INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND

Summary Plan Description

April 1, 2024

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INTRODUCTION

The Fund

International Brotherhood of Electrical Workers Local No. 150 Welfare Fund (the "Fund") has been established pursuant to a collective bargaining agreement entered into between International Brotherhood of Electrical Workers, Local No. 150 (the "Union") and Lake County Division, Northeastern Illinois Chapter, National Electrical Contractors, Inc. ("NECA"). The Fund is a "welfare plan" and its purpose is to provide health and welfare benefits to Covered Persons.

This summary plan description is intended to acquaint you with the important features of the Fund. The provisions of the Fund, a companion trust agreement, and an insurance contract and certificate, however, necessarily govern the rights of persons under the Fund. Copies of the Fund Rules and Regulations, trust, insurance contract, and certificate are at the Fund's office. You may look at them if you wish.

Contributions

Each year, the Participating Employers contribute the amounts required of them under the collective bargaining agreement or otherwise. Certain Covered Persons also make contributions to the Fund. Finally, the Fund receives contributions from other welfare funds pursuant to reciprocity agreements. All contributions are paid to the Trustees of the Fund (the "Trustees").

Employers

Certain Participating Employers that are not members of NECA have entered into individual collective bargaining agreements with the union. The Union, the Joint Apprenticeship and Training Trust Fund (the "JATC"), the Fund itself, and International Brotherhood of Electrical Workers Local No. 150 Pension Fund (the "Pension Fund") also are Participating Employers under the Fund. Upon written request to the Fund, an individual may obtain information as to whether a particular employer is a Participating Employer and whether a particular employer is required to pay contributions to the Fund.

Defined Terms

Capitalized terms used in this summary plan description are defined in the formal plan document for the Fund which is available upon request.

WHEN COVERAGE STARTS

FOR YOU

Eligible Status

You are in an eligible status if you are an Employee, a Clerical Worker, an Apprentice, or a Retired Employee not excluded below. Being in an eligible status allows you to become a Covered Person when you have completed any applicable waiting period.

Upon turning age 65, Retired Employees and their Dependents age 65 or older become eligible for medical and prescription drug benefits under the Plan's insured arrangement with UnitedHealthcare, or its successor ("MAPD Program"). At this time, you become ineligible for self-funded benefits provided under the Plan, except for the following: (a) dental benefits; (b) vision benefits (excluding the annual vision examination benefit); and (c) medical expenses (but only to the extent not covered by the MAPD Program, and coverage will be in the amount of 20% of the allowed amount for such medical expenses). If your Dependents are under age 65 when you turn 65, your Dependents continue to be eligible for coverage until they turn 65, at which time their coverage will end (except as noted above), and they will become eligible for the MPAD Program.

Exclusions

If you are a Retired Employee, you are not eligible for the time loss weekly benefit.

Resumption of Eligibility Period for Employees

If you return to an eligible status after your coverage has ceased:

- You will become eligible on the first day of the month that follows any three-month period during which you work 375 hours for one or more Participating Employers.

- Except as explained below in "Retired and Disabled Employees and Surviving Spouses," you may not become eligible as a Retired Employee unless you first become eligible as an Employee.

Eligibility and Waiting Period For Apprentices, Newly-Organized Employees, and Clerical Workers

In general, if you are an Apprentice, a newly-organized Employee, or a Clerical Worker, you will become eligible on the first day of the month coincident with or next following the date you complete 60 days in an eligible status.

If you return to an eligible status after your coverage has ceased, you will become eligible on the first day of the month coincident with or next following the date you again complete 375 hours in any consecutive three months.

If you are a Clerical Worker, you will not be eligible unless your employer (excluding the union, the Pension Fund, this Fund, and the JATC) has entered into a participation agreement with the Trustees.

Exceptions to the Waiting Period

If you return to an eligible status after coverage ceased because you entered full time service in the armed forces, you will become a Covered Person on the first day of the month following discharge from the armed forces if you are available for Active Work at that time. If you were in an eligible status on the date you entered the armed forces, but had not yet qualified for coverage, the hours worked for a Participating Employer in the contribution quarter during which you entered the armed forces, and in the preceding contribution quarter, may be applied towards qualifying for an eligibility quarter following discharge. To qualify for the second eligibility quarter following discharge, the hours you worked for a Participating Employer in the contribution quarter during which you entered the armed forces may be applied. The Trustees will apply the provisions of this subsection relating to individuals who serve in the armed forces in a manner consistent with the terms of the Uniform Services Employment and Reemployment Rights Act of 1994, as amended and in effect from time to time. Your newborn Child will become a Covered Person at the moment of birth if you enroll the Child within 31 days after the birth. Your adopted Child will be covered as of the earlier of (i) the date you adopt the Child or (ii) the date as of which you acquire the legal obligation for total or partial support of the Child pursuant to a court order in anticipation of an adoption.

Retired and Disabled Employees and Surviving Spouses

In general, you will become eligible as a Retired Employee on your retirement date. A Retired Employee means a person who: (1) retires from active work on or after the date they turn 55; (2) has applied for coverage under the Plan as a Retired Employee; (3) was eligible for benefits under the Plan immediately prior to retirement; (4) was eligible for benefits under the Plan continuously for the 12 months immediately preceding retirement; and (5) either (a) was employed by a Participating Lake County Employer (other than the Union, the IBEW Local 150 Pension Fund, the Plan or JATC) and at the time of retirement, qualified for a retirement or disability benefit under the IBEW Local 150 Pension Fund; or, (b) was employed by a Participating Employer as a Clerical Worker at the time of retirement, completed ten years of employment with a Participating Employer and, on account of such employment, had at least 120 months of contributions made on his or her behalf. You may elect Member only coverage, Member and spouse coverage, Member and family coverage, or no coverage. If you elect no coverage at the time of your retirement, you may change your mind thereafter—such as when you reach age 65 or lose other coverage. If you elect coverage at the time of your retirement and then drop your coverage—for any reason—you should speak to someone in the Fund Office. There are rules that govern what steps you must take to regain coverage. In addition, if a Retired Employee who has not attained age 65 ceases making self-payments to the Fund and elects coverage under the Health Insurance Market Place, then such individual (and spouse) cannot again resume participation in the Fund. Furthermore, a Retired Employee who opts out of Plan coverage prior to age 65 for any other reason will not be permitted to resume participation in the Plan unless he elects to resume participation hereunder prior to age 65.

A Retired Employee is not eligible for time loss weekly benefits.

If you become Totally Disabled, you will be eligible to continue coverage. After one year your coverage will terminate unless you return to Active Work.

Your Surviving Spouse may choose to continue medical coverage through self-payment. A Surviving Spouse may elect single coverage or (if he or she has one or more Dependents) family coverage.

Continuation of Eligibility For Employees and Apprentices Only

Your coverage shall continue until the last day of the eligibility quarter in which you cease being in an eligible status. To maintain your coverage for a succeeding eligibility quarter, you must work for a Participating Employer for at least:

- 375 hours in the contribution quarter preceding the eligibility quarter; or
- 750 hours in the two consecutive contribution quarters preceding the eligibility quarter; or
- 1,125 hours in the three consecutive contribution quarters preceding the eligibility quarter; or
- 1,500 hours in the four consecutive contribution quarters preceding the eligibility quarter.

First year Apprentices' actual hours only spent in the classroom, as reflected in the monthly JATC reports for the first two eligibility quarters, will be considered as hours of work for this purpose. If you return to an eligible status following a discharge from the armed forces, the hours worked in the contribution quarter during which you entered the armed forces and the three preceding contribution quarters may be applied toward meeting the work requirements.

An "hour of work" does **not** include any period during which you are employed outside the jurisdiction of the International Brotherhood of Electrical Workers and the Trustees will not accept any contributions from anyone in connection with such employment except toward the WRA benefit.

Contribution Quarters and Eligibility Quarters For Employees

Satisfying any of the work requirements for a contribution quarter qualifies you for coverage during the next following eligibility quarter:

Contribution Quarters	Eligibility Quarters
January, February, March	May, June, July
April, May, June	August, September, October
July, August, September	November, December, January
October, November, December	February, March, April

Reinstatement

An Employee whose medical expense benefits coverage ceased on account of his failure to meet the eligibility requirements may reinstate such coverage through self-payment, provided he has at least 299 hours in his hour bank at the time of such reinstatement. The amount of an Employee's self-payment contributions for reinstatement purposes will be the difference between the number of hours the Employee was required to work to maintain coverage and the number of hours in his bank multiplied by the hourly rate determined by the Trustees.

Forfeiture

If an Employee or Apprentice becomes employed by an employer that is not obligated to contribute to the Plan on his behalf, and such employment is in the same trade or craft for which contributions were previously made to the Plan on his behalf, then he shall cease to be in eligible status as of the end of the month in which such employment begins and his hour bank for eligibility shall be forfeited at that time, unless the Employee or Apprentice is working under a reciprocity agreement.

Contributions

Contributions for your coverage are required only if (1) you are a Retired Employee, or are receiving a disability benefit, under the Pension Fund; (2) you are a Surviving Spouse; (3) you are continuing your coverage through self-payment; or (4) you or your Dependents elect to continue coverage in accordance with COBRA.

Contribution Formula

If you are a Retired Employee or a Surviving Spouse, the amount of your contribution will be a percentage of the actual cost of your coverage, as determined by the Trustees.

If you are a Surviving Spouse under age 65, then you will pay 70% of the actual cost of your coverage. If you are a Surviving Spouse age 65 or older, then you will pay 40% of the actual cost of your coverage.

If you are a Retired Member and have attained age 63, the amount of your contribution will be 50% of the actual cost of your coverage. If you are a Retired Member who has not yet attained age 63, the percentage of the actual cost you must contribute depends on the year you retired, as shown in the following table:

If Retirement Date Occurs In	The Applicable % Will Be
2009	75%
2010	80%
2011	85%
2012	90%
2013	95%
2014 and After	100%

For Retired Employees aged 65 and older that elect coverage under the MAPD Program, the applicable percentage is 100%.

The Trustees reserve the right to change the applicable percentages at any time.

FOR YOUR DEPENDENTS

In general, your Dependents include your Spouse and your children. Please refer to the Definitions section for the full definition of Dependent, Spouse and Child.

A spouse who is legally separated or on active military duty is not considered a Dependent. If both you and your Spouse are in an eligible status, each of you will be insured as an Employee for life insurance and accidental death and dismemberment benefits and covered for loss of time benefits. With respect to medical, dental, and vision expense benefits, each of you will be covered as an Employee **and** as a Dependent. Your benefits then will be "coordinated" to make sure that your coverage does not exceed 100% of each claim.

> **Example:** You and your Spouse qualify as Employees. After meeting the deductible for a year, you incur a fully eligible charge of $200. The first 80% of the charge ($160) is covered because you are an Employee. Another 80% of the charge ($160) is covered because you are a Dependent of an Employee. Before coordination, you would be entitled to receive $320 for a $200 claim. After coordination, 100% ($200) of the charge would be paid by the Fund.

Your Dependents become eligible for coverage on the later of the following dates:

- The date you become eligible for coverage as a Member.
- The date you acquire your first Dependent if you provide the Fund Office with a birth certificate (in the case of a newborn) or a marriage certificate (if you are a newlywed) within 30 days. If you delay providing such documentation, coverage will begin on the first day of the month after you provide it.
- For adopted children, the earlier of (i) the date of adoption or (ii) the date you acquire the legal obligation for total or partial support of the child in anticipation of such adoption and the Fund Office is notified **in writing** within 30 days.

