondary Plan." If "Another Plan" does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored and the order of benefits shall be determined in accordance with Section 10.03(e) or (f) as applicable. This rule does not apply if the rule in Section 10.03(a) can determine the order of benefits.

(e) Longer or Shorter Length of Coverage

If the rules in Sections 10.03(a) – (d) do not determine the order of benefits, the plan that covered the person for the longer period of time is the "Primary Plan" and the plan that covered the person for the shorter period of time is the "Secondary Plan."

(f) Rule if None of the Preceding Rules Apply

If the rules in Sections 10.03(a) – (e) do not determine the order of benefits, the "Allowable Expense" shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the "Primary Plan."

Section 10.04 – Coordination of Benefits with Medicare

If Medicare would be the "Primary Plan" for you or your Dependents, but you (or your Dependents) have not enrolled in Medicare Parts A and B, the Plan will reduce the benefits it pays by the amount that would have been paid by Medicare Parts A and B.

The following chart summarizes when Medicare will be the "Primary Plan" for you and your Dependents. You should look at the categories on the left-column of the chart and see which one describes you. Some of these descriptions contain an * at the end of the description. **If you fit into a category with an *, it means you should be enrolled in Medicare Parts A and B. If you are in a category with an * and you are not enrolled in Medicare Parts A and B, the Plan will reduce the benefits it pays by the amount that would have been paid by Medicare Parts A and B.** This means that if you fit in one of these categories and you are not enrolled in both Medicare Part A and Medicare Part B you will be responsible for the amount that would have been paid by Medicare.

The chart is solely for the purpose of providing a summary of the rules regarding the Plan's coordination of benefits with Medicare. The chart is not intended to (and should not be used to) inform you of the rules regarding when and if you are eligible for Medicare. For a more detailed description of the rules regarding the Plan's coordination of benefits with Medicare, you should read the language below the chart and/or contact the Plan Administrator. For information regarding whether you are entitled to Medicare, contact the Center for Medicare and Medicaid Services at 1-800-MEDICARE or www.MyMedicare.gov.

If you are…	Your Primary Plan will be…	Your Secondary Plan will be…
A Covered Employee and you are eligible for Medicare based on disability or age	This Plan	Medicare
A Dependent of a Covered Employee and you are eligible for Medicare based on disability or age	This Plan	Medicare
A Retiree, you use your Dollar Bank to pay the Retiree Premium, and you are eligible for Medicare based on disability or age	This Plan	Medicare
A Dependent of a Retiree who uses his Dollar Bank to pay the Retiree Premium and you are eligible for Medicare based on disability or age	This Plan	Medicare
A Retiree, you self-pay the entire Retiree Premium (i.e. you have $0 in your Dollar Bank), and you are eligible for Medicare based on disability or age*	Medicare	This Plan
A Dependent of a Retiree who self-pays the entire Retiree Premium (i.e. the Retiree has $0 in his Dollar Bank), and you are entitled to Medicare based on disability or age*	Medicare	This Plan
A qualified beneficiary (i.e. you are covered by COBRA) and you are eligible for Medicare based on disability or age*	Medicare	This Plan
A Covered Person, you are eligible for Medicare based on End Stage Renal Disease, and you have been eligible for Medicare for less than 31 months	This Plan	Medicare
A Covered Person, you are eligible for Medicare based on End State Renal Disease, and you have been eligible for Medicare for more than 30 months*	Medicare	This Plan

If a Covered Person has coverage from "Another Plan" as defined by Section 10.01(a)(1)(viii) (i.e. the Covered Person is also covered by Medicare), the Plan will determine whether it is the "Primary Plan" or the "Secondary Plan" in accordance with the rules listed below in this Section 10.04.

These Medicare coordination rules shall apply with respect to any Covered Person who is entitled to benefits under Part A or Part B of Medicare, regardless of whether he is enrolled.

The Plan does not coordinate with Medicare Part D, and the rules below do not apply to coordination with Medicare Part D. If a Covered Person enrolls in Medicare Part D, he will no longer be eligible for Prescription Drug Benefits from the Plan.

(a) Notwithstanding the order of benefit determination rules in Section 10.03, the following rules shall determine the order of benefits payable in the circumstances described below:

(1) If a Covered Employee is eligible for Medicare based on disability or age, this Plan shall be the "Primary Plan" for the Covered Employee and his Dependents and Medicare shall be the "Secondary Plan."

(2) If a Dependent of a Covered Employee is eligible for Medicare based on disability or age, this Plan shall be the "Primary Plan" for the Dependent and Medicare shall be the "Secondary Plan."

(3) If a Retiree uses his Dollar Bank to pay the Retiree Premium and he is eligible for Medicare based on disability or age, this Plan shall be the "Primary Plan" for the Retiree and his Dependents and Medicare shall be the "Secondary Plan."

(4) If a Dependent of a Retiree who uses his Dollar Bank to pay the Retiree Premium is eligible for Medicare based on disability or age, this Plan shall be the "Primary Plan" for the Dependent and Medicare shall be the "Secondary Plan."

(5) If a Retiree self-pays the entire Retiree Premium amount in accordance with Section 1.09, and he is eligible for Medicare based on disability or age, this Plan shall be the "Secondary Plan" for the Retiree and Medicare shall be the "Primary Plan."

(6) If a Dependent of a Retiree who self-pays the entire Retiree Premium amount in accordance with Section 1.09 is eligible for Medicare based on disability or age, this Plan shall be the "Secondary Plan" for the Dependent and Medicare shall be the "Primary Plan."

(7) If a qualified beneficiary is eligible for Medicare based on age or disability, and is covered under this Plan's COBRA continuation coverage, this Plan shall be the "Secondary Plan" and Medicare shall be the "Primary Plan." Nothing in this Section 10.04(a)(7) shall be construed to mean that a qualified beneficiary is entitled to continue to receive coverage under this Plan's COBRA continuation coverage once he is entitled to Medicare.

(8) If any Covered Person is eligible for Medicare based on End Stage Renal Disease (ERSD), this Plan shall be the "Primary Plan" for the first 30 months of such person's eligibility or entitlement to Medicare and Medicare shall be the "Secondary Plan" during these 30 months. After the Covered Person's first 30 months of Medicare eligibility or entitlement, this Plan shall be the "Secondary Plan" and Medicare shall be the "Primary Plan."

(b) In the case of any Medicare-entitled Covered Person who is not enrolled in Medicare Parts A and B, the Plan shall determine the benefit amount that would have been payable by Medicare Parts A and B, and shall reduce its secondary payments accordingly. In other words, if Medicare would be your "Primary Plan" but you have not enrolled in Medicare Parts A and B, this Plan will still reduce the benefits it pays by the amount that would have been paid by Medicare Parts A and B.

(c) If Medicare is the "Primary Plan" and a Covered Person's benefits are not payable by Medicare because he failed to follow Medicare's claim filing procedures, such as by seeking care from a provider who does not participate with the Medicare plan in which the individual is enrolled, this Plan will coordinate with the amount that would have been payable under the original Medicare plan.

Section 10.05 – Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits payable under this Plan and "Another Plan." The Plan may get the facts it needs from, or may provide necessary facts to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and "Another Plan" covering the Covered Person. This Plan does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to apply these coordination of benefits rules and determine benefits payable.

Section 10.06 – Facility of Payment

A payment made under "Another Plan" may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again and, to the extent of such payment, the Plan shall be fully discharged from any liability. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

Section 10.07 – Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under the coordination of benefits rules in this Article, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services

provided for the Covered Person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services. The Plan may also recover any overpayments in accordance with Section 13.18.

Section 10.08 – Claims Involving Third-Party Liability

Any liability arising out of a third party's responsibility for the Sickness or Injury suffered by a Covered Person shall be addressed in accordance with Article XI – Subrogation and Reimbursement and will not be paid in accordance with this Article.

ARTICLE XI – SUBROGATION AND REIMBURSEMENT

The following topics are discussed under this Article on Subrogation and Reimbursement:

If you or your Dependent incurs medical expenses as a result of an Injury or accident, a third party may be liable for those expenses. In this case, the Plan may make advance payments to cover your health benefits in accordance with the subrogation and reimbursement rules in this Article.

To understand the Plan's subrogation and reimbursement rules, you need to understand the meaning of the terms subrogation and reimbursement.

Subrogation allows the Plan to "stand in your shoes" to recover benefits paid by this Plan from any other plan or person who should have properly paid those benefits. For example, if you are injured in an auto accident due to another driver's fault, and the Plan pays expenses for the treatment of your injuries, the Plan can "stand in your shoes" and make a claim to recover those expenses from either the responsible driver or the responsible driver's insurance company. In subrogation, the Plan is asserting your rights to collect against a responsible party.

With reimbursement, the Plan is not asserting your rights, but instead is requiring repayment of the benefits paid on your behalf. For example, say you are crossing the street and are hit by a car that failed to stop for the crosswalk. The Plan pays expenses for the treatment of your injuries. You hire an attorney and file suit against the driver, eventually arriving at a settlement. Under the Plan's reimbursement provisions, you must use the proceeds of your settlement to repay the Plan for the expenses it has paid for the treatment of your injuries. With reimbursement, you have asserted your rights to collect against the responsible party, and you must use the money that you collected to repay the Plan.