If you choose not to cover your Dependents, but then later choose to do so, your Dependents will be eligible:

- On the date of their enrollment, if you enroll them within 31 days of becoming eligible.
- The first day of the month coincident with or following the date of their enrollment, if you enroll them more than 31 days after they become eligible. However, no coverage will be provided for any Illness for which the Dependent

received treatment during the 6 months before enrollment. This exclusion expires after the Dependent has been covered under the Fund for 12 months. This exclusion does not apply to individuals under age 19 or after July 1, 2014.

SPECIAL ENROLLMENT RIGHTS

Persons Who Lose Other Coverage. If you are eligible for benefits but did not enroll yourself, your eligible Dependent Spouse and/or children for coverage when you were first eligible to do so, you will be allowed to enroll yourself, your eligible Dependent Spouse and/or children for coverage **if *all* of the following three conditions are met**:

- You were and/or your eligible Dependent was covered under a different group health plan or health insurance coverage at the time coverage previously was offered; and
- Your and/or your Dependent's coverage ended because of (a) loss of eligibility (including legal separation, divorce, death, termination of employment, reduction in the number of hours of employment), (b) termination of the employer's contribution toward such other coverage, (c) exhaustion of coverage under COBRA, (d) denial of a claim due to operation of a lifetime or annual limit, or (e) if coverage was provided by an HMO, you are no longer residing, living or working in the service area of the HMO and the HMO does not provide coverage for that reason; and
- You request enrollment in this Fund for yourself and/or your Dependents no later than 30 days after the date other coverage was lost for one of the reasons listed in item 2 above.

Acquisition of Eligible Dependent. Employees, Spouses and Dependent children may enroll under the Fund following the acquisition of a new Dependent **if *all* of the following three conditions are met**:

- You and your Dependent are eligible for coverage (e.g., satisfied the 375-hour rule);
- A Spouse and/or a child becomes your Dependent through marriage, birth, adoption, or placement for adoption; and
- You request enrollment for yourself, your Spouse (whether or not previously eligible), and/or the child(ren) newly acquired through the marriage, birth, adoption or placement for adoption within 30 days of the event.

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program (SCHIP). If you did not enroll yourself, your eligible Dependent Spouse and/or children for coverage when you were first eligible to do so, you will be allowed to enroll yourself, your eligible Dependent Spouse and/or children for coverage **if *all* of the following four conditions are met**:

- You and/or your Dependent are currently eligible for coverage under the Fund;
- You and/or your Dependent were covered under Medicaid or SCHIP;

- You and/or your Dependent loses eligibility under Medicaid or SCHIP; and
- You request enrollment for yourself and/or your Dependent within 60 days of the date Medicaid or SCHIP coverage terminates.

Eligibility for Financial Assistance Under Medicaid or SCHIP. If you did not enroll yourself, your eligible Dependent Spouse and/or children for coverage when you were first eligible to do so, you will be allowed to enroll yourself, your eligible Dependent Spouse and/or children for coverage **if *all* of the following three conditions are met:**

- You and/or your Dependent are eligible for coverage under the Fund;
- You and/or your Dependent become eligible for financial assistance through Medicaid or SCHIP, for example through a premium assistance subsidy, for coverage under the Fund; and
- You request enrollment for yourself and/or your Dependent within 60 days of the date you or your Dependent becomes eligible for the financial assistance.

Effective Date of Coverage. If you provide notice within 30 days, the effective date of coverage for purposes of these special enrollment rights will be:

- For marriage – date of marriage;
- For birth – date of birth;
- For adoption or placement for adoption – date of adoption or the date you acquire the legal obligation for total or partial support of the child;
- For loss of coverage – date of loss of coverage;
- For loss of coverage or financial assistance under Medicaid or SCHIP – no later than the first day of the first calendar month beginning after receipt of completed request for enrollment.

You must promptly notify the Fund Office in writing of any change of address or employment that results in regaining eligibility for coverage.

WHEN COVERAGE STOPS

Your coverage will stop on the earliest of the following dates:

- The date the Fund terminates or, if you are covered on account of a participation agreement, the date the participation agreement terminates.
- The date your eligibility ceases upon the "run-out" of your hours.
- The end of the month in which you cease to be in an eligible status, subject to the "run-out" provision for Employees.
- The date you enter full-time service in the armed forces.

If you cease to be eligible due to Total Disability or layoff, coverage for you and your Dependents may be continued:

- With self-payments, for not more than one year in case of Total Disability.
- With self-payments, for not more than the period of "run-out" of your hours plus 18 months in case of layoff or leave of absence.

The "run-out" provision does not apply to Clerical Employees or to Retired Employees.

A Dependent's coverage will stop on the earliest of the following dates:

- The date the Fund terminates.
- The last day of the month in which you cease to be a Covered Person.
- The date such person ceases to qualify as a Dependent.

If your Dependent ceases to be eligible because of your death, his or her coverage will end on the earliest of the following dates:

- The date the Fund terminates.
- The date your Surviving Spouse dies.
- The date your coverage would have ended upon the "run-out" of your hours.

Notwithstanding the foregoing, your Surviving Spouse's coverage will continue until the earliest of the following to occur (subject to self-payment):

- The date your Surviving Spouse dies,
- The date your Surviving Spouse becomes eligible for coverage under another group medical plan, or

- The date your Surviving Spouse is no longer eligible for benefits under the IBEW Local No. 150 Pension Fund.

Self-Payment Options for Employees Only

If you are an Employee whose medical expense benefits coverage has ceased, you may continue your coverage through either self-payment or COBRA, provided you are not employed during such period at a location outside the IBEW jurisdiction. You may only choose one option. If you choose self-payment, you cannot later choose COBRA continuation coverage unless the Employee experiences an additional qualifying event. The amount you pay will be determined by the Trustees based on the difference between the number of hours you were required to work to maintain coverage and the number of hours you actually worked. Your self-payment must be made to the Trustees, in advance, on a quarterly basis. You may continue your coverage only while you are available for Active Work. You may not continue your coverage:

- For more than 18 months after the date your coverage otherwise would have stopped on account of your failure to work any hours during those months.

If you stop making self-payments, your coverage will stop on the last day of the month for which self-payment was made.

Self-Payment For Retirees

If you are a Retired Employee, you may continue your medical expense benefits coverage through self-payments. Self-payments will begin on the first day of the month in which your retirement occurs. You can elect single or family coverage. The amount you will pay is discussed above in the Contributions Formula section.

Self-Payment for Surviving Spouses

If you are a Surviving Spouse, you may continue your medical expense benefit coverage through self-payment. You can elect single or family coverage. The amount you will pay is discussed above in the Contributions Formula section.

COBRA Continuation

Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), coverage for health care benefits may be continued beyond the date it otherwise would stop, subject to certain conditions. The COBRA Notice used by the Fund forms a part of this summary plan description.

If a Covered Person is entitled to have his health care benefits coverage continued, whether at no cost or through self-payment or pursuant to COBRA, he or she shall elect which, if any, continuation coverage is desired. **PLEASE NOTE THAT IF A QUALIFYING EVENT OCCURS AND YOU CHOOSE TO CONTINUE YOUR COVERAGE EITHER AT NO COST OR THROUGH SELF-PAYMENT, YOU WILL NOT BE ENTITLED TO COBRA CONTINUATION ON ACCOUNT OF THAT EVENT.**

USERRA Continuation

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") is a federal law providing protections for Employees who leave employment for military service. For Fund purposes, USERRA applies only to health coverage (*i.e.*, medical, dental, drug, vision).

If you satisfy USERRA's eligibility requirements, you are entitled to elect continuation coverage for yourself and your Dependents during your absence from employment for military service. You are also entitled to immediate reinstatement in the Fund upon your return from military service as if you had been continuously employed during the military service. If you do not satisfy USERRA's eligibility requirements, you are not entitled to any of the protections described in this section.

Continuation of Coverage During Military Service. The law requires that coverage by the Fund continue during a leave covered by USERRA. Coverage must be the same as provided to similar Employees; thus, if coverage changes for similar Employees, it will also change for the person on leave. The employee's cost of such coverage will equal:

1. For leaves of 30 days or less, no charge;

2. For leaves of 31 days or more, the COBRA premium (up to 102% of the full contribution).

You will be deemed to be on military leave of absence effective on the date you leave employment to enter military service. If your leave of absence is less than 31 days, your Fund coverage will be continued as though you were Actively at Work for the duration of the leave. If your leave of absence is 31 days or more, your Fund coverage will terminate as of the date you begin your military leave of absence, subject to the USERRA continuation of health coverage provisions described below.

If you fail to provide advance notice of your military service, your Fund coverage will terminate on the date you leave employment to enter military service, and you will not be eligible to continue coverage unless the failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may elect to continue coverage retroactive to the date your military leave of absence began, provided that you elect such coverage and pay all amounts required for the continuation coverage, as discussed below.

After the Fund receives notice of your military leave of absence, you will have the option of continuing your coverage pursuant to the Fund. USERRA continuation coverage is similar, but not identical, to COBRA continuation coverage. The rules for election of continuation coverage are the same as the COBRA election rules described in this summary plan description, provided that the COBRA election rules do not conflict with USERRA. If you do not elect continuation coverage within the applicable COBRA timeframe, you will lose the right to USERRA continuation coverage and such right will not be reinstated.

You must make timely self-payments at the COBRA rate determined by the Trustees from time to time to purchase COBRA continuation coverage. The COBRA payment rules apply to payment for USERRA continuation coverage, provided the COBRA payment rules do not conflict with USERRA. If you do not submit payment for all amounts required to continue coverage within the applicable COBRA timeframe, you will lose the right to USERRA continuation coverage and such right will not be reinstated.

Maximum Period of Coverage during Military Service. Continued coverage under this provision will terminate on the earlier of the following events:

(a) The date you fail to return to employment with the Participating Employer after completion of your leave. Employees must return to employment within:

(i) the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

(ii) 14 days of completing military service, for leaves of 31 to 180 days;

(iii) 90 days of completing military service, for leaves of more than 180 days;

(b) 24 months from the date your leave began;

(c) The date that the Fund no longer provides group health care coverage to any Employees;

(d) The day after the date you fail to elect continuation coverage as required by the COBRA continuation coverage election rules; or

(e) The first day of the month for which a timely self-payment has not been.

The Fund will provide continuation coverage to the extent required by USERRA. You may also have continuation coverage rights under COBRA. As noted above, although the COBRA and USERRA provisions are similar, COBRA continuation coverage and USERRA continuation coverage are not identical. As long as you remain simultaneously eligible for both COBRA and USERRA continuation coverage, you will receive the more generous benefit rights that apply under these statutes. The COBRA and USERRA continuation coverage periods will run concurrently. Please contact the Fund Office for more information about USERRA continuation coverage.

Reinstatement of Coverage Following Military Service. USERRA requires that coverage be reinstated upon your return to work. Reinstatement will apply whether coverage pursuant to the Fund was maintained during the leave or not. To be eligible for reinstatement, you must have provided advance notice of your military service (unless failure to provide such notice is excused), be honorably discharged from the military service and return to work within:

(a) The first, full business day after your military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

(b) 14 days after your military service ends, for leaves of 31 to 180 days;

(c) 90 days after your military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if your military service causes an Illness or Injury or worsens an Illness or Injury. Your failure to return within the times stated must be due to such an Illness or Injury. In that case, you may take up to a period of two years to return to work. If, for reasons beyond your control, you cannot return to work within two years, you must return as soon as is reasonably possible. Your USERRA rights may be limited if your period of military service exceeds 5 years (note, however, that many periods do not count against this 5-year rule, such as periods during which you were retained on active duty due to war or national emergency).