These rules are explained in greater detail below.

Section 11.01 – Definition of Allowable Expense

When the term, "Allowable Expense" is used in this Article, it shall mean any health care expense, including deductibles, coinsurance or copays that is covered at least in part under any of the health plans covering the Covered Person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the Covered Person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense. For examples of expenses that are not Allowable Expenses, see Section 10.01(b).

Section 11.02 – Subrogation

(a) If a Covered Person is injured by a third party, he must complete a subrogation agreement and provide any requested information to the Plan Administrator before the Plan will pay any benefits for such Injury or Sickness.

(b) This Plan shall be subrogated to the extent of benefits paid under this Plan to any monies recovered from any other plan or person by reason of the Injury or Sickness which occasioned the payment of benefits

under this Plan. This Plan shall also be subrogated to the extent of benefits paid under this Plan to any claim the Covered Person may have against any other plan or person for the Injury or Sickness which occasioned the payment of benefits under this Plan. Upon written notification to the Claimant, this Plan may (but shall not be required to) collect on the claim directly from the other plan or person in any manner this plan chooses without the consent of the Covered Person.

(c) This Plan shall apply any monies collected from any other plan or person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to the Covered Person as soon as administratively practicable. In other words, if the Plan recovers money in a subrogation action, the Plan will use the money to cover payments made by the Plan and any reasonable costs and expenses the Plan incurred collecting that money (including attorneys' fees) up to the amount of the award or settlement. If there is any money remaining, it will be paid to you.

(d) The Plan's rights to subrogation and reimbursement take priority over any other use of monies that a Covered Person recovers, including payment of attorney's fees and expenses, and regardless of whether the Covered Person obtains a full or partial recovery for the Injury or Sickness. The Plan's subrogation and reimbursement rights under this Article are not limited by the "common fund" doctrine. The characterization of any amount recovered by a Covered Person from another plan or person, whether through settlement agreement or otherwise, shall not affect the Plan's priority right to recover the full amount of benefits paid to or on behalf of such Covered Person, or to characterize otherwise Covered Charges as excludable expenses pursuant to the provisions of this Article. Nor will the amount of the Plan's recovery right be limited simply because the amount recovered by the Covered Person from the responsible third party is insufficient to reimburse the Covered Person for all of his damages, including non-medical expense items, such as "pain and suffering" or property damage. This Plan's subrogation and reimbursement rights are not limited by the "make whole" doctrine that is sometimes applicable in other legal contexts. The Trustees or their designee may, within their sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

(e) This Plan shall not be responsible for any costs or expenses incurred in connection with any recovery from any other plan or person unless this Plan agrees in writing to pay a part of those expenses.

(f) The Board of Trustees, within its sole discretion, shall determine which of this Plan's rights and remedies is within the best interests of this Plan to pursue. The Trustees may decide to recover less than the full amount of excess payments or to accept less than full reimbursement if:

(1) This Plan has made, or caused to be made, such reasonable, diligent, and systematic collection efforts as are appropriate under the circumstances; and

(2) Such decision is reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

Section 11.03 – Recovery and Reimbursement

(a) Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount that at any time is in excess of the maximum amount of payment necessary at that time to satisfy the intent of these rules, this Plan shall have a right to recover these payments, to the extent of any excess, in accordance with Section 13.18.

(b) The Trustees may, in their discretion, elect to set-off any amounts paid by this Plan that are in excess of the amounts for which this Plan is liable under this Article in accordance with Section 13.18. The Trustees, in their discretion, may also elect to set-off any amounts paid by this Plan that are in excess of the amounts for which the Plan is liable under this Article against any amount owed by the Plan at that time or in the future, to the same insurance company, or other organization to whom the overpayment was made. The Trustees have sole and absolute discretion whether to recover or set-off, and from whom to recover.

(c) If the Plan makes payment of Allowable Expenses incurred for treatment of an Injury or Sickness for which another plan or person (a responsible third party) is or may be liable, and in which this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays for treatment of the Injury or Sickness, the Plan may elect to set-off any payments in accordance with Section 13.18. The Plan may also elect to set-off any excess payments against any amount owed by the Plan at that time or in the future to the same insurance company, or other organization to whom payment was made. If the responsible third party, or such person's insurer (or anyone else on behalf of the responsible third party), makes payment to a Covered Person, or on behalf of a Covered Person, as compensation for an Injury or Sickness, and this Plan is not subrogated with respect to that payment, this Plan is entitled to reimbursement from the Covered Person in an amount equal to the lesser of the benefits paid by this Plan for treatment of that Injury or Sickness, or the amount paid to or on behalf of the Covered Person by the responsible third party or its insurer. This Section 11.03(c) shall not apply when the responsible third party or its insurer is Another Plan (as that term is defined in Section 10.01(a)(1)) with respect to which this Plan is the primary payer of an Allowable Expense in accordance with the coordination of benefits rules in Article X – Coordination of Benefits.

(d) If a responsible third party or its insurer pays compensation to or on behalf of a Covered Person for an Injury or Sickness for which the responsible third party is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise Allowable Expenses for treatment of that Injury or Sickness, such otherwise Allowable Expenses incurred after the date on which the compensation was paid, or incurred prior to such date but not paid by this Plan as of that date, shall be excluded from coverage to the extent of the excess (if any) of the compensation the Covered Person receives over the Allowable Expenses which the Plan has already paid for treatment of the Sickness or Injury that is the subject of the compensation from the responsible third party, and as to which expenses the Plan has already received reimbursement. This rule shall not apply with respect to Allowable Expenses incurred by a Covered Person for treatment of asbestosis and/or its related conditions after the Covered Person's receipt of compensation from a responsible third party or such party's insurer related to the Covered Person's claim against such responsible third party for compensation on account of having contracted asbestosis.

The following example illustrates how this Section 11.03(d) works:

On June 1, 2012, Phillip gets injured in a car accident with Chris. The car accident is Chris' fault. On June 1, 2012, Phillip incurs $1,000 of Allowable Expenses for injuries caused by the car accident. On June 10, 2012, the Fund Office requests information from Phillip regarding the Injury and sends him a subrogation agreement to sign. On June 15, 2012, Phillip provides the Fund Office the requested information and a signed subrogation agreement. On June 16, 2012, the Fund Office pays the $1,000 of Allowable Expenses. On June 20, 2012, Chris' insurance company pays Phillip $11,000. On June 22, 2012, Phillip pays the Plan $1,000 to reimburse the expenses the Plan paid on June 16, 2012. On July 1, 2012, Phillip incurs $15,000 of additional Allowable Expenses for injuries caused by the car accident. The Plan will not pay $10,000 of Phillip's additional Allowable Expenses.

(e) The Plan's right to reimbursement takes priority over any other uses of monies recovered, including payment of attorneys' fees and expenses, and regardless of whether the Covered Person obtains a full or

partial recovery for his Injury or Sickness, or for other damages sustained as a result of an action by a responsible third party that also resulted in the Covered Person's Injury or Sickness. This Plan shall not be responsible for any costs or expenses incurred in connection with any recovery from any other plan or person unless this Plan agrees in writing to pay a part of those expenses. This Plan's reimbursement rights are not limited by the "common fund" doctrine. The characterization of any amount a Covered Person recovers from another plan or person, whether through settlement agreement or otherwise, shall not affect the Plan's priority right to recover the full amount of benefits paid to or on behalf of a Covered Person, or the Plan's right to characterize otherwise Covered Charges as excludable expenses pursuant to the provisions of Section 11.03(b). Nor will the amount of this Plan's recovery right be limited simply because the amount a Covered Person recovers from another plan or person is insufficient to reimburse the Covered Person for all of his damages, including non-medical expense items such as "pain and suffering" or property damage. This Plan's reimbursement rights are not limited by the "make whole" doctrine that is sometimes applicable in other legal contexts.

Section 11.04 – Work-Related Claims

In general, the Plan does not cover charges relating to any Injury or Sickness for which a Covered Person has received or is entitled to receive compensation under any Workers' Compensation or occupational disease or similar law or program. However, an exception exists if a Covered Person has a work-related Injury or Sickness for which a claim has been filed with a Workers' Compensation insurance carrier or with a federal or state court or agency. In the event that claim was initially denied, then the Plan may pay benefits arising from the work-related Injury or Sickness in accordance with this Section 11.04.

A Covered Person must complete a subrogation agreement and provide any requested information to the Plan Administrator before the Plan will pay any benefits in accordance with this Section 11.04. Benefits paid in accordance with this Section 11.04 are subject to the subrogation and reimbursement provisions in this Article (i.e. all of the Plan's rights with respect to subrogation and reimbursements shall apply to benefits paid in accordance with this Section 11.04).