Upon reinstatement, all provisions and limits of the Fund will apply to the extent that they would have applied had you not taken leave. The eligibility period will be waived, and the pre-existing condition limit will be credited as if you would have been continually covered by the Fund, except with respect to Injuries or Illnesses determined by the Secretary of Veterans Affairs to have been caused or worsened by military service.

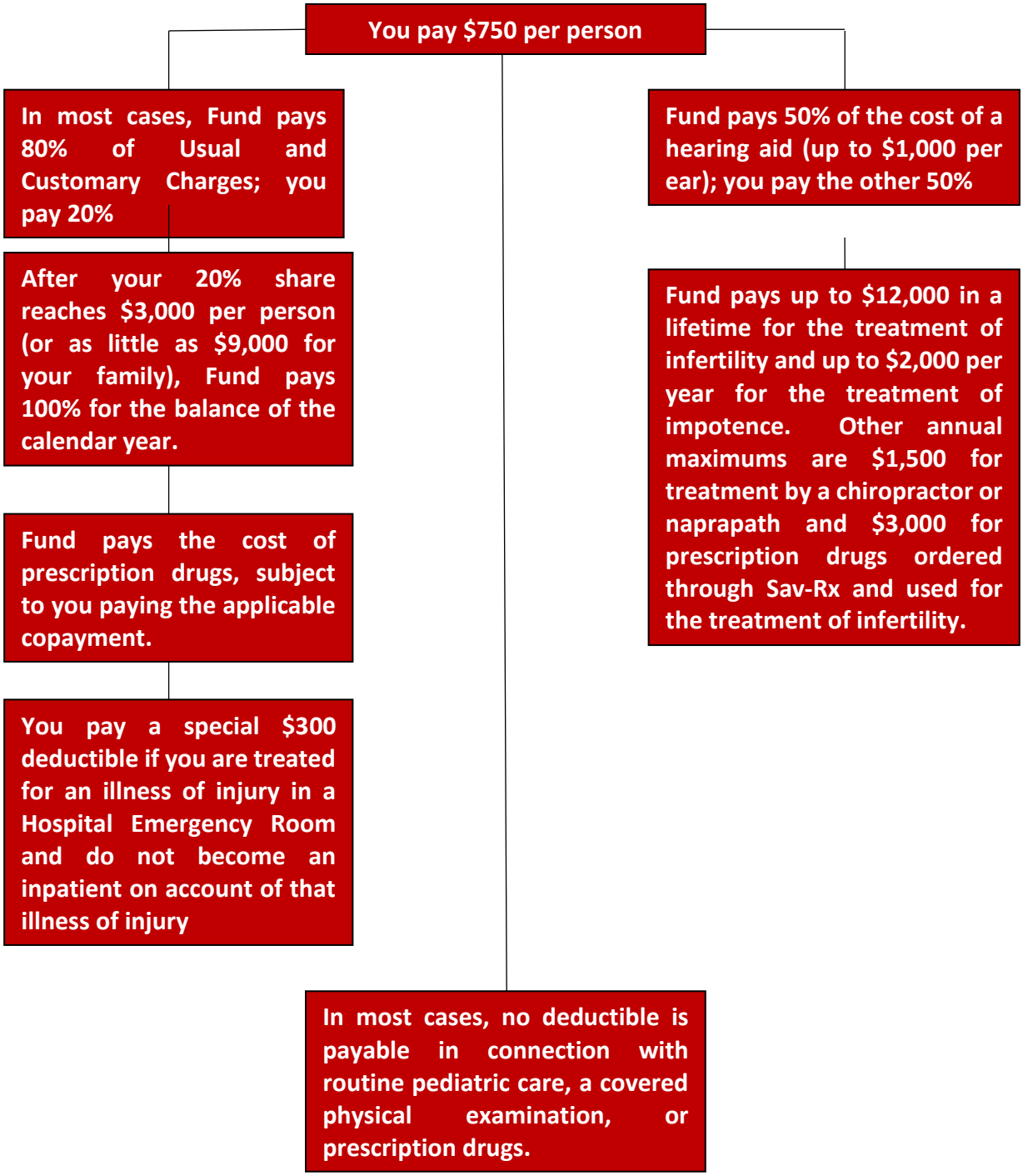
These rules are intended to comply with the requirements of USERRA. The USERRA provisions will control in the event of any inconsistencies between the Fund documents and USERRA.

NOTE: For complete information regarding your rights pursuant to USERRA, contact your Participating Employer.

Family and/or Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") enables you, if you qualify, to take up to 12 weeks of unpaid leave for your serious Illness, after the birth or adoption of a child, or to care for your seriously Ill spouse, parent or child. The FMLA requires certain Participating Employers to maintain health care coverage during the leave period. If you think that this law may apply to you, please contact your Participating Employer.

CHARGES COVERED BY THE MEDICAL PLAN



MEDICAL EXPENSE BENEFITS

How Your Medical Plan Works

Briefly, when you or one of your eligible Dependents has covered medical expenses:

- You pay the first $750 of those expenses for each person during each calendar year.
- The Fund then pays 80% of **most** other Usual and Customary Charges for that person during the balance of the calendar year.

You Pay The First $750 - The "Deductible"

The Fund starts paying benefits as soon as a Covered Person's expenses go over $750. The first $750 that you pay is called the "deductible." It applies separately to you and each eligible Dependent - but just once in any calendar year. The Fund has three features that can help to reduce the deductible:

Family Provision

If three or more covered persons in your family satisfy the deductible for a calendar year, no deductible must be satisfied by any other covered person in your family for the rest of that calendar year.

Common Accident Provision

When two or more covered members of your family are hurt in the same Accident, only one deductible applies that year to all expenses resulting from the Accident.

Carryover Provision

Another exception occurs if a Covered Person incurs medical expenses in the final three months of a calendar year that are applied to his deductible for that year. In that case, such expenses also are applied to that Covered Person's deductible for the following calendar year.

Deductible Not Applicable

In most cases, no deductible is applicable in connection with routine pediatric care or a standard physical examination.

Emergency Room Deductible

If you or your Dependent are treated in the Emergency Room of a Hospital and are not admitted to the Hospital on account of the Illness or Injury, you will pay a special deductible of $300.

The Fund Pays 80% of the Rest

After you pay the deductible for each person, the Fund takes care of 80% of **most** other covered expenses for the rest of the year.

You Pay 20% - But There is a $3,000 Per Year Medical Out of Pocket Maximum

While the Fund pays 80% of the eligible charges, you'll pay the other 20%. But, in most cases, you will not pay more than $3,000 for any one person in a calendar year. And if your 20% share of covered expenses reaches $9,000 total for members of your family during any calendar year, the Fund then pays 100% of the Usual and Customary Charges incurred by your family for the rest of that year. These maximums limit the amount of eligible expenses you'll pay in any calendar year. Regardless of how high your medical expenses climb in a year, the Fund pays the usual and customary portion of all remaining eligible expenses. (There are some ineligible expenses. For example, the maximum lifetime amount payable to or an account of a Covered Person for infertility treatment is $12,000. The maximum annual amount payable to or on behalf of a Covered Person for the treatment of impotence is $2,000, for chiropractic care, $1,500, for naprapathic care, $1,500, and for prescription drugs used in the treatment of infertility, $3,000.)

The ACA Out of Pocket Maximum

The Trustees have added an "ACA out of pocket maximum" in addition to the medical out of pocket maximum. Like the medical out of pocket maximum, the ACA out of pocket maximum takes into account all medical, dental, and vision benefits paid under the Fund. However, unlike the medical out of pocket maximum, the ACA out of pocket maximum also takes into account prescription drug benefits paid by the Fund. The ACA out of pocket maximum is $9,100 per individual and $18,200 per family for the 2024 Calendar Year, with these amounts indexed to increase annually. Note that the ACA out of pocket maximum only takes into account benefits paid in-network (either the PPO network or the Fund's preferred prescription drug network). After you reach the ACA out of pocket maximum, the Fund pays 100% of eligible expenses incurred in network. Notwithstanding anything to the contrary, any amount you pay (or is paid on your behalf from a source other than the Plan) for Protected Services, Continuing Care Services, and Misidentified Provider Services will count towards you satisfying the ACA out of pocket maximum, even if the items or services you receive were furnished by a provider outside the Blue Cross/Blue Shield of Illinois preferred provider network.

The Exceptions

- If you or your Dependent are treated in a Hospital that is not a member of the preferred provider network that was formed and administered by Blue Cross/Blue Shield of Illinois, the Fund will pay only 70% of the Usual and Customary Charges.

- The Fund pays 50% of the Usual and Customary Charges for the treatment of infertility. You pay the other 50%. Your share of these expenses will not apply towards the maximum out-of-pocket level described above. The maximum

lifetime amount payable by the Fund on account of the treatment of infertility is $12,000.

- In most cases, the Fund pays 50% of the cost of a hearing aid prescribed by a Doctor. For purposes of the Fund, a "hearing aid" means a device used in one ear. You may replace a hearing aid not more frequently than once every three years. The maximum amount payable by the Fund for a hearing aid is $1,000 per ear every three years. Your share of hearing aid expenses will not apply towards the maximum out-of-pocket level described above.

  Example: On June 1, 2021, you spend $2,400 (a piece) to purchase a hearing aid for each of your ears. Subject to the deductible, the Fund will cover $2,000 of the cost of the hearing aids so long as three years have passed since you last purchased a hearing aid. If you replace one or both of your hearing aids after June 1, 2024, the Fund again would cover the first $1,000 per ear of the replacement cost.

- Prescription drugs are covered separately under a prescription drug card program.

- An expense will not be paid if a claim is submitted later than one year following the date that the expense was incurred.

- Preventive care benefits required by the Patient Protection and Affordable Care Act ("ACA") are covered at 100% if received in network (Blue Cross Blue Shield).

- If you receive Protected Services, Continuing Care Services, or Misidentified Prover Services from a provider outside the Blue Cross/Blue Shield of Illinois preferred provider network, the Plan will, after the satisfaction of the deductible, impose cost-sharing as if you received the items or services from a provider within the Blue Cross/Blue Shield of Illinois preferred provider network, in accordance with the No Suprises Act and its implementing regulations.

Covered Expenses

In general, after you have satisfied the deductible, the Fund pays 80% of the Usual and Customary Charges for the following services if they are for Medically Necessary treatment of an Illness or Injury incurred off the job:

- Hospital and Hospice expenses,

- approved Substance Abuse Treatment Center,

- post-hospital and home health care,

- Doctor's care,
- replacement of organs or tissues when Medically Necessary and not Experimental,
- surgery, and
- maternity care, including charges from a Birthing Center.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of 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 Caesarean 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Hospital and Substance Abuse Treatment Center Expenses - In-Patient Care

The Fund covers the Hospital's and the Substance Abuse Treatment Center's charges for:

- semi-private room, board, and
- an unlimited number of days for each Hospital confinement.

If your Doctor determines that you require private accommodations or if you require intensive or specialized care, the Fund covers the cost of room and board. Otherwise, it covers the most common semi-private room charge.

Hospital services means most services and supplies provided by the Hospital, including general nursing care, drugs and medicines, cases and dressings, X-rays and lab tests, physical therapy, and the use of operating, intensive care, and other treatment rooms and equipment.