Section 11.05 – Duty of Cooperation and the Right to Obtain and Release Information

Each Covered Person has a duty to cooperate with this Plan and, at the request of the Board of Trustees or its designee and as a condition of receiving benefits under this Plan, a Covered Person shall take any action, give information and assistance and execute documents required by this Plan to enforce its rights under this Article. The Plan will make no payments to or on behalf of a Covered Person until the Plan is satisfied that the Claimant has complied with the requirements of this Article. The Board of Trustees or its designee, without the consent of or notice to any person may release to or obtain from any person any information, with respect to any person, which the Board of Trustees or its designee deems necessary to make payment for medical care, to determine and enforce any applicable cost sharing requirements of this Plan and to enforce this Plan's rights to recovery, reimbursement and/or subrogation.

ARTICLE XII – PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

The following topics are discussed under this Article on Privacy and Security of Protected Health Information:

This Article provides a summary of the Plan's legal obligations and your legal rights regarding your Protected Health Information ("PHI") held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

In general, PHI is Individually Identifiable Health Information, including demographic information, that is created or received by the Plan that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

The Plan has a separate Notice of Privacy Practices that provides a complete description of your rights and the Plan's legal duties with respect to your PHI. The Notice of Privacy Practices also tells you when the Plan may Use or Disclose your PHI, when your permission or written authorization is required, how you can get access to your PHI and what actions you can take regarding your PHI. You can obtain a copy of the Notice of Privacy Practices at the Fund Office or at the website www.ibew347benefits.com.

Section 12.01 – Definitions for this Article XII Only

The terms in this Section 12.01 are specifically defined in the Standards for Privacy of Individually Identifiable Health Information found at 45 C.F.R. Part 160 and Subparts A and E of Part 164 (the "Privacy Rule") and the Security Standards for the Protection of Electronic Protected Health Information found at 45 C.F.R. Part 160 and Subparts A and C of Part 164 (the "Security Rule"). The definitions set forth in the HIPAA Privacy Rule and the HIPAA Security Rule shall govern the meaning of the following terms when they are used in this Article:

(a) Business Associate
(b) Covered Entity
(c) Disclosure
(d) Electronic Protected Health Information (ePHI)
(e) Health Care Operations
(f) Health Care Provider
(g) Individually Identifiable Health Information
(h) Payment
(i) Protected Health Information (PHI)
(j) Required By Law
(k) Secretary
(l) Security Measures
(m) Security Incident
(n) Treatment
(o) Use

Section 12.02 – Use and Disclosure of Protected Health Information by the Plan

The Plan may Use and Disclose PHI for the purposes listed in this Section 12.02 to the extent such Use or Disclosure is permitted by and in accordance with the provisions of the HIPAA Privacy Rule, the HIPAA Security Rule and all other applicable law.

(a) Use and Disclosure of PHI to a Covered Person or His Personal Representative

The Plan is required to and will Disclose your PHI to you or your personal representative upon written request. You (or your personal representative) may request your PHI by sending a written request to the Fund Office. If your personal representative is requesting your PHI, he must also submit documentation demonstrating that he has the authority to act on your behalf (for example, a power of attorney).

For purposes of this Section 12.02(a), an individual is considered your personal representative if under applicable law, he has the authority to act on your behalf in making decisions related to health care. For example, state law will determine the extent to which a parent may act on behalf of a minor child with regard to the child's PHI.

The Plan will provide your personal representative with access to your PHI in the same manner as it would provide you with access unless, in the exercise of professional judgment, the Plan decides that treating an individual as your personal representative would not be in your best interest and the Plan has a reasonable belief that:

(1) You have been or may be subjected to domestic violence, abuse or neglect by the person seeking to be treated as your personal representative; or

(2) Treating the individual as your personal representative could endanger you.

(b) Use and Disclosure of PHI Pursuant to a Valid Authorization

The Plan will Disclose your PHI to your authorized representative upon receipt of a completed written Protected Health Information Authorization Form. Protected Health Information Authorization Forms are available at the Fund Office or at the website www.ibew347benefits.com.

The Plan will provide your authorized representative PHI in accordance with the Protected Health Information Authorization Form, HIPAA, and all other applicable law. You can revoke a Protected Health Information Authorization Form at any time by sending a written request for revocation to the Fund Office. A request for revocation will become effective on the date that it is received by the Fund Office.

(c) Use and Disclosure of PHI for Treatment, Payment or Heath Care Operations

The Plan does not perform any Treatment activities, but may Disclose PHI to Health Care Providers treating a Covered Person in order to facilitate the providers' Treatment of the Covered Person. For example, the Plan may disclose the name of your treating radiologist to your treating primary care Physician so that your primary care Physician may ask your radiologist for your x-rays.

The Plan may Use and Disclose the minimum necessary PHI for Payment activities and Health Care Operations in accordance with the following rules:

(1) The Plan may Use and Disclose the minimum necessary PHI for the Plan's Payment activities.

Payment generally means the activities of the Plan to collect contributions, premiums and self-payment amounts; to fulfill its coverage responsibilities and provide benefits under the Plan; and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to the following:

- **Determining your eligibility and coverage for Plan benefits**
  For example, the Plan may Use information obtained from your Employer to determine whether you are an Eligible Employee.

- **Determining and fulfilling the Plan's responsibility to provide benefits**
  For example, the Plan may Use your healthcare claims to determine if services provided by your Physician are covered by the Plan.

- **Enforcing the Plan's rights to recovery, reimbursement and/or subrogation**
  For example, if you are in an auto accident due to another driver's fault and the Plan pays expenses for the treatment of your injuries, the Plan may Use and Disclose information regarding the accident, expenses and treatment in order to enforce the Plan's subrogation rights.

- **Providing Prior Authorization**
  For example, if you are scheduled to have surgery and prior to your surgery your provider contacts the Plan to obtain prior approval for your surgery, the Plan may Disclose to your provider whether the surgery will be covered.

- **Coordinating benefits with other plans under which you have health coverage**
  For example, the Plan may Use information about your benefits from another group health plan to determine the benefits that this Plan will pay for a specific claim.

(2) The Plan may Use and Disclose the minimum necessary PHI for the Plan's Health Care Operations.

Health Care Operations generally means certain administrative, financial, legal and quality improvement activities of the Plan that are necessary to run its business and to support the core functions of Treatment and Payment. These specific activities are limited to those listed in the definition of Health Care Operations found at 45 C.F.R. Section 164.501. The following is a summary of these activities:

- **Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination and contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment.**
  For example, a case manager may contact you or your provider to discuss Treatment alternatives.

- **Reviewing the competence or qualifications of health care professionals, evaluating provider and Plan performance, training health care and non-health care professionals, accreditation, certification, licensing or credentialing activities**.
  For example, the Plan may train new claims processors by having them process health benefit claims under close supervision.

- **Underwriting and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims.**
  For example, if the Plan decides to purchase stop-loss insurance, it may disclose your demographic information (such as your age) to carriers to obtain quotes.

- **Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs**.
  For example, the Plan's auditor (who is a Business Associate) may review your health care claims to determine if they were paid correctly.

- **Business planning and development, such as conducting cost-management and planning analysis related to managing and operating the Plan**.
  For example, the Plan's consultant (who is a Business Associate) can review PHI to project future benefit costs.

- **Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other administrative simplification rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set and fundraising for the benefit of the Plan.**
  For example, the Plan may Use your PHI for the purpose of creating de-identified information.

(3) The Plan may Use and Disclose the minimum necessary PHI for the Payment activities of another Covered Entity or Health Care Provider.
For example if you have secondary coverage from another plan, this Plan may disclose information to that other plan regarding this Plan's Payment for your health care.

(4) The Plan may Use and Disclose the minimum necessary PHI for certain (but not all) Health Care Operations of another Covered Entity if the Covered Entity has a relationship with the Covered Person, the PHI pertains to that relationship, and the Disclosure is permitted by and made in accordance with 45 C.F.R. Section 164.506.
For example, the Plan can Disclose your PHI to another Covered Entity for quality assessment and improvement, case management, performance evaluation and fraud abuse and detection.

(d) Use and Disclosure of PHI for Notification and Involvement in a Covered Person's Care
The Plan may Disclose your PHI to a family member, other relative, close personal friend or other person that you identify, to the extent the PHI is directly relevant to such person's involvement with your care or the Payment is related to your care, and the Disclosure is in accordance with this Section 12.02(d) and 45 C.F.R. Section 164.510.

The Plan may also Disclose your PHI to notify (or assist in the notification of, including identifying or locating), a family member, your personal representative or another person responsible for your care of your location, general condition or death in accordance with this Section 12.02(d) and 45 C.F.R. Section 164.510.

The following rules apply to Disclosures made pursuant to this Section 12.02(d);

(1) Uses and Disclosures with the Covered Person Present
If you are present for, or otherwise available prior to, a Use or Disclosure permitted by this Section 12.02(d), and you have the capacity to make health care decisions, the Plan may Use or Disclose your PHI if the Plan:

- obtains your agreement;
- provides you with the opportunity to object to the Disclosure and you do not express an objection; or
- based on the exercise of professional judgment reasonably infers from the circumstances that you do not object to the Disclosure.

(2) Uses and Disclosures if the Covered Person is not Present

If you are not present, or you cannot agree or object to a Use or Disclosure because you are incapacitated or there is an emergency circumstance, the Plan may, in the exercise of professional judgment, determine whether the Use or Disclosure is in your best interests, and, if so, Disclose only the PHI that is directly relevant to the person's involvement with your health care.

(e) Use and Disclosure of PHI Required by Law

The Plan may Use or Disclose your PHI to the extent that such Use or Disclosure is Required By Law and the Use or Disclosure complies with and is limited to the relevant requirements of such law.

(f) Disclosures About Victims of Abuse, Neglect or Domestic Violence

Except for reports of child abuse or neglect that are permitted to be Disclosed to a public health authority in accordance with Section 12.02(i)(2) below, if the Plan reasonably believes that you are a victim of abuse, neglect or domestic violence, the Plan may Disclose your PHI to a government authority (including a social service or protective services agency) that is authorized by law to receive reports of such abuse, neglect or domestic violence if you agree to the Disclosure.

Even if you have not agreed to the Disclosure, the Plan may Disclose your PHI to a government authority to the extent the Disclosure is Required By Law and the Disclosure complies with and is limited to the relevant requirements of such law. The Plan may also Disclose your PHI to a government authority if the Disclosure is expressly authorized by statute or regulation and:

- The Plan, in the exercise of professional judgment, believes the Disclosure is necessary to prevent serious harm to you or other potential victims; or
- You do not have the capacity to agree and law enforcement (or other public official authorized to receive the report) represents that the information is not intended to be used against you and immediate law enforcement activity depends on the Disclosure.

If the Plan makes a Disclosure permitted by this Section 12.02(f), the Plan will promptly notify you that the Disclosure has or will be made unless, in the exercise of professional judgment, (i) the Plan believes informing you would place you at risk of serious harm; or (ii) the Plan would be informing a personal representative and in the exercise of professional judgment, the Plan reasonably believes the personal representative is responsible for the abuse, neglect or other Injury and that informing such person would not be in your best interests.

(g) Disclosures for Judicial and Administrative Proceedings

The Plan may Disclose your PHI in the course of any judicial or administrative proceeding in response to:

- an order of a court or administrative tribunal so long as the Plan only Discloses the PHI that is expressly authorized by such order; or
- a subpoena, discovery request or other lawful process that is not accompanied by an order of a court or an administrative tribunal if the Plan receives satisfactory assurances (as defined by 45 C.F.R. Section 164.512) from the party seeking the information that reasonable efforts have been made by such party to ensure that you have been given notice of the request or that the party seeking the PHI has made reasonable efforts to secure a qualified protective order.

(h) Disclosures for Law Enforcement Purposes

The Plan may Disclose your PHI to a law enforcement official for a law enforcement purpose in accordance with this Section 12.02(h) and 45 C.F.R. Section 164.512.

- The Plan may Disclose your PHI as Required By Law, including laws that require the reporting of certain types of wounds or other physical injuries (except for Disclosures for public health reporting and Disclosures about victims of abuse, neglect or domestic violence which are governed by the more specific rules in Section 12.02(f) and Section 12.02(i)(2)).

- The Plan may Disclose your PHI in compliance with, and as limited by, the relevant requirements of a court order, a court-ordered warrant, a subpoena or summons, or an investigative demand or similar process so long as the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited to the extent reasonably practicable in light of the purpose for which the information is sought, and de-identified information could not reasonably be used.

- The Plan may Disclose your PHI in response to a law enforcement official's request for the information for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The information the Plan may Disclose for this purpose is limited to your name, address, date and place of birth, Social Security number, ABO blood type and rh factor, type of Injury, date and time of treatment, date and time of death (if applicable) and certain distinguishing characteristics (for example, height, weight and gender).

- The Plan may Disclose your PHI in response to a law enforcement official's request for the information if you are (or are suspected to be) a victim of a crime and you agree to the Disclosure or the Plan is unable to obtain your agreement because of your incapacity or an emergency circumstance and the law enforcement official represents that the information is needed to determine whether a person (other than you) has violated the law, the information is not intended to be used against you, immediate law enforcement activity depends on the Disclosure, and in the exercise of professional judgment the Plan determines that the Disclosure is in your best interest.

- The Plan may Disclose your PHI to law enforcement officials after your death for the purpose of alerting them of your death if the Plan has a suspicion that your death may have resulted from criminal conduct.

- The Plan may Disclose your PHI that the Plan believes in good faith constitutes evidence of criminal conduct that occurred on the Plan's premises.

(i) Use and Disclosure of PHI for Public Health Activities

The Plan may Disclose your PHI to the following entities for the public health activities and purposes described in this Section 12.02(i) in accordance with 45 C.F.R. Section 164.512:

(1) The Plan may Disclose your PHI to a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, such as the reporting of disease, injury or vital events (e.g. birth, or death), and conducting public health surveillance, public health investigations and public health interventions.

(2) The Plan may Disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect.

(3) The Plan may Disclose your PHI to a person who has responsibility to the Food and Drug Administration (FDA) regarding the quality, safety or effectiveness of such FDA-regulated product or activity.

(4) The Plan may Disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition if the Plan is authorized by law to notify such person.

(j) Use and Disclosure of PHI for Health Care Oversight Activities

The Plan may Disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits; civil administrative or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other appropriate oversight activities. This Section 12.02(j) does not apply if you are the subject of an investigation or other activity that does not arise out of and is not directly related to the receipt of health care, a claim for public benefits related to health, or the qualification for or receipt of public benefits or services when a patient's health is integral to the claim for public benefits or services.

(k) Use and Disclosure of a Decedent's PHI

The Plan may Disclose your PHI to a coroner or medical examiner after your death for the purpose of identifying you, determining your cause of death or other duties as authorized by law. The Plan may also Disclose your PHI to funeral directors either upon your death or before and in reasonable anticipation of your death, consistent with applicable law, and as necessary for the funeral director to carry out his duties.

(l) Use and Disclosure of PHI for Cadaveric Organ, Eye or Tissue Donation Purposes

The Plan may Disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

(m) Use and Disclosure of PHI to Avert a Serious Threat to Health or Safety

The Plan may, consistent with 45 C.F.R. Section 164.512, all other applicable law(s) and standards of ethical conduct, Use or Disclose your PHI if the Plan in good faith believes that the Use or Disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may only Disclose PHI for this purpose if the Disclosure is to a person reasonably able to prevent or reduce the threat, including the target of the threat.

(n) Use and Disclosure of PHI for Specialized Government Functions

The Plan may Disclose your PHI if you are in the Armed Forces and the PHI is deemed necessary by the appropriate military command authorities. The Plan may also Disclose your PHI to authorized federal officials for the conduct of national security activities and protection of the President, and to a correctional institution where you are being held.

(o) Use and Disclose of PHI for Workers' Compensation

The Plan may Disclose your PHI as authorized by and to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

(p) Disclosure of PHI to the Secretary of Health and Human Services

The Plan is required to and will Disclose your PHI to the Secretary of Health and Human Services (HHS), or his designee when such PHI is required by the Secretary to investigate or determine the Plan's compliance with the Privacy Rule.

Section 12.03 – Use and Disclosure of PHI to and by the Board of Trustees

The Board of Trustees has delegated the daily responsibility for administering the Plan to Business Associates. The Plan's Business Associates will carry out their administrative duties on behalf of the Plan, such as claims processing and regular Plan administration, without Disclosing PHI to the Board of Trustees unless such Disclosure is necessary, and then shall Disclose only the minimum information necessary to carry out the purpose of the Disclosure to the Board of Trustees, and only in accordance with the terms of the Privacy Rule, the Security Rule and this Plan document.

The Plan and its Business Associates may Disclose the minimum necessary Individually Identifiable Health Information to the Board of Trustees for the Plan administrative functions that the Board of Trustees

performs for the Plan. The Board may Use and Disclose only the minimum Individually Identifiable Health Information necessary for the Board to perform the Plan administrative functions described in this Section 12.03 or as otherwise permitted or required by HIPAA. Notwithstanding any provisions of this Plan to the contrary, in no event shall the Board of Trustees (or any member of the Board of Trustees) be permitted to Use or Disclose PHI in a manner that is inconsistent with 45 C.F.R. Section 164.504(f).

(a) Payment

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to perform Payment activities (as the term Payment is defined in 45 C.F.R. Section 164.501) that the Board has not delegated to a Business Associate (in other words, Payment activities that the Board of Trustees performs for the Plan). The Board of Trustees may Use and Disclose only the minimum information necessary to perform such Payment activities. The Payment activities that the Board of Trustees performs for the Plan include, but are not limited to the following:

(1) Benefit Determinations on Review (i.e. Appeals)

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to render determinations on appeals. The Board may Use and Disclose only the minimum information necessary to decide the appeal, and shall avoid making any Disclosure of the information unless necessary to the claim determination, such as for the purpose of obtaining medical, legal or actuarial advice regarding the appeal. When Disclosing any such information, the Board shall obtain adequate assurances from the party to whom the information is being Disclosed that such party will protect the privacy of the information. In order to accomplish this purpose efficiently, the Board shall avoid making any Disclosure of PHI to any entity that has not entered into a Business Associate Agreement with the Plan. Any Business Associate Agreement entered into between the third party and the Plan shall protect the Board of Trustees to the same extent it protects the Plan.