Hospice Care

The Fund covers Hospice charges of you or your Dependent is terminally ill with 6 months or less to live, as diagnosed by a Doctor, and the Hospice provides a plan of care furnished to the Trustees that:

- is prescribed by a Doctor,
- is reviewed and approved by a Doctor monthly,
- is not for curative treatment, and
- states the Hospice's and Doctor's belief that the Hospice care will cost less than any comparable alternative.

Hospice Care may be provided in you or your Dependent's home by a Home Health Agency or Hospice Agency or in a Hospice inpatient facility. However, the Fund will pay for charges in a Hospice inpatient facility only up to 150% of the average Hospital semi-private room daily rate in the geographic area of the Hospice.

Nursing Home and Home Care

If your physician sends you to a Nursing Home, the Fund covers the cost of room, board, and services, not to exceed 50% of the average semi-private room daily rate for Hospitals in the area of the Nursing Home, provided that your confinement begins within 7 days of your Hospital release. If a Doctor arranges for home nursing visits through a Home Health Care Agency as a substitute for Hospital confinement, the Fund will pay the agency's charges, subject to a biweekly review of the home health care plan submitted by the Doctor.

The Fund covers Home Health Agency charges if the Trustees are provided with a plan of care that is prescribed by a Doctor, who reviews and approves the plan every two weeks, and contains a statement expressing the Doctor's and the Home Health Agency's belief that:

- the number of days of home health care does not exceed the number of days that would have been required in a Hospital or Nursing Home,
- the home health care will probably cost less per day than the daily rate for confinement in a Hospital or Nursing Home and
- confinement in a Hospital or Nursing Home would otherwise be required.

Home health care includes skilled nursing care and home health aide services and other services provided in lieu of the services that would have been required if you or your Dependent was confined in a Hospital or Nursing Home. Home health care does not include housekeeping or custodial care.

Preventive Services

This Fund provides coverage for certain Preventive Services as required by the ACA. Preventive Services are paid for based on the Fund's payment schedules for the individual services. Coverage is provided on a PPO Network basis (i.e., through Blue Cross/Blue Shield of Illinois) with no cost-sharing (for example, no deductibles, coinsurance, or copayments), and on an out-of-network basis with normal cost sharing as reflected in the booklet. The Preventive Services covered by the Fund include the following:

- Items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention;
- Preventive care and screenings for newborns, infants and children as provided for in the comprehensive guidelines supported by the Health Resources and

Services Administration, including the American Academy of Pediatrics Bright Futures guidelines; and

- Preventive care and screenings as provided for women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Pediatric Care

Under the Fund, routine medical care, including physical examinations, are covered for eligible children under age 2. Required immunizations for eligible children (under 18) are also covered. In determining which immunizations are required, the Fund relies on an immunization schedule prepared by the American Academy of Pediatrics. A copy of the schedule is on file with TIC International Corporation.

Organ and Tissue Transplants

The Fund covers charges for Medically Necessary organ and tissue transplants provided they are not Experimental or Investigational. You must obtain a second opinion prior to the transplant.

Gene Therapy Treatment Prescribed By A Physician

The Fund covers gene therapy approved by the federal Food and Drug Administration for the use for which it is prescribed at the time the gene therapy treatment is provided. Coverage is provided for all phases of related gene therapy treatment, including, but not limited to genetic testing, treatments, procedures, services, supplies and medicines provided in connection with admission, the extraction of cells, the administration of the gene therapy treatment, and follow-up care.

Other Services

The Fund also covers the usual and customary expenses for Necessary treatment for an off-the-job Illness or Injury. These other "covered expenses" include:

- registered and licensed practical nurses, other than a close relative or someone living in your home;
- professional ambulance service;
- physical therapy;
- blood and blood plasma;
- anesthesia, oxygen, and rental of equipment to administer them;
- initial purchase of custom-fitted orthotics, artificial limbs and eyes, or similar appliances;

- rental of Hospital beds, wheelchairs, or other Durable Medical Equipment;
- casts, splints, braces, trusses, and crutches;
- services and supplies provided for the treatment of impotence;
- Doctor's examination and reporting services for a second opinion by a board-certified specialist;
- diagnostic tests and radioactive therapy;
- expenses for the services of an oral surgeon incurred by a Covered Person in connection with the removal of one or more impacted wisdom teeth;
- services and supplies, other than prescription drugs, prescribed to male or female Covered Persons for the purpose of birth control;
- hearing examinations performed on a Covered Person not more frequently than once in every third calendar year;
- mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema; and
- expenses for a diabetic instruction program that is designed to teach you and your family about the disease process and daily management of diabetic therapy.

Items Not Covered By the Fund

- Supplies or services for which the Covered Person is not required to pay.
- Supplies or services that are not Medically Necessary.
- Expense for a work related Illness or for which a Covered Person is entitled to payment under a workers' compensation or other law.
- Expenses for prescription drugs except while an inpatient or to the extent permitted under the prescription drug card program administered by Sav-Rx.
- Most expenses for cosmetic surgery.
- Expense for the services of a private duty Nurse when the Covered Person is Hospital Confined.
- Expense incurred by a Covered Person during a period of incarceration if such period is at least 30 days.

- Expense for the services of a person who normally lives in your household, or who is the parent, Spouse, child, brother or sister of you or your Dependent.

- Expense for services or supplies that are Experimental or Investigational or for education (other than the education portion of a substance abuse treatment program).

- Expense for the purchase of exercise equipment.

- Expense for Work-Related Illness or Injury.

- Expense for services and supplies you or your Dependent receive from the Uniformed Services Medical Care Facilities, unless otherwise required by law.

- Expense for any of the services listed below unless, and except to the extent that, payments for such services are specifically provided for under the medical, dental or vision plans forming a part of the Fund:

  – Dental x-rays; treatment on or to the teeth (for medical or dental reasons); treatment of gums other than for tumors; or treatment of other structures mainly involved in the treatment or replacement of the teeth. However, this exclusion does not apply to: (1) treatment received within two years after the date of an Accident to repair the damage to natural teeth caused by that Accident, (2) procedures that are required and incidental in conjunction with the treatment of a pre-existing, unrelated, and purely medical condition, as certified by a Doctor, or (3) services or supplies provided in connection with the administration of general anesthetics as part of treatment of teeth or gums.

  – Expense for eye refractions, or eye glasses other than for a contact lens used in the treatment of keratoconus or to replace a lens removed because of a cataract.

  – Expense for radial keratotomies or other procedures for surgical correction of myopia and/or other refractive errors.

- Expense for custodial care, except when provided by a Hospice.

- Expense incurred for routine nursery care except when furnished to a newborn child at a Hospital or Birthing Center while the mother is confined there on account of the birth of the child. Any requirement that an expense must be incurred on account of Illness does not apply during such confinement.

- Expenses incurred while you or your Dependent is not a Covered Person or while you are employed outside the IBEW jurisdiction.

- Expenses incurred (as a result of an Illness or Injury) that occurs due to the negligence, or an act or omission, of a third party unless before any such expenses are to be paid hereunder, the Covered Person or his authorized representative shall agree in writing to:

  – Reimburse the Fund in full (regardless of whether the Covered Person is made whole) from all monies collected, regardless of whether by an action at law, settlement, underinsured motorist claim, uninsured motorist claim, no fault claim, personal injury protection claim, or any other manner or source, for all benefits the Fund pays or may be required to pay for the expenses incurred as a result of such Illness or Injury.

  – Provide the Fund with a lien, to the extent permitted by law, with first priority to the extent of all benefits the Fund pays.

  – Acknowledge that the Fund may, at its option, intervene in or initiate any proceeding, including a subrogation action, to protect its right to recover any damages from any third party that may be legally responsible for the Illness or Injury of the Covered Person for all benefits the Fund pays or may be required to pay and that the Covered Person or his authorized representative will cooperate fully with the Fund and its representatives in any proceeding initiated by the Fund.

  – Provide a signed, fully completed and truthful reimbursement agreement and an informational questionnaire, both in the form prescribed by the Fund, relating to the Illness or Injury.

  – Disclose to the Fund prior to the settlement of the claim the terms and conditions of the settlement any future settlements and suits that may be related to the claim.

- Expenses for immunizations, routine examinations or check-ups, unless otherwise covered as required preventive benefits under the ACA.

- Expenses for care, services or treatment for transsexualism, gender dysphoria or sexual reassignment or transformation. This exclusion includes medications, implants, hormone therapy, surgery, and any other medical or psychiatric treatment.

- Examinations, screenings, tests, items, or services when they are solely required as a condition of participating in a sports program.

- Charges for services, supplies, prescription drugs or treatment in connection with or related to weight loss or obesity including vitamins, dietary and/or nutritional supplements, whether or not prescribed by a physician, bariatric or other weight loss-related surgery, removal of excess fat in any part of the body or resection of excess skin or fat following weight loss or pregnancy.

PRESCRIPTION DRUG BENEFITS

Retail Pharmacy Prescriptions

The Fund participates in a prescription drug program administered by Sav-Rx. Sav-Rx maintains a network of pharmacies to fill prescriptions for you and your covered Dependents. Before filling a prescription at a retail pharmacy, ask if the pharmacy is a member of the Sav-Rx network.

You must present your prescription drug identification card to receive benefits for drugs bought at a retail pharmacy. For your covered Dependents' prescriptions, you may also need to provide a date of birth.

The prescription drug benefit is separate from your medical benefit. So, prescription drug copays do not apply to the medical deductible and out-of-pocket maximum. Nor do the medical benefit deductible and copay provisions apply to the prescription drug benefit. However, prescription drug copays for drugs obtained at an in-network pharmacy will apply to the ACA out-of-pocket maximum.

When you purchase up to a 30-day supply of prescribed drugs and medications from a retail network pharmacy, the Fund pays 100% after you make a copayment in an amount equal to:

- The greater of $10 or 20% of the cost of the prescription for a generic drug but not more than $35, or

- The greater of $25 or 20% of the cost of the prescription (but in no event more than $100) for a brand-name drug.

Notwithstanding the foregoing, for high cost Specialty Drugs, there is a maximum copay of $250. The Fund uses Sav-Rx's protocols for preauthorization and step therapy for these drugs. It is important that you check these requirements before beginning a Specialty Drug. If you do not present your prescription drug identification card, you still may be reimbursed for a drug purchase, provided you:

- pay the full price of the prescription at the time of purchase, and

- submit a completed claim form to Sav-Rx for reimbursement.

The Plan implemented the following programs with Sav-Rx: hyperinflationary drugs, mandatory generic and compound drug program. If you are prescribed drugs that are subject to these programs, Sav-Rx will contact you and advise you of your options.

Mail-Order Prescriptions

If you take prescribed drugs on a long-term or continuing basis, you can buy them by mail order from Sav-Rx. You pay a copay of (i) the greater of $30 or 20% of the cost of the prescription for a generic drug (but not more than $70), (ii) the greater of $75 or 20% of the cost of the prescription for a brand-name drug (but not more than $150), for a 90-day supply.

For further information, order forms and pre-addressed envelopes, please call Sav-Rx at (866) 233-4239.

Prescription Drug Expenses Covered

Covered drugs include:

- Prescribed drugs that are lawfully obtainable only from a licensed dispenser of drugs under the written order of a physician or Dentist licensed to prescribe.
- Injectable insulin.
- Prescribed syringes and hypodermic needles in quantities compatible with the number of doses of insulin prescribed.