(2) Collection Activities and Subrogation

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to make determinations related to collection activities and subrogation, such as for the purpose of deciding whether to attempt to recover on an overpayment made by the Plan or whether to settle with a Covered Person or outside party in a collection or subrogation matter. The Board may Use and Disclose only the minimum information necessary to render determinations regarding collection activities and subrogation, and shall avoid making any Disclosure of the information unless necessary, such as for the purpose of obtaining legal or actuarial advice regarding the collection activity or subrogation matter. When Disclosing any such information, the Board shall obtain adequate assurances from the party to whom the information is being Disclosed that such party will protect the privacy of the information. In order to accomplish this purpose efficiently, the Board shall avoid making any Disclosure of PHI to any entity that has not entered into a Business Associate Agreement with the Plan. Any Business Associate Agreement entered into between the third party and the Plan shall protect the Board of Trustees to the same extent it protects the Plan.

(b) Health Care Operations

The Plan and its Business Associates may Disclose the minimum necessary PHI to the Board of Trustees in order for the Board to perform Health Care Operations (as the term Health Care Operations is defined in 45 C.F.R. Section 164.501) that the Board has not delegated to a Business Associate (in other words, Health Care Operations that the Board performs for the Plan). The Board of Trustees may Use and Disclose only the minimum information necessary to perform such Health Care Operations.

Section 12.04 – Conditions of Disclosure of PHI to the Board of Trustees and Agreement by the Board of Trustees

Neither the Plan nor any Business Associate servicing the Plan will Disclose PHI to the Board of Trustees unless and until the Plan receives a certification by the Board of Trustees that the Plan documents have been amended to incorporate the following provisions, and that the Board of Trustees agrees to each of the provisions in this Section 12.04. By adopting this Plan, the Board of Trustees agrees:

(a) Not to Use or Disclose PHI other than as permitted or required by the Plan documents or as required by law;

(b) To ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to such information and that such agent (including a subcontractor) agrees to implement reasonable and appropriate Security Measures to protect the PHI;

(c) Not to Use or Disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan that receives contributions in accordance with the Collective Bargaining Agreement;

(d) To report to the Plan any Use or Disclosure of the PHI that is inconsistent with the Uses or Disclosures provided for of which it becomes aware;

(e) To make available PHI in accordance with 45 C.F.R. Section 164.524 to the extent that the Board of Trustees rather than a Business Associate has control of such PHI;

(f) To make available PHI for amendment and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526 to the extent that the Board of Trustees, rather than a Business Associate, has control of such PHI;

(g) To make available the information required to provide an accounting of Disclosures in accordance with 45 C.F.R. Section 164.528, to the extent that the Board of Trustees rather than a Business Associate has control of such information;

(h) To make its internal practices, books and records relating to the Use and Disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance with the Privacy Rule by the Plan;

(i) If feasible, to return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and to retain no copies of such information when it is no longer needed for the purpose which the Disclosure was made, except that, if such destruction is not feasible, to limit future Uses and Disclosures to those purposes that make the return or destruction of the information infeasible;

(j) To ensure that adequate separation required by 45 C.F.R. Section 164.504 (f)(2)(iii) is established and is supported by reasonable and appropriate Security Measures;

(k) To implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Trustees create, receive, maintain or transmit on behalf of the Plan; and

(l) To report to the Plan any Security Incident of which the Board of Trustees becomes aware.

Section 12.05 – Adequate Separation between the Plan and the Board of Trustees

Adequate separation will exist at all times between the Plan and the Board of Trustees. All members of the Board of Trustees may have access to PHI when such access is required to perform the Plan administrative

functions that the Board of Trustees performs for the Plan. No member of the Board of Trustees shall have any access to PHI except as provided for in Section 12.03 or as otherwise permitted or required by HIPAA (for example, the Plan will Disclose PHI to the Board of Trustees if the Disclosure is necessary for the Board of Trustees to comply with its obligations under Section 12.04).

The Board of Trustees does not have any employees, thus it is not possible for any employee of the Board of Trustees to have access to PHI. The Board of Trustees shall protect the privacy of Individually Identifiable Health Information received, created or maintained and shall Use and/or Disclose such information only in accordance with the terms of this Plan document. The Board of Trustees has developed a privacy policy that includes an effective mechanism for resolving any issues of noncompliance with this Article. Any member of the Board of Trustees that does not comply with this Article will be subject to the privacy policy's disciplinary provisions for noncompliance.

The Board has delegated the daily responsibility for administering the Plan to Business Associates, including a third-party administrator, a prescription benefit manager and a PPO. These Business Associates and their employees do and shall have access to PHI in the course of the services they perform for the Plan. The Plan has entered into contracts with its Business Associates in accordance with the Privacy Rule, the Security Rule and the HITECH Act.

Section 12.06 – Compliance with the HITECH Act

The Plan shall comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act and its implementing regulations.

ARTICLE XIII – MISCELLANEOUS PROVISIONS

The following topics are discussed under this Article on Miscellaneous Provisions:

Section 13.01 – Name of Plan

The name of the Plan is the IBEW Local 347 Electrical Workers Health and Welfare Fund.

Section 13.02 – Type of Plan

The Plan is a welfare benefit Plan providing medical, prescription, dental, vision, short-term disability and death benefits to Participants and their Beneficiaries.

Section 13.03 – Type of Administration

The Plan is self-funded and is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association.

The Board of Trustees retains ultimate authority as the Plan Administrator for this Plan, but it has delegated responsibility for performing the day-to-day administrative functions to Wilson-McShane Corporation. The phone number and address for the administrative office of the Fund (i.e. the Fund Office) is:

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266
Telephone: (515) 224-4308
Toll-Free: (877) 224-4308

Section 13.04 – Plan Sponsor

The Plan sponsor is the Board of Trustees of the IBEW Local 347 Electrical Workers Health and Welfare Fund.

Section 13.05 – Employer Identification Number and Plan Number

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 23-7091121. The Plan number is 501.

Section 13.06 – Plan Year

The Plan Year is the calendar year that begins on January 1 and ends on December 31.

Section 13.07 – Name and Address of the Person Designated as Agent for Service of Legal Process

Paul Theirl
Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266

Service of Legal process may also be made upon the Board of Trustees or any individual Trustee.

Section 13.08 – Names, Titles and Addresses of the Trustees

Union Trustees	Employer Trustees
Mr. Kevin Clark IBEW Local 347 850 18th Street Des Moines, IA 50314	Ms. Angela S. Bowersox Iowa Chapter, NECA 2900 Westown Parkway, Suite 140 West Des Moines, IA 50266
Mr. Matt DeAngelo IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. Steve Ball Ball Electric Company 505 New York Avenue Des Moines, IA 50313
Mr. Allen DeHeer IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. John Irving Baker Electric 111 S Jackson Street Des Moines, IA 50315
Mr. Doug Wolf IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. John Layland Baker Electric 111 S Jackson Street Des Moines, IA 50315
Mr. Jerry Kurimski (alternate) IBEW Local 347 850 18th Street Des Moines, IA 50314	Mr. Jim Davis (alternate) The Waldinger Corporation 2601 Bell Avenue Des Moines, IA 50321

The Board of Trustees may be contacted at the following Fund Office address and phone number:

Wilson-McShane Corporation
IBEW Local 347 Electrical Workers Health and Welfare Fund Office
4200 University Avenue, Suite 320
West Des Moines, IA 50266
Telephone: (515) 224-4308
Toll-Free: (877) 224-4308

Section 13.09 – Collective Bargaining Agreements

The Plan is maintained pursuant to Collective Bargaining Agreements. A Participant or Beneficiary may obtain a copy of any Collective Bargaining Agreement by submitting a written request to the Plan Administrator. The Collective Bargaining Agreements are also available for inspection at the Fund Office.

Section 13.10 – Amendment or Elimination of Benefits and Termination of the Plan

The Board of Trustees has complete power and discretion to amend the Plan, in whole or in part, at any time. This means that the Trustees can reduce or eliminate benefits, terminate all benefits for certain Participants (for example Retirees) or modify the availability, nature and extent of benefits and the conditions for and method of payment of benefits. The Trustees may also modify the eligibility and coverage requirements, and the rules surrounding a Participant's Dollar Bank, including but not limited to, the rules regarding freezing and forfeiting a Dollar Bank.

The Board of Trustees also has complete power and discretion to determine when and if the Plan should be terminated. The Plan may be terminated by a document in writing executed by all of the Trustees if:

- In the opinion of the Trustees, the Fund is not adequate to carry out the intent and purpose of the Trust Agreement, or is not adequate to meet the payments due or to become due under the Plan;
- There are no individuals living who can qualify as Participants or Beneficiaries under the Plan; or
- There is no longer any Collective Bargaining Agreement requiring contributions to the Fund.

If the Plan is terminated, the Trustees will:

- Make provision out of the Fund for the payment of expenses incurred up to the date of termination of the Plan and the expenses incidental to such termination;
- Arrange for a final audit and report of their transactions and accounts for the purposes of termination of their trusteeship;
- Give any notice and prepare and file any reports which may be required by law; and
- Apply the Fund in accordance with the provisions of ERISA and this Plan document.

No part of the corpus or income of the Fund shall be used for or diverted to purposes other than the exclusive benefit of Participants and their Beneficiaries, or the administration expenses of the Fund. Under no circumstances shall any portion of the Fund, either directly or indirectly, revert or inure to the benefit of any Employer, the Association or the Union.

Upon termination of the Plan, the Trustees will promptly notify the Employers, the Association, the Union, and all other interested parties. The Trustees will continue to serve as Trustees for the purpose of winding up the affairs of the Plan.

Section 13.11 – Source of Financing of the Plan and Identity of any Organization through Which Benefits are Provided

The Plan is funded through Employer contributions and by investment income earned on a portion of the Fund's assets. In addition, Employees, Retirees, Dependents and individuals continuing coverage under COBRA or as a surviving spouse may be required to make contributions in order to maintain coverage under the Plan. The funds are held in Trust until disbursed. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the Collective Bargaining Agreements. The amount of any contributions or premiums required to be paid by Employees, Retirees, Dependents or other Beneficiaries (including a surviving spouse or a qualified beneficiary continuing

coverage under the COBRA provisions) is determined by the Board of Trustees and may be based on an actuarial determination of the cost to the Plan to provide benefits.

The Fund Office will provide any Plan Participant or Beneficiary, upon written request, information as to whether a particular employer is contributing to this Fund, and if so, that Employer's address.

Benefits under this Plan are paid directly from the Fund. Benefits under this Plan are not financed, in whole or in part, by a health insurance issuer. Further, benefits under this Plan are not guaranteed under a contract or a policy of insurance issued by a health insurance issuer. There is no liability on the Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund.

The Plan has entered into arrangements with various organizations for purposes such as claims processing and case management. The following is a list of those organizations and the services they provide to the Plan:

- **Wilson-McShane Corporation:** Provides day-to-day administration for the Plan as its third-party administrator. This day-to-day administration includes, but is not limited to, determining whether an individual is eligible for coverage, issuing Certificates of Creditable Group Health Plan Coverage and administering COBRA. Wilson-McShane Corporation also processes claims for Comprehensive Medical Benefits, Short-Term Disability Benefits and Death Benefits.

- **UnitedHealthcare:** Administers the Preferred Provider Organization; provides case management services; and provides advance benefit determinations when requested by a provider in accordance with Section 9.12(b). Benefits are funded by the Trust Fund, and UnitedHealthcare does not guarantee payment of medical benefits (in other words, the Fund actually pays for medical benefits, not UnitedHealthcare).

- **LDI:** Administers the Prescription Drug Benefits for the Plan as its Prescription Benefit Manager. LDI processes Prescription Drug Benefit claims and then requests and receives money from the Fund to pay the claims. This means that Prescription Drug Benefits are funded by the Trust Fund and LDI does not guarantee payment of Prescription Drug Benefits.

- **Delta Dental:** Administers the Dental Benefits for the Plan. Delta Dental processes Dental Benefit claims, then requests and receives money from the Fund to pay the claims, and makes payment on the claims to providers. This means that Dental Benefits are funded by the Trust Fund and Delta Dental does not guarantee payment of Dental Benefits.

- **VSP:** Administers the Vision Benefits for the Plan. VSP processes Vision Benefit claims, then requests and receives money from the Fund to pay for the claims, and makes payment on the claims to providers. This means that Vision Benefits are funded by the Trust Fund and VSP does not guarantee payment of Vision Benefits.

The address for each of the organizations listed above is provided on page 1 of this Summary Plan Description.

Section 13.12 – Interpretation

The Board of Trustees shall have the sole and exclusive power and discretion to interpret this Plan and to decide all questions and issues including but not limited to questions of coverage and eligibility, the method of providing or arranging for benefits and all other related matters. Any interpretation of the Plan by the Board of Trustees shall be final and binding on all persons and parties, including the Union, the Association, Employers, Employees, Retirees and their Beneficiaries. Additionally, the Board of Trustees shall have the sole and exclusive power and discretion to interpret and construe any policy, rule or regulation established by the Board of Trustees.

Any interpretation by the Trustees of any policy, rule or regulation established by the Board shall be final and binding upon all persons and parties, including the Union, the Association, Employers, Employees, Retirees and their Beneficiaries.

The Board of Trustees' authority and power includes, for example, the administrative discretion necessary to determine whether an individual meets the Plan's written eligibility requirements, or to interpret any other term contained in this Plan document. Further, to the extent that any Plan benefit is subject to a determination of Medical Necessity, reasonableness or the like, the Board of Trustees, in consultation with appropriate health care professionals or other appropriate experts, will make the final factual determination.

Any decisions or actions of the Board of Trustees shall be final, binding and conclusive as to all persons. Any such decision or action shall be accorded the highest level of judicial deference and shall be subject to reversal by a court of competent jurisdiction only if such court determines that the decision of the Board of Trustees was arbitrary or capricious.

Section 13.13 – Non-Alienation

All the benefits, monies or property of the Fund shall be free from the interference and control of any creditor. Neither the Association, Union, Employers, Employees, Retirees nor Beneficiaries shall have any right, title or interest in the Fund other than as specifically provided for in this Plan. No Employee, Dependent or other Beneficiary shall have the right to receive any part of the contributions made to the Fund by Employers or others (except as benefits provided for hereunder) in lieu of obtaining coverage under this Plan. No benefits under this Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, attachment, execution or levy of any kind, nor to seizure or to sale under any legal, equitable or any other process except as required by ERISA, and except as specifically set forth below:

- In making a claim for benefits, a Covered Person may direct that the benefits be paid directly to the health care provider who provided the treatment that is the subject of that claim;
- The Plan may direct that benefits under this Plan be paid directly to the provider of benefits, in whole or in part, in whatever manner deemed reasonable and appropriate by the Board of Trustees;
- The Plan will honor any assignment of rights made by a Covered Person or on behalf of a Covered Person as required by Medicaid. In addition, the Plan will reimburse Medicaid for payments made by Medicaid for which the Plan has a legal liability, but only to the extent the Plan is required to do so by State statute; and
- If a person who is entitled to receive a payment under the Plan is, in the determination of the Board of Trustees or the Plan Administrator or its designee, incapable of giving a valid receipt for the payment, and if no guardian or conservator has been appointed for that person, the Plan may make the payment to a person or persons who, in the judgment of the Board of Trustees, has assumed the obligations of caring for the person on whose behalf the payment is being made. In the case of an expense incurred for the treatment of a minor child, the Plan may make the payment to the child's custodial parent, whether or not that parent is covered under this Plan.

Section 13.14 – Exclusive Benefit

This Plan is maintained for the exclusive benefit of persons eligible for benefits under the terms of this Plan document, and it shall be impossible hereunder, at any time before the satisfaction of all liabilities, for any part of the corpus or income to be used for, or diverted to, purposes other than the exclusive benefit of such persons. However, nothing herein shall prevent the Trustees from returning Employer contributions made to the Fund due to a mistake of law or fact, provided that the contributions are returned within six months from the date on which the Plan Administrator determines that the contributions were made due to such a mistake. No Participant or Beneficiary or any person claiming by or through a Participant or Beneficiary shall have any rights,

title or interest in or to the Fund, or any part thereof, except as may be specifically determined by the Trustees for the payment of benefits specified in this Plan document.

Section 13.15 – Gender and Number
In the construction of this Plan, the masculine shall include the feminine, and the singular shall include the plural, in all cases in which those meanings would be appropriate.

Section 13.16 – Plan not in Place of Workers' Compensation
This Plan is not in place of and does not affect any requirement of coverage for Workers' Compensation insurance.

Section 13.17 – Governing Law
The Plan is established in the State of Iowa. To the extent that Federal law does not apply, any questions arising under the Plan shall be determined under the laws of the State of Iowa.

Section 13.18 – Recovery of Overpayments
No person is entitled to any benefit under the Plan except as expressly provided under the Plan. The fact that payments have been made from the Plan in connection with any claim for benefits under the Plan does not establish the validity of the claim, or provide the right to have such benefits continue for any period of time, or prevent the Plan from recovering the benefits paid to the extent the Trustees ultimately determine that in fact, there was no right to payment of the benefits under the Plan.

The Plan shall have the right to recover, by all legal and equitable means, any amounts paid that the recipient was not rightfully entitled to under the terms of this Plan (i.e. overpayments). This right to recovery shall include, but not be limited to, the right to recoup such amounts from future benefits to be paid to or on behalf of the Participant and his Dependents and the right to recoup such amounts from any benefits to be paid to or on behalf of any survivors of the Participant or Dependent. This right to recovery shall further include the right to collect additional costs incurred by the Plan to recover the overpayment (for example, attorney's fees). For purposes of this Section 13.18, the term "overpayment" shall include payments made on behalf of an individual who was not eligible for coverage from the Plan (for example, if a Dependent child had other coverage available through his employer and the Participant did not notify the Fund Office of the other coverage, payments made for claims on behalf of the child are considered overpayments).