Please call Sav-Rx at (866) 233-4239 if you have any questions about whether or not a drug is covered.

Prescription Drug Expenses Not Covered

The following are not covered:

- Fertility drugs.
- Drugs or medications lawfully obtainable without a prescription, except insulin.
- Therapeutic devices and appliances, support garments or other nonmedical items, regardless of their intended use.
- Drugs labeled "caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual.
- Charges for the administration of prescription drugs or injectable insulin.
- Drugs taken by or administered to an individual in whole or in part while an inpatient in a Hospital or other health care facility for dispensing pharmaceuticals.
- A quantity in excess of the number specified by the prescriber or a 30-day supply (90-day for mail-order).
- Any refill dispensed more than one year after the date of the prescription.
- Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers' Compensation.
- Renova (Tretinoin).

- Lifestyle drugs such as drugs treating weight loss (except in the certain cases), and hair loss.

- Expenses for drugs obtained through another medical or prescription drug program (no coordination of benefits).

- Prescription drugs purchased at an out-of-network pharmacy.

- Claims filed more than one year after the date the expense was incurred. For example, if you incurred charges at a dentist on February 1, 2023, but no claim or invoice was filed with the Plan by January 31, 2024, then no amount would be payable with respect to this service.

DEATH BENEFITS

Eligibility for Life and Accidental Death & Dismemberment Coverage

You are eligible for life and accidental death & dismemberment insurance coverage the later of: (1) the date you enter eligible status under the Fund; or (2) the date you return to Active Work if you were not Actively at Work on the date coverage would otherwise begin. Your life and accidental death & dismemberment insurance coverage ends on the date you are no longer an Active Member in the Fund.

Life Insurance Coverage

If you die by any cause before you retire and while your life insurance coverage is in effect, your beneficiary will receive a lump sum life insurance benefit of $20,000. Upon request, all or part of your life insurance benefit will be paid in equal monthly installments. The request must be made in writing by you or, after your death, by a beneficiary other than your estate.

Life Insurance Conversion

You may purchase a personal policy (without evidence of insurability) during the 31 day period beginning on the date your life insurance coverage ceased for any of the following reasons: (1) you are no longer Actively at Work; (2) you are no longer eligible for coverage under the Fund; or (3) the Fund or the life insurance group policy is changed or cancelled and you have been covered under the group policy for at least five years in a row. If you die during that period, the amount of life insurance that you were entitled to convert to a personal policy still will be paid.

Extension of Your Life Insurance While Totally Disabled

An extension of your life insurance coverage will occur if you become Totally Disabled before retirement while life insurance coverage is in effect for you. You may have to furnish proof of Total Disability from time to time.

The extension will cease on the earliest to occur of (i) the date you no longer are Totally Disabled (ii) the date you begin to receive a benefit under the Pension Fund (iii) the one-year anniversary of when the extension began after you became Totally Disabled. If a requested proof of disability is not furnished, the Total Disability will be deemed to cease on the date of the request.

Accidental Death and Dismemberment Coverage

If you suffer accidental bodily Injury that causes you to lose your life, a limb, or your sight, the benefits stated below will be paid. Your loss must occur within 180 days after the date of the Accident causing the loss and the cause of the loss cannot be excluded. If more than one loss is sustained as a result of the same Accident, payment shall be made for only the one loss for which the largest amount is payable.

For loss of life, $20,000 is payable. For the losses described below:

(1) $20,000 is payable for the loss of: Both hands, both feet, one hand and one foot, one hand or one foot and the sight of one eye, or the sight of both eyes.

(2) $10,000 is payable for the loss of: One hand, one foot, or the sight of one eye. Loss of sight means total and permanent loss of sight. Loss of a hand means severance of the hand at or above the wrist. Loss of a foot means severance of the foot at or above the ankle.

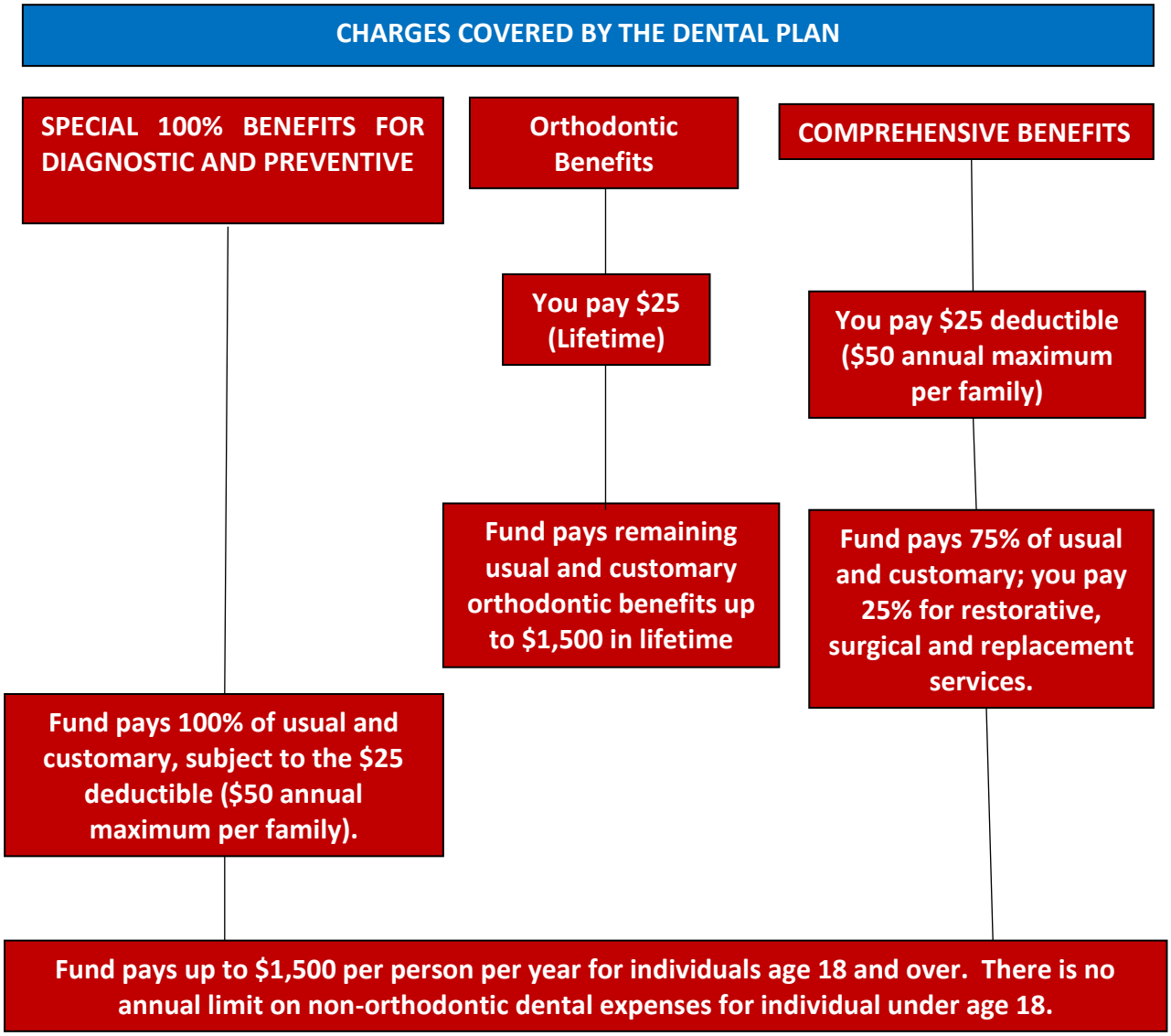
Exclusions

No accidental death and dismemberment benefits shall be paid if your loss is directly caused by any of the following:

- Physical or mental illness
- Bacterial infection or poisoning, except:
  - Infection from a cut or wound caused by an Accident.
  - Accidental ingestion of a poisonous food substance.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government or during the commission of a felony.
- Use of any drug, narcotic, or hallucinogenic agent -
  - Unless prescribed by a Doctor.
  - Which is illegal.
  - Not taken as directed by the Doctor or the manufacturer.
- Intoxication; that is, the blood alcohol of the deceased meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.

Beneficiaries of Death Benefits

Benefits payable on account of your death are payable to your named beneficiary (if any) or in the following order of preference: Your Spouse; children, including legally adopted children; parents; and executor or administrator of your estate.


CHARGES COVERED BY THE DENTAL PLAN
SPECIAL 100% BENEFITS FOR DIAGNOSTIC AND PREVENTIVE
Orthodontic Benefits
COMPREHENSIVE BENEFITS
You pay $25 (Lifetime)
You pay $25 deductible ($50 annual maximum per family)
Fund pays remaining usual and customary orthodontic benefits up to $1,500 in lifetime
Fund pays 75% of usual and customary; you pay 25% for restorative, surgical and replacement services.
Fund pays 100% of usual and customary, subject to the $25 deductible ($50 annual maximum per family).
Fund pays up to $1,500 per person per year for individuals age 18 and over. There is no annual limit on non-orthodontic dental expenses for individual under age 18.

DENTAL EXPENSE BENEFITS

How Your Dental Plan Works

Briefly, when you or one of your Dependents has covered dental expenses:

- You pay the first $25 of those expenses for each person during each calendar year.
- The Fund pays 100% of those expenses that were incurred for diagnostic and preventive services.
- The Fund pays 75% of other dental expenses.

Each person may receive up to $1,500 of lifetime orthodontic expenses and up to $1,500 per calendar year for other dental expenses. There is no annual dollar limit on non-orthodontic dental expenses for individuals under age 18. However, the Fund will cover no more than 4 visits to a Dentist per year for non-orthodontic dental services for such individuals.

You Pay The First $25 - The "Deductible"

The Fund starts paying benefits as soon as expenses go over $25. The first $25 that you pay is the "deductible". It applies separately to you and each eligible Dependent - but just once in any calendar year. The Fund has four features that can help to reduce the deductible:

Family Maximum

Although the $25 deductible applies separately to each Covered Person in your family, it is considered to have been satisfied if it is paid for two members of your family.

Carryover Provision

Another exception occurs if a Covered Person incurs dental expenses in the final three months of a calendar year that are applied to his deductible for that year. In that case, such expenses also are applied to the deductible for the following calendar year.

Orthodontics

If a Covered Person incurs orthodontic expenses, there is a lifetime deductible of $25, rather than an annual deductible.

Waiver of Deductible

The deductible is waived for covered dental expenses incurred on account of diagnostic and preventive care.

The Fund Pays 75% (or 100%) of the Rest

After you pay the deductible for each person, the Fund takes care of 75% of the other covered dental expenses for the rest of the year. In the case of diagnostic and preventive services and supplies, the Fund pays 100%. The Fund, however, will not pay more than $1,500 for any Covered Person in any calendar year. There is no annual dollar limit on non-orthodontic dental expenses for individuals under age 18. However, the Fund will cover no more than 4 visits to a Dentist per year for non-orthodontic dental services for such individuals. Also, the Fund pays only the portion of your eligible expenses that represents the Usual and Customary Charges for the services or supplies involved.

The Exceptions

Orthodontic expenses are covered only if the procedure starts while an individual is a Covered Person and before the individual reaches age 19. Also, there is a lifetime (rather than annual) limit of $1,500 on the amount the Fund will pay for orthodontic expenses.

Covered Expenses

Subject to the deductible, the Fund pays 100% of the Usual and Customary Charges (up to $1,500 per person per year, if applicable) for the following diagnostic and preventive services and supplies, and 75% of the following restorative, surgical, and replacement services and supplies, if authorized by a Dentist at prescribed intervals:

Diagnostic and Preventive

- Cleaning of teeth (Not more than twice every 12 months)
- Diagnostic services
  - Routine oral exam (Not more than twice every 12 months)
  - Full mouth x-rays (Once every two years)
  - Bitewing x-rays (Not more than twice every 12 months)
- Fluoride and/or sealant applications (Not more than twice every 12 months)
- Space maintainers and their fitting

Restorative and Surgical

- Oral surgery that is not covered as a medical expense benefit, including extractions, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw
- Gum and supporting structures of the teeth treatments

- Root canal therapy and other endodontic treatment
- General anesthetic and administration
- Emergency treatment
- Antibiotics and therapeutic injections

Replacement

- Fillings
- Full, temporary full or partial dentures, including addition of teeth to a denture, repair or rebasing of a denture
- Crowns
- Inlays
- Bridges

Items Not Covered By The Fund

- More than two routine oral exams in any 12-month period
- Most cosmetic treatment
- Procedures relating to correction of the bite except for minor spot grinding
- A temporary full denture
- Treatments of temporomandibular joint disturbances except for a diagnostic exam and x-rays, injections, and one non-orthodontic appliance
- Expenses for a Work-Related Illness or Injury for which a Covered Person is entitled to payment under workers' compensation or other law
- Any supplies or services for which no charge is made or for which a Covered Person is not required to pay
- Adjustment or relining of a denture within six months after placement
- Tooth implants and implant posts.
- Supplies or services you receive under a government program or plan (except Medicare, TRICARE or where not permitted by law) or from the Uniformed Services Medical Care Facilities

- Any procedure that began before your coverage starts; however, this exclusion will not apply to individuals under age 19

- Any procedure the main purpose of which is to change vertical dimension

- Diet planning or training in oral hygiene or preventive care

- Replacement of a Prosthesis that your Dentist believes can be repaired or does not need repair

- Replacement of a Prosthesis within five years after it was placed, except for:

  (1) a crown needed for restoration only

  (2) replacement needed because of the first time placement of an opposing full denture or the extraction of natural teeth

  (3) a permanent Prosthesis that replaces a stay plate or other temporary Prosthesis or

  (4) replacement of a Prosthesis damaged beyond repair as a result of an Accident that occurred while in the mouth of the Covered Person

- Services or supplies for which no claim was submitted within one year and 90 days of when the expenses were incurred.

- Tooth implants and implant posts.

Extension of Benefits

No benefits will be paid for covered dental expenses incurred after the date you cease to be a Covered Person except as follows:

- If you incur dental expenses within one month after your coverage ceased, such expenses will be covered if the treatment (not including x-rays or prophylaxis) began while you were a Covered Person and if the Fund has not terminated.

- If on the date the Fund terminates, you are Totally Disabled as a result of an Accident that occurred while you were a Covered Person, benefits will be paid for dental expense incurred for repair of damage to natural teeth due to such Accident. However, the expense must be incurred within three months after the date of the Accident.

TIME LOSS WEEKLY BENEFITS

How Your Time Loss Weekly Benefit Plan Works

If you become Totally Disabled, you will receive $475 for each full week that you are so disabled. Your entitlement to payment starts with the first day after the end of your waiting period. Your waiting period will be 0 days if your disability was the result of an Injury. Otherwise, your waiting period will be 7 days. (Note, if you are a clerical worker, you may receive less than $475 per week pursuant to the participation agreement entered into between the Trustees and your employer.)

Payment would be made for no longer than the "maximum term"; that is, not more than 39 weeks in any 24-month period. If any period for which benefits are payable is less than a full week, you will be receive one-fifth the amount of the weekly benefit for each day in such period. The maximum term applies to each period of Total Disability, whether because of one or more causes. A new period will start when you become Totally Disabled again after returning to Active Work for two or more weeks if the cause is related to the prior Total Disability or for one or more days if the cause is unrelated to the prior Total Disability.

Periods For Which Benefits Are Not Payable

No time loss weekly benefit will be paid for or on account of any period of disability:

- For which you are not under the regular care of a Doctor.
- For which you have or had a right to payment under any workers' compensation law or occupational disease law.
- For which you have or had a right to payment under the temporary disability benefit laws of any state.
- For which you receive a benefit under the Pension Fund.
- After the Fund terminates or after time loss weekly benefits no longer are provided under the Fund.
- If you are a Clerical Worker, for which coverage is denied under the terms of a participation agreement entered into between the Trustees and a Participating Employer.

If you cease to be a Covered Person due to Total Disability, layoff, or leave of absence, time loss weekly benefit coverage will not be continued.

VISION EXPENSE BENEFITS

How Your Vision Plan Works

In general, when you or one of your eligible Dependents has covered vision expenses:

- You pay the first 10% of those expenses; and
- The Fund pays 90% of such expenses to the extent they are Medically Necessary and do not exceed the Usual and Customary Charges for the services and/or supplies involved.

The Exceptions

The Fund pays 50% (but not more than $350 in any calendar year) of a Covered Person's expenses incurred for frames and lenses. This $350 limit does not apply to individuals under age 18; however, the Fund will cover only one set of frames and lenses or contacts every 24 months. Furthermore, the Fund will not pay more than $600 of a Covered Person's expenses for sub-normal vision care. Finally, the Fund will pay 50% of the cost of corrective eye surgery, subject to a lifetime maximum of $600 per eye.

Sub-normal vision care includes use of contact lenses, telescopic lenses and other vision aids, including the professional services required to fit, administer or prepare such vision aids. Expenses for sub-normal vision care are covered if such care is needed after cataract surgery or vision in one or both eyes can be corrected to at least 20/70 only with subnormal vision aids.

Vision Exclusions

Covered vision expense shall not include expense incurred on account of:

- More than one eye refraction during any 12-month period.
- More than one frame in any 12-month period (any 24-month period for individuals under age 18).
- More than one pair of lenses, or set of contact lenses (other than disposable contact lenses), during any 12-month period (any 24-month period for individual under age 18).
- Sunglasses, safety lenses, or goggles unless prescribed by a physician.
- Orthoptics, vision training, or aniseikonia.
- Replacement of eye glasses unless an examination reveals that, using the existing prescription, a visual defect equal to at least one-half of one diopter in strength exists or a change of at least 10% in axis for astigmatism is required.

- Expense for a work related Illness or for which a Covered Person is entitled to payment under a workers' compensation or other law.

- Services or supplies for which the Covered Person is not required to pay.

- Expense for the services of a person who normally lives in your household, or who is the parent, Spouse, child, brother or sister of you or your Dependent.

- Surgical or medical treatment of eye disease or Injury except as provided above.

- Supplies and services you receive under a government program or plan (except Medicare, TRICARE, or where not permitted by law) or from the Uniformed Services Medical Care Facilities.

- Expenses for Work-Related Illnesses or injuries.

- Expenses for services or supplies for which no claim is submitted within one year of when the expenses were incurred.

- Expense for services or supplies that are for education, Experimental, or research purposes.

Extension of Benefits

No benefits will be paid for covered vision expense incurred after the date you cease to be a Covered Person, except for frames and lenses prescribed before such date and received within 30 days after such date.

WELFARE REIMBURSEMENT ACCOUNT

What is a Welfare Reimbursement Account ("WRA")?

A welfare reimbursement account is an account kept for you under the Fund.

Who is Eligible for an Account?

Generally, an account is kept for anyone who is eligible for coverage under the Fund as a Member, an Apprentice, or a Clerical Worker. Likewise, no account will be kept for any Employee who chooses to send the Fund contributions made on his behalf to another welfare fund pursuant to the reciprocity program.

How Much is Credited to my Account?

A portion of the amount your Participating Employer contributes to the Fund on your behalf will be credited to your WRA. The formula used in determining the amount of contributions to be made to your account depends upon the terms of the collective bargaining agreement to which your Participating Employer is a party.

If you work outside of Lake County, you may be able to maintain your Fund coverage. You would do so by directing to have the welfare fund contributions made on your behalf sent to the Fund through the reciprocity program. Even if you maintain your coverage, however, it is possible that no portion of your reciprocated contributions will be credited to your account. Only that portion of a monthly reciprocated welfare fund contribution that exceeds an amount equal to 23% (22% for residential) of your gross earnings will be credited to your account. If a contribution is made on behalf of a Retired Employee through reciprocity, the entire contribution shall be credited to the retiree's account.

How Can I Use my Account Balance?

At least once each quarter, the Trustees shall reimburse you for medical care costs (described below) incurred by you or a family member that qualifies for reimbursement. ("Medical care costs" do not include any such costs that are reimbursable under the basic Fund.) If you do not work enough hours in a quarter to maintain your Fund coverage, you may use the money in your account to cover all or part of any self-payment you must make to stay covered. The Fund Office has forms that you must use in order to draw on your account. These forms must be completed and returned to the Fund Office, along with written evidence that the medical care costs have been paid by you or your family. (For example, if a payment is to be made to you as of March 31 of a year, your completed forms must be in the Fund Office by March 15 of that year.) The minimum amount of any reimbursement request is $50. You must submit your request for reimbursement no later than two years after the date on which the cost was incurred.

What are Medical Care Costs?

Reimbursable Expenses

- Calendar year deductible Participant co-payments

- Amounts in excess of any maximum benefits or limitations
- Payment of otherwise covered medical expenses for work-related sicknesses or injuries which are excluded by the Fund
- Reimbursement of a self-payment or retiree premium for continued eligibility
- Payment of expenses for medical, dental or vision services or for prescription drugs which are otherwise excluded under the Fund. The Trustees will determine which prescription drugs are reimbursable, subject to Federal Law.

Non-Reimbursable Expenses

- Non-Prescription drugs, medicines and vitamins
- Expenses for which reimbursement can be made by some other source
- Expenses incurred that you (the employee) are not required to pay
- Expenses for which reimbursement is not permitted under § 213 of the Internal Revenue Code
- Expenses not listed under "Reimbursable Expenses" above

Do I Have to Make Withdrawals from my Account?

No. Even if you incur medical care costs that are eligible for reimbursement, you may choose not to ask for a withdrawal. Instead, you might decide to let your account balance grow so that it is available for you when you retire. If you have an account balance at retirement, you can use that balance to manage the cost of your retiree coverage.

What Happens to my Account if I Retire or Die?

After you retire, you can continue accessing your account. If you die, your family may continue to seek reimbursement of eligible medical care costs. If you have no surviving family members, your account will be forfeited and become part of the general assets of the fund.

Are Payments from my Account Subject to Income Taxes?

No income taxes are payable on money you withdraw as reimbursement for medical expenses or to pay self-payment amounts.

Is it Possible to Forfeit an Account Balance?

Yes. If you die and you have no surviving family members, your account will be forfeited. Also, you have the opportunity to opt-out of your WRA account annually or upon loss of coverage under the Plan or upon becoming eligible for retiree coverage hereunder. If you elect

to opt-out of your account, any amounts remaining in your account will be forfeited. Any amount forfeited will become part of the general assets of the Fund.

Is it Possible to Forfeit an Account Balance by Engaging in Prohibited Employment?

Yes. If an employee or apprentice becomes employed by an employer that is not obligated to contribute to the Fund on his behalf, and such employment is in the same trade or craft for which contributions were previously made to the Fund on his behalf, then he shall cease to be in eligible status as of the end of the month in which such employment begins, and his WRA account balance shall be forfeited at that time, unless the employee or apprentice is working under a reciprocity agreement.