The Plan's right to recovery shall include but not be limited to the following:

(a) In the event of an overpayment of benefits to or on behalf of a Participant (including an individual who ceased to meet the Plan's definition of Participant), the Plan may recover the overpayment by:

    (1) A direct recovery from the Participant;

    (2) A direct recovery from the medical provider who received the overpayment;

    (3) Reducing future benefits to or on behalf of the Participant; or

    (4) Reducing future benefits to or on behalf of the Participant's Dependents.

(b) In the event of an overpayment of benefits to or on behalf of a Dependent (including an individual who ceased to meet the Plan's definition of Dependent), the Plan may recover the overpayment by:

    (1) A direct recovery from the Dependent;

    (2) A direct recovery from the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan;

    (3) A direct recovery from the medical provider who received the overpayment;

(4) Reducing future benefits to or on behalf of the Dependent;

(5) Reducing future benefits to or on behalf of the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan; or

(6) Reducing future benefits to any additional Dependent of the Participant whose participation in the Plan was the basis for the Dependent's eligibility in the Plan.

ARTICLE XIV – STATEMENT OF ERISA RIGHTS

As a Participant in the IBEW Local 347 Electrical Workers Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XV – DEFINITIONS

THE FOLLOWING WORDS HAVE SPECIFIC MEANINIGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.

Section 15.01 – Annual Out-of-Pocket Maximum

"Annual Out-of-Pocket Maximum" means the amount of eligible Covered Charges a Covered Person must incur in a single calendar year before the Plan begins to pay 100% for most Comprehensive Medical Benefits provided by PPO Providers and 80% for most Comprehensive Medical Benefits provided by non-PPO providers. The Annual Out-of-Pocket Maximum is per individual; there is not a separate family Annual Out-of-Pocket Maximum. The Annual Out-of-Pocket Maximum is calculated based on Covered Charges from both PPO Providers and non-PPO providers. The following Covered Charges are not eligible Covered Charges and do not count towards the Annual Out-of-Pocket Maximum:

- The portion of Covered Charges paid as a Deductible;
- Covered Charges for services and treatment for which a Covered Person is only responsible for a Copay;

- Covered Charges for services and treatment for which a Covered Person is not responsible for any portion of the cost of the services or treatment; and

- Covered Charges paid for treatment and services in Article III – Prescription Drug Benefits, Article IV – Dental Benefits, and Article V – Vision Benefits.

Section 15.02 – Association
"Association" means the Des Moines Division, Iowa Chapter, National Electrical Contractors Association and its successors and/or assigns.

Section 15.03 – Beneficiary
"Beneficiary" means any person who is eligible to receive benefits under this Plan based on a Participant's participation in this Plan. Beneficiaries under this Plan include Dependents of Covered Employees, Dependents of Retirees and Designated Beneficiaries of Death Benefit Participants.

Section 15.04 – Board of Trustees or Trustees
"Board of Trustees" or "Trustees" means the persons designated as members of the Board of Trustees of the IBEW Local 347 Electrical Workers Health and Welfare Fund, in accordance with the Agreement and Declaration of Trust.

Section 15.05 – Claimant
"Claimant" means the individual who received the treatment that is the subject of a claim for benefits submitted to the Plan. Claimant also means an authorized representative or personal representative who acts on the primary Claimant's behalf with respect to a particular claim in accordance with Section 9.01.

Section 15.06 – Collective Bargaining Agreement
"Collective Bargaining Agreement" means any written agreement requiring an Employer to submit contributions to the Fund in a manner and amount acceptable to the Trustees for work performed by one or more Employees, and such written agreement is in force and effect between either:

- The Union and the Association;
- The Union and one or more Employers doing the type of work performed by members of the Association;
- The International Brotherhood of Electrical Workers and one or more Employers doing the type of work performed by members of the Association; or
- The International Brotherhood of Electrical Workers and an Employer's Association.

It shall also mean participation agreements between the Fund and any Employer or Employer's Association which requires contributions to the Fund in an amount and manner acceptable to the Trustees.

Section 15.07 – Copay
"Copay" means a specified dollar amount that must be paid by a Covered Person for treatment before Plan benefits are payable.

Section 15.08 – Cosmetic
"Cosmetic" means treatment which is not Medically Necessary and is provided solely to enhance the texture, appearance, size or position of a body part.

Section 15.09 – Covered Charges
"Covered Charges" means Prevailing Charges which are made for preventive services specifically listed as covered by the Plan (e.g. mammograms, routine physical exams) or Medically Necessary treatment, supplies and prescription drugs that are prescribed, performed or ordered by a Physician for treatment of a Sickness or Injury. Covered Charges include only those charges incurred by a Covered Person while he is eligible for benefits under this Plan. In no event will Covered Charges exceed Prevailing Charges. No amount in excess of the actual charge for a treatment will be considered a Covered Charge.

For surgical services, Covered Charges for multiple surgical procedures during the same anesthesia period will be adjusted paid as follows:

- Primary Procedure: 100% of Prevailing Charges
- Secondary Procedure: 50% of Prevailing Charges
- All Others: 25% of Prevailing Charges
- If an assistant surgeon is utilized, the assistant surgeon's Prevailing Charge will be calculated at 25% of the surgeon's Prevailing Charge.

Section 15.10 – Covered Employee
"Covered Employee" means an Eligible Employee who either has at least the Monthly Premium amount in his Dollar Bank on the last day of the preceding month or self-pays the Monthly Premium in accordance with Section 1.03(a) or Section 1.03(b). A Covered Employee is eligible to receive benefits from this Plan.

Section 15.11 – Covered Employment
"Covered Employment" means any work covered by the Collective Bargaining Agreement for which contributions are required to be made to this Plan.

Section 15.12 – Covered Person
"Covered Person" means any person who is eligible to receive benefits from this Plan, including Participants, Dependents and Beneficiaries.

Section 15.13 – Custodial Care
"Custodial Care" means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (RN) licensed practical nurse (LPN), or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.

Section 15.14 – Deductible
"Deductible" means the amount of Covered Charges that a Covered Person must pay each calendar year before benefits are payable from the Plan.

Section 15.15 – Dentist
"Dentist" means a person licensed to practice dentistry.

Section 15.16 – Dependent
"Dependent" means a child or spouse of a Participant who has met the requirements to obtain eligibility and coverage from the Plan in accordance with Section 1.17.

Section 15.17 – Designated Beneficiary
"Designated Beneficiary" means the person designated by the Death Benefit Participant, or by the terms of this Plan, to receive such Death Benefit Participant's Death Benefits.

Section 15.18 – Dollar Bank
"Dollar Bank" means an account that is established for an Employee and credited with contributions earned by an Employee when he works for an Employer. The contributions in a Participant's Dollar Bank may be used by a Participant and/or his surviving spouse to gain coverage under the Plan in accordance with the rules in Article I – Eligibility. A Dollar Bank is merely a record keeping account with the purpose of keeping track of contributions. A Dollar Bank consists solely of Employer contributions and is not credited with any interest income earned on the Plan's reserves. A Dollar Bank is a non-vested benefit and it can be forfeited in accordance with the rules in Article I – Eligibility.

Section 15.19 – Eligible Employee
"Eligible Employee" means an Employee or former Employee who has met the requirements to obtain eligibility from the Plan and on whose behalf contributions have been made to the Plan pursuant to a Collective Bargaining Agreement. An Eligible Employee is covered under the Plan only if he is also a Covered Employee. The Plan will not pay any claims for an Eligible Employee unless the Eligible Employee is also a Covered Employee on the date the claims are incurred. A Retiree is not an Eligible Employee.

Section 15.20 – Employee
"Employee" means any person employed by an Employer to perform work covered by a Collective Bargaining Agreement.

Section 15.21 – Employer
"Employer" means an entity that that is signatory to a Collective Bargaining Agreement, who employs persons to perform work covered by that Collective Bargaining Agreement, and who makes contributions to the Fund as required by the Collective Bargaining Agreement. Employer shall also mean the Union and the Apprenticeship Fund.

Section 15.22 – Experimental or Investigational
"Experimental" or "Investigational" means a treatment, service, prescription drug, or supply that is not generally accepted by specialists in the particular field of medicine in the state in which this Plan is established regardless of any claimed therapeutic value. A treatment, service, prescription drug, or supply is considered generally accepted if it adheres to the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature.

Section 15.23 – Facility
"Facility" means a place of service that is designed to provide medical treatment and is not used as an office or clinic for the private practice of a Physician or other professional medical provider.

A Facility must be licensed by the proper authority of the state in which it is located, have an organized Physician staff, and have permanent building space equipped and operated primarily for the purpose of performing medical services. Nurse practitioner retail clinic's, rest homes, homes for the aged, and nursing homes are not Facilities.

Section 15.24 – Fund
"Fund" means the IBEW Local 347 Electrical Workers Health and Welfare Fund.

Section 15.25 – Fund Office
"Fund Office" means any office or other physical location out of which the Fund is administered.

Section 15.26 – Hospital
"Hospital" means an institution that is licensed as a Hospital by the proper authority of the state in which it is located and that provides:

- Diagnosis, medical and surgical treatment under the supervision of a Physician on an inpatient basis; and
- 24-hour a day nursing services provided by registered nurses.