Is it Possible to Forfeit an Account Balance Due to Termination of Status as Union Member?

Yes. If you cease to be a member of the Union or of another local of the International Brotherhood of Electrical Workers, your WRA Account balance shall be forfeited immediately.

ADMINISTRATION AND CLAIMS

Important Information About the Fund

Fund Name

The name of the Fund is the International Brotherhood of Electrical Workers Local No. 150 Welfare Fund.

Board Of Trustees

A Board of Trustees is responsible for the operation of the Fund. The Board of Trustees consists of an equal number of employer representatives and union representatives. Union representatives are selected by the employees and the union, which have entered into collective bargaining agreements relating to the Fund. These collective bargaining agreements are described below. If you wish to contact the Board of Trustees, you may use the address and the telephone number below:

BOARD OF TRUSTEES
International Brotherhood of Electrical Workers Local No. 150 Welfare Fund
31290 N. U.S. Highway 45
Libertyville, Illinois 60048

As of the date of this SPD, the Trustees of the Fund are:

Employer Trustees

Ms. Lizabeth Karson
Electrical Contractors, Inc.
1252 Allanson Road
Mundelein, IL 60060

Mr. Anthony V. Arnone
Division Manager, Electrical Engineer
Kelso-Burnett Co.
1378 Saint Paul Avenue
Gurnee, IL 60031

Mr. Jeffrey A. Harger
President
HLP Systems, Inc.
426 North Avenue
Libertyville, IL 60048

Employee Trustees

Mr. Christopher Schulz
IBEW Local Union 150 AFL-CIO
31290 N. US Highway 45, Unit B
Libertyville, IL 60048

Mr. Steve Smart
IBEW Local Union 150 AFL-CIO
31290 N. US Highway 45, Unit B
Libertyville, IL 60048

Mr. Jeffrey W. Schwingbeck
IBEW Local Union 150 AFL-CIO
31290 North U.S. Highway 45, Unit B
Libertyville, IL 60048

Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor and Plan Administrator of the Fund. The Plan Administrator has sole and absolute discretion and authority to determine eligibility for benefits, interpret Fund language and amend or terminate the Fund. Benefits under the Fund will be paid only if and when the Plan Administrator, or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decide the participant or beneficiary are entitled to benefits under the terms of the Fund. Any exercise by the Plan Administrator of its discretionary authority with respect to the construction and interpretation of the plan documents or eligibility for benefits is final and binding on all persons dealing with the Fund or claiming a benefit from the Fund. The Plan Administrator's decisions will receive judicial deference to the extent they are not arbitrary and capricious, and do not constitute an abuse of discretion.

Type of Administration

The Board of Trustees has delegated certain administrative responsibilities to the Fund Administrator. The Fund Administrator is Mr. James E. Schreiber at TIC International Corporation. The contact information for Fund Administrator is:

TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275
(517) 321-7502
(877) 478-4542
Fax: (517) 321-7508

The Fund Administrator has been designated as the Fund's agent for service of legal process. Accordingly, if legal disputes involving the Fund arise, any legal document should be served upon the Fund at the above address.

In addition, service of legal process may be made upon any member of the Board of Trustees at the following address:

International Brotherhood of Electrical Workers Local No. 150 Welfare Fund
31290 N. U.S. Highway 45
Libertyville, Illinois 60048

or such documents may also be served upon any individual Trustee.

Plan Identification Numbers

The plan serial number assigned to this Fund by the Board of Trustees pursuant to instructions by the Internal Revenue Service is 36-2327771. The identification number assigned to the Board of Trustees by the Internal Revenue Service is 501.

Collective Bargaining Agreement

The Fund is maintained in accordance with a collective bargaining agreement between the International Brotherhood of Electrical Workers, Local No. 150 and Lake County Division, Northeastern Illinois Chapter, National Electrical Contractors, Inc. Other agreements may be in effect from time to time. The agreements specify the contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of participants working under a collective bargaining agreement or with a list of such employers. You may obtain a copy of the collective bargaining agreement under which you are covered, at a reasonable charge, upon written request to the Fund Office. You may also review these agreements, at no charge, at the Fund Office, at the principal office of each participating Union, and at Employer worksites at which 50 Covered Persons customarily work.

Source of Contributions

The benefits described in this summary plan description are provided through employer contributions, self-contributions, and contributions made pursuant to reciprocity agreements. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements and the amount of monies necessary to provide the coverage required by the Fund. The Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the trust.

Trust Fund

The Trust Fund consists of all assets that are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement and held for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. All of the benefits in this Fund are provided on a self-funded basis except for life, accidental death and dismemberment and excess coverage, which is provided under an insurance contract. The Plan's assets are managed by professional asset managers selected by the Board of Trustees.

The Fund assumes liability for (1) all time loss weekly benefits and (2) claims of up to $225,000 for covered medical, dental, and vision expenses incurred by any Covered Person in any plan year and (3) claims of up to 125% of the claim level anticipated at the beginning of a year. The insurance company is liable for all claims for covered expenses for which the Fund is not liable.

Plan Year

The fiscal records of the Fund are kept separately for each plan year. The plan year begins on July 1st and ends on June 30th. Benefits are determined on a calendar year basis.

Type Of Plan

The Fund is a welfare plan maintained for the purpose of providing life insurance, accidental death and dismemberment insurance, short-term disability, and medical benefits (including prescription drugs, vision care, and dental care), in the event of death, sickness or accident.

HIPAA Privacy

The Trustees are required by federal law to maintain the privacy of your protected health information. You can request a copy of the Fund's HIPAA Privacy Notice by contracting TIC, the administrator of the Fund.

Amendment and Termination

The Fund is expected to continue indefinitely, but the Trustees expressly reserve the right, in their sole discretion, and without advance notice, acting within accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend the Fund in whole or in part at any time. You will be notified in writing of any changes to the Fund. In addition, the Fund could terminate if:

- An agreement provide for such termination is entered into between the union and NECA; or

- All Participating Employers complete discontinue making contributions under the Fund.

In the event of a termination, the Trustees would provide for payment of covered expenses incurred up to the date of termination and distribute any remaining Fund assets in a manner consistent with the Fund's purpose.

Non-Guarantee of Employment

Nothing contained in this summary plan description shall be construed as a contract of employment between any Participating Employer and any Employee, or as a right of any employee to be continued in the employment of any Participating Employer, or as a limitation of the right of any Participating Employer to discharge any of its Employees, with or without cause.

Claim Filing Procedure

Some medical care providers will submit a claim on your behalf. If you must submit a claim yourself, the following steps should be taken:

(1) Complete and sign your portion of the claim form. (Claim forms and envelopes addressed to the claims agent may be obtained at the Fund Office.)

(2) Give the form to the provider of the service. Ask him or her to complete the provider's portion and return the form to you.

(3) When you have the completed form back from the provider, attach to it any itemized bills you have. Then, send it to the claims agent as soon as possible.

(4) If after filing your claim, you have further claims relating to it, send the itemized bills to the claims agent.

(5) A separate claim form is required to file a claim for each family member and for each separate disability.

(6) Depending upon the nature of your claim, the claims agent may ask you to complete additional forms.

(7) Any questions about your benefits or about how to file your claim should be asked of the claims agent. From time to time, the claims agent may ask you questions about the treatment you received. In order to expedite the processing of your claim, please respond promptly to any such questions.

To be paid, you must file your claim within one year of the date you incurred an expense or suffered a loss**.**

Claims and Appeals Procedures

The following details the time frames applicable to the Fund to make an initial decision on a claim for benefits and also describes the Fund's appeal procedure with respect to claims for benefits. These provisions do not apply to claims made on the basis of an insurance contract governing insured benefits. Claims made for these insured benefits will be determined solely by the insurance company in accordance with federal law.

Please be advised that you may name an authorized representative to act on your behalf in filing a claim, providing requested information or pursuing an appeal of an adverse decision, provided such authorization must be in writing (other than for Urgent Care claims). In the case of an Urgent Care claim, a health care professional with knowledge of your medical condition is permitted to act as your authorized representative. Please contact the Fund Office for information regarding naming an authorized representative.

Initial Decision on Claim

Health Claims

- **Urgent Care Claims.** The Fund will inform you of the decision on an Urgent Care claim as soon as possible, but not later than 72 hours after the claim was filed. If, during the review, additional information is required, you will be so notified within 24 hours and will be allowed at least 48 hours to provide the information. In such a case, the Fund will inform you of the decision no later than 48 hours after the additional information is submitted.

  An Urgent Care claim is a claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of you or your eligible Dependent or subject you or your eligible Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an Urgent Care claim will be determined by the Fund, deferring to the judgment of a physician with knowledge of your or your eligible Dependent's condition.

- **Pre-Service Claims.** The Fund will inform you of the decision on a Pre-Service claim within 15 days of the date the claim is filed. Within that 15-day period, you will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the end of the initial 15-day benefit determination period, by which you can expect to receive a decision.

  If during the review, additional information is required, you will be so notified within the required time period for notice of a decision detailed above. You will have at least 45 days to provide such information. Following the provision of the required information, or the expiration of the time period for providing such information, the Fund will issue a written notice of the decision. The timing requirement for issuance of a decision will be tolled while the Fund waits for you to provide the additional required information.

  A Pre-Service claim is a claim for medical care or treatment with respect to which the Fund requires approval of the benefit in advance of obtaining medical care.

- **Post-Service Claims.** The Fund will inform you of the decision on a Post-Service claim within 30 days of the date the claim is filed. Within that 30-day period, you will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the end of the initial 30-day benefit determination period, by which you can expect to receive a decision.

  If during the review, additional information is required, you will be so notified within the required time period for notice of a decision detailed above. You will have at least 45 days to provide such information. Following the provision of the required information, or the expiration of the time period for providing such information, the Fund will issue a written notice of the decision. The timing requirement for issuance of a decision will be tolled while the Fund waits for you to provide the additional required information.

- **Concurrent Care Claims.** Any request by you to extend the duration or number of treatments previously approved through a Pre-Service claim is a Concurrent Care claim. The Fund will inform you of the decision on a Concurrent Care claim involving Urgent Care within 24 hours after receiving the claim, if the claim was received by the Fund at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You may provide any additional information required to reach a decision. If the Concurrent Care claim does not involve Urgent Care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Fund will respond according to the type of claim involved (i.e., Urgent, other Pre-Service or Post-Service).

- **Time Loss Weekly Benefit Claims**. If your claim for time loss weekly benefits is denied in whole or in part, the Fund will inform you of the denial within 45

days of the date the initial claim was received, regardless of whether the claim included all the necessary information.

- **Extension.** Special circumstances may require more time to review a claim. If so, written notice shall be provided within the 45-day period explaining the reason for the delay and setting a date upon which the notice will be issued, no later than 30 days after the end of the initial 45-day benefit determination period. If special circumstances again require more time to review a claim, a second 30-day extension may be taken subject to written notice within the initial 30-day extension, subject to the same rules as detailed above.

- **Additional Information.** If, during the review, additional information is required, the Fund Office will notify you within the required time periods noted above. You shall have at least 45 days to provide such information. Following receipt of the additional information you provide or the expiration of the time period for providing such information, the Fund shall issue a written notice any denial within 30 days, unless special circumstances require a second 30-day extension.

Content of Denial Notice

If your claim is partially or wholly denied, you will receive a notice:

(1) stating the specific reason(s) for the denial and a specific reference to the pertinent Fund provision(s) on which the denial is based;

(2) including information sufficient to identify the claim involved, plus a statement that diagnosis, treatment and denial codes, as well as their corresponding meanings, are available upon request free of charge (for health claims)

(3) describing and explaining any additional material or information required of you in order to make your claim valid;

(4) explaining the Fund's appeal procedure and your right to appeal the initial decision;

(5) explaining that the initial decision will be a final decision unless the decision is appealed as described below;

(6) detailing your right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on an appeal;

(7) notifying you that, if a specific rule or guideline was relied upon, a copy of such rule or guidelines is available upon request;

(8) notifying you that, if the determination is based upon a Medical Necessity or Experimental treatment exclusion, a copy of an explanation of the scientific judgment supporting the determination is available upon request; and

(9) describing the expedited review process for urgent care claims, if applicable.

For Time Loss Weekly Benefit claims, the claim denial notice will also contain the following:

(1) a discussion of the decision and the basis for disagreement with or not following:

(a) a health care or vocational professional who treated or evaluated you;

(b) a medical or vocational expert whose advice was solicited by the Fund in connection with the claim; and

(c) a disability determination made by the Social Security Administration

(2) copies of any internal rule, guideline, protocol or similar criteria relied on, or a statement that no such rule, guideline, protocol or similar criteria exists; and

(3) a statement that you are entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to your claim upon request, free of charge

Appeal Procedure

If you feel that the action taken on your claim is incorrect, you have the right to appeal to the Board of Trustees, or a Committee designated by the Trustees, for a further review. The following paragraphs describe the procedure for appealing to the Trustees.

After you receive a notice denying a claim for benefit payment which you feel is incorrect, you should notify the Fund Office in writing of the wish to have the claim reviewed by the Board of Trustees (or a Committee designated by the Trustees). Such notice of appeal must be filed within 180 days from the date the written notice of denial was mailed.

The request for review should include all information regarding the claim as well as the reason(s) you feel the original decision was incorrect. Copies of any documents relevant to the claim will be provided at no cost, upon request. The review on appeal will consider all comments, documents, records and other information you submit, regardless of whether the information was submitted or considered in the initial determination. If the decision requires medical judgment, the Board of Trustees (or the Committee) will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

You will be provided with any new or additional evidence or rationale generated by the Fund, the Board of Trustees or the Committee, or relied upon in connection with the Claim. Such new or additional evidence or rational will be provided as soon as possible and sufficiently in advance of the final decision in order to give you a reasonable opportunity to respond.

The Trustees (or the Committee) will act on the request for review within the following time periods:

- **Urgent Care Claims.** The Fund will inform you of the decision on the review of an Urgent Care claim within 72 hours of the Fund's receipt of the request for review.

- **Pre-Service Claims.** The Fund will inform you of the decision on the review of a Pre-Service claim within 30 days of the Fund's receipt of the request for review.

- **Post-Service Claims.** The Trustees or Claims Appeal Committee shall meet quarterly to render a determination on appeals of Post-Service and Loss of Time Claims received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the second quarterly meeting following the Fund's receipt of your appeal. If special circumstances require a delay in the decision, the decision will be rendered no later than the third quarterly meeting following receipt of the appeal, and the Fund will notify you of the reasons for the delay prior to any extension. The Fund will notify you of the decision within five days of the date the decision is made.

- **Concurrent Care Claims.** The Fund will inform you of the decision on the review of a Concurrent Care claim within 72 hours of the Fund's receipt of the request for review if the claim involves an Urgent Care claim. The Fund will inform you of the decision on the review of a Concurrent Care claim within 30 days if the claim involves a Pre-Service claim; and in accordance with the quarterly meeting rule described above if the claim involves a Post-Service claim.

- **Loss of Time Benefits**. The Trustees or Claims Appeal Committee shall meet quarterly to render a determination on appeals of Loss of Time Benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the second quarterly meeting following the Fund's receipt of your appeal. If special circumstances require a delay in the decision, the decision will be rendered no later than the third quarterly meeting following receipt of the appeal, and the Fund will notify you of the reasons for the delay prior to any extension. The Fund will notify you of the decision within five days of the date the decision is made.

Content of Denial Notice on Review

You will receive the Trustees' decision in writing. If your claim is denied, the decision will include:

(1) the reasons for the decision and a discussion of the decision making;

(2) information sufficient to identify the claim involved, plus a statement that diagnosis, treatment and denial codes, as well as their corresponding meanings, are available upon request free of charge;

(3) reference to specific Fund provisions on which the decision is based;

(4) 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;

(5) notice if a specific rule or guideline was relied upon in making the Fund determination and that a copy of such rule or guideline is available upon request;

(6) if the determination is based on a Medical Necessity or Experimental treatment exclusion, notice that a copy of an explanation of the scientific judgment supporting the determination is available;

(7) notice informing you of any additional voluntary procedures offered by the Fund; and

(8) notice of your right to file suit against the Fund under ERISA section 502(a) or, for certain health claims, to request an external review with an independent review organization following an adverse benefit determination on appeal.

External Review of a Denied Health Claim

- **Right to Request External Review.** You have the right to request an external review of your denied health claim if the denial involved (i) medical judgment; (ii) a rescission of coverage; or (iii) an adverse benefit determination involving consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act and related regulations.

- **Claims Eligible for External Review.** Only health claims are eligible for external review. Loss of time benefits and all other welfare benefits are not eligible for external review.

- **How to Request an External Review.** If you want your denied health claim reviewed by an independent review organization, you must send a written request for an external review of the claim denial to the Plan no later than four months after the date you receive the notice of denial or appeal. You may submit additional information for consideration or review, including a written explanation and comments on the issues.

Further Action

No lawsuit or other action against the Fund or its Trustees may be filed until you exhaust the Fund's appeal procedure. Further, in the event a claim has been reviewed under the Fund's appeal procedure and the claim has been denied, no lawsuit or other action against the Fund or its Trustees may be filed after 180 days from the date you or your beneficiary has been given written notice of the Trustees' decision on the appeal. If this time limitation is less than that required by law, the limitation will be extended to agree with the minimum period permitted by law.

Rights Under ERISA

As a Covered Person, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that:

- You may look at, and obtain copies of, the Fund and trust, any amendments to the Fund or trust, the collective bargaining agreements, the insurance contracts, and the annual reports (Form 5500 Series) and summary plan descriptions filed with the U.S. Department of Labor. This may be done at the Fund office. If you wish to do this, please contact the Fund's Fund Administrator so that the necessary arrangements may be made. Although there is no charge for reviewing the documents, you will have to pay a reasonable charge for any copies you might want. The Fund's annual report also is available at the Public Disclosure Room of the Employee Benefits Security Administration.

- You will receive copies of the Fund's summary annual financial report.

Enforcing Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of the Fund documents or the latest annual report from the Fund Administrator 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 Fund to pay you up to $1,736 per day until you receive the materials unless the materials were not sent because of reasons beyond the Fund's control. If your claim for a benefit is denied in whole or in part, you may file suit in a state or federal court after you have exhausted the Fund's claims and appeals procedures. If you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If you believe that Fund fiduciaries misuse the Fund's money or that you were discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. If there is a lawsuit, the court will decide who should pay court costs and legal fees. If you are successful, the court may, if it so decides, require the other party to pay those costs and fees. Similarly, if you are unsuccessful, the court might require you to pay those costs and fees, for example, if it finds your claim is frivolous.

Continue Your Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse, and Dependents if there is a loss of coverage under the Fund 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 Fund to learn the rules governing your COBRA continuation coverage rights.

Prudent Actions by Fiduciaries

A fiduciary is a person who is responsible for the operation of an employee benefit plan. ERISA imposes certain obligations on fiduciaries. Fiduciaries must act solely in the interests of

participants and their beneficiaries and be prudent in performing their Fund duties. No one may fire a Covered Person or discriminate against him to prevent him from obtaining Fund benefits or exercising his or her rights under ERISA.

Questions and Other Information

If you have any questions about the plan, you should contact the Fund Administrator. If you have any questions about your rights under ERISA or you need assistance in obtaining documents from the Fund Administrator, you may 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 at (866) 444-3272.

The Fund was established effective January 19, 1956, and operates on a "plan year" that ends on each June 30. The employer identification number issued to the Trustees by the Internal Revenue Service is 36-2327771. The Fund's "plan number" is 501. The Fund Administrator has been designated as the agent for service of legal process if the Fund is sued. Service of legal process, however, may be made on any Trustee.

The Fund is expected to continue indefinitely. The Trustees may amend the Fund at any time. In addition, the Fund could terminate if:

- An agreement providing for such termination is entered into between the union and NECA; or

- All Participating Employers completely discontinue making contributions under the Fund.

If the Fund terminates, the Trustees would provide for payment of covered expenses incurred up to the date of termination and distribute any remaining Fund assets in a manner consistent with the Fund's purpose.

Subrogation and Reimbursement

The Fund shall be entitled to subrogation or reimbursement with regard to all rights of recovery of a Covered Person or Immediate Family, representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Covered Person (collectively, for purposes of this section 13, "Individual") to the extent of any amounts which the Fund has paid or may become obligated to pay on account of any claim including accidental death and dismemberment against any person, organization or other entity in connection with the Injury, Illness, sickness, Work-Related Illness or Injury, accident or condition to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured motorist coverage,

underinsured motorist coverage, homeowner's insurance coverage and any employer of the Individual under the provisions of a Worker's Compensation or Occupational Disease Law. The Fund shall also be entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by the Individual. Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses and regardless of whether liability is admitted to or contested by any Source. Once the Fund makes or is obligated to make payments on behalf of an Individual on account of the claim, the Fund is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Individual from any Source.

Action Required of Individual

If requested in writing by the Trustees, the Individual shall take, through any representatives designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Fund from any Source and shall hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Fund to be paid to the Fund immediately upon recovery thereof. The Individual shall not do anything to impair, release, discharge or prejudice the rights referred to in this section 13. The Individual shall assist and cooperate with representatives designated by the Fund to recover payments made by the Fund and shall do everything that may be necessary to enable the Fund to exercise its subrogation and reimbursement rights described herein.

The Trustees may require the Individual to execute a Subrogation and Reimbursement Agreement ("Agreement"), in a form provided by and acceptable to the Trustees, as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s), at the Fund's request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may suspend all benefit payments due a Covered Person or Dependents. However, in its sole discretion, if the Fund advances claims in the absence of an Agreement, or if the Fund advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person's parent, the Individual (in the case of a minor dependent child), the Individual's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Fund. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Individual agrees that out of any Source, as described in subsection (13.1) above, the identified amount that the Fund has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Fund's benefit and that the Fund shall have an equitable lien by agreement which shall be enforceable if necessary under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Fund's subrogation and reimbursement rights shall apply regardless whether the Individual executes an Agreement.

Enforcement of Rights

The Fund has the right to recover amounts representing the Fund's subrogation and reimbursement interests under this section 13 through any appropriate legal or equitable remedy, including, but not limited to the initiation of a recognized cause of action under ERISA section 502(a)(3), (including injunctive action to ensure the claim amounts that the Fund has advanced are preserved and not disbursed), or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Fund's subrogation and reimbursement interests, and its rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

Further, in the event an Individual receives monies as the result of an Injury, Illness, sickness, Work-Related Illness or Injury, accident or condition and the Fund is entitled to such monies in accordance with this section 13 and is not reimbursed the amount it has paid for such Injury, Illness, sickness, Work-Related Illness or Injury, accident or condition, the Fund shall have the right to reduce future