Skilled Nursing Facilities, convalescent homes, rest homes, homes for the aged, and nursing homes are not Hospitals.

Section 15.27 – Injury
"Injury" means physical harm sustained as the direct result of an accident and all related symptoms and recurrent conditions resulting from the same accident.

Section 15.28 – Medical Emergency
"Medical Emergency" means any situation in which, due to an Injury or Sickness, a person requires immediate medical care and delay could endanger the person's life, health, functioning or could cause extreme pain that cannot be controlled without such medical care.

Section 15.29 – Medically Necessary
"Medically Necessary" means a treatment, service, prescription drug, or supply that is:

- furnished or prescribed by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected Sickness or Injury;
- appropriate and necessary for the symptoms, diagnosis, or treatment of the Sickness or Injury;
- in accordance with standards of good medical practice within the organized medical community;
- not primarily for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Physician or other licensed provider, or any Hospital or Facility. The fact that a Physician may provide, order, recommend or approve a treatment, service, prescription drug, or supply does not mean that it will be considered Medically Necessary for the medical coverage provided by the Plan; and
- the most appropriate level of treatment that can be provided safely for the patient. For Hospital – Inpatient Services, this means that acute care as an inpatient is needed due to the kind of treatment the patient is receiving or the severity of the patient's condition, and that safe and adequate care cannot be received on an outpatient basis or in a less intensified medical setting.

Section 15.30 – Medicare
"Medicare" means the program of benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Section 15.31 – Monthly Premium
"Monthly Premium" means the dollar amount required for an Eligible Employee to receive a month of coverage from the Plan. The Monthly Premium is established by the Board of Trustees based on the average monthly cost of benefits for the past 12 months. This means that the Monthly Premium changes each month. The Board of Trustees has the authority to establish and change the Monthly Premium as it may deem appropriate in its sole and exclusive discretion.

Section 15.32 – Nurse Practitioner Retail Clinic Visit
"Nurse Practitioner Retail Clinic Visit" means a face-to-face meeting between a Physician and a patient provided at a clinic located in a retail store, supermarket or pharmacy for the purpose of medical treatment (e.g. CVS MinuteClinics, Walgreens Take Care Clinics, and Mercy Quick Clinics). Such clinics are staffed primarily by licensed nurse practitioners or physician assistants.

Section 15.33 – Participant
"Participant" means a Covered Employee or a Retiree.

Section 15.34– Participating Dentist
"Participating Dentist" means a Dentist that has agreed to participate in the Plan's dental network. The Plan currently utilizes Delta Dental as its dental network.

Section 15.35 – Participating Pharmacy
"Participating Pharmacy" means any pharmacy, including a designated mail order pharmacy, that has entered into an agreement with the Plan's prescription benefit manager. The Plan currently utilizes LDI as its prescription benefit manager.

Section 15.36 – Physician
"Physician" means Doctor of Medicine (MD); Doctor of Osteopathy (DO); Audiologist; Certified Registered Nurse Anesthetist (CRNA); Chiropractor (DC); Occupational Therapist (OT); Optometrist; Physical Therapist and Physiotherapist (PT); Physiotherapist; Advanced Registered Nurse Practitioner (ARNP); Physician's Assistant (PA); Podiatrist (DPM); Psychologist; Social Worker; Speech-Language Pathologist (SLP); Doctor of Dental Medicine (DMD), including Oral Surgeons; Licensed Professional Counselor (LPC); Certified Addiction Counselor; Psychiatrist; Master of Social Work (MSW); Licensed Professional Counselor; and Doctor of Psychiatry (PSY.D.).

Section 15.37 – Physician Office Visit
"Physician Office Visit" means a face-to-face meeting between a Physician and a patient provided at the Physician's private practice office for the purpose of medical treatment.

Section 15.38 – Plan
"Plan" means the IBEW Local 347 Electrical Workers Health and Welfare Fund as set forth in this document and as amended from time to time by the Trustees.

Section 15.39 – Plan Administrator
Plan Administrator means the Board of Trustees of IBEW Local 347 Electrical Workers Health and Welfare Fund. The Board of Trustees retains ultimate authority as the Plan Administrator for this Plan, but it has delegated responsibility for performing regular Plan administrative functions and activities, along with the authority to carry out such functions and activities, to Wilson-McShane Corporation. When used in this Plan document, the term Plan Administrator refers to any person or entity responsible for carrying out the regular administrative functions and activities on behalf of the Plan.

Section 15.40 – Preferred Provider or PPO Provider
"Preferred Provider" or "PPO Provider" means a Hospital, Facility, Physician, vision provider or other provider that has agreed to participate in the Plan's Preferred Provider Organization (PPO) network. The Plan currently utilizes UnitedHealthcare as its medical PPO Provider and VSP as its vision Preferred Provider.

Section 15.41 – Prevailing Charges
"Prevailing Charges" means:

- For treatment received from PPO Providers, the negotiated fee between the provider and the PPO Provider;
- For treatment received from non-PPO providers, the usual and customary amount that most health care providers within a geographic cost area charge for a treatment;
- For drugs and medicines requiring a Physician's prescription and considered a covered treatment, Prevailing Charges will not exceed the negotiated amount for Participating Pharmacies. For non-participating pharmacies the Prevailing Charges will not exceed the amount the Plan would have paid for the prescription if it was filled at a Participating Pharmacy; and
- For dental services, the amount which Delta Dental establishes as its maximum allowable fee for dental services contained in the "Current Dental Terminology" published by the American Dental Association. For dental services received outside of Iowa, the Prevailing Charge is based upon information from that state's Delta Dental Member Company.

Section 15.42 – Retiree or Disabled Retiree
"Retiree" or "Disabled Retiree" means a former Employee who has met the requirements to obtain eligibility and coverage from the Plan in accordance with Section 1.06 or Section 1.07. An individual is not a 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 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 this Section 15.42, an individual is considered to have performed work for 120 hours or more during a consecutive three month period on the first day of the third month after he has completed the 120 hours. See Section 1.12 for in-depth rules regarding a Retiree's return to work for an Employer.

Section 15.43 – Retiree Premium
"Retiree Premium" means the dollar amount required for a Retiree to receive a month of coverage from the Plan. The Retiree Premium changes each month. 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.

Section 15.44 – Sickness
"Sickness" means any abnormal physical or mental condition, including physical sickness, mental illness, or functional nervous disorders, that affects the person's ability to function normally and all related symptoms and recurrent conditions resulting from the same physical or mental condition. Sickness also means pregnancy, childbirth, or resulting complications.

Section 15.45 – Skilled Nursing Facility
"Skilled Nursing Facility" means a lawfully operated institution for the care and treatment of Covered Persons convalescing from a Sickness or Injury which provides room and board and 24-hour nursing service by a registered licensed nurse and is under the full-time supervision of a legally qualified Physician.

Rest homes, homes for the aged, and nursing homes are not Skilled Nursing Facilities.

Section 15.46 – Specialty Drug
"Specialty Drug" means an oral, injectable, infused, or inhaled medication that is either self-administered or administered by a healthcare provider, and used or obtained in either an outpatient or home setting.

Injectable medications including specialty oral medications shall encompass all medications, and biological, human or animal derived products or biosynthetic agents, including preparations that are sterile and pyrogen-free including, inhalation or implantation.

Specialty drugs have the following key characteristics:

- Need frequent dosage adjustments;
- Cause more severe side effects than traditional drugs;
- Need special storage, handling, and/or administration;
- Have a narrow therapeutic range; and
- Require periodic laboratory or diagnostic testing.

Section 15.47 – Summary Plan Description
"Summary Plan Description" means this combination Plan document and Summary Plan Description, and any amendments to this Plan document and Summary Plan Description.

Section 15.48 – Totally and Permanently Disabled
"Totally and Permanently Disabled" means a Participant is disabled as the result of an Injury or Sickness, either occupational or non-occupational in cause, and he meets at least one of the following criteria:

- He is receiving Social Security Disability Benefits, or other benefits under the federal Social Security Act on account of his disability, when the determination is based on a finding by the Social Security Administration that he is unable to engage in any substantial gainful activity because of a physical or mental impairment;
- He is receiving a Disability Pension Benefit from the National Electrical Benefit Fund;
- He has received a written opinion from a Physician stating that he will be prevented for life from pursuing his trade as an electrician; or
- He has received a written opinion from a Physician stating that he has been diagnosed with a terminal illness with a life expectancy of 12 months or less.

Section 15.49 – Trust or Trust Agreement
"Trust" or "Trust Agreement" means the Agreement and Declaration of Trust made as of May 11, 1953, by and among the Union, the Association and the Board of Trustees, as amended and restated in 1982, and as further amended and restated on January 1, 2007, as the Restated Agreement and Declaration of Trust of the IBEW Local 347 Electrical Workers Health and Welfare Fund, and as may be amended or restated from time to time in the future.

Section 15.50 – Union
"Union" means IBEW Local 347.

ARTICLE XVI – SUMMARY OF MATERIAL MODIFICATIONS

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INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
ORGANIZED NOV. 28, 1891
REG. U. S. PAT. OFF.
NECA
IOWA CHAPTER
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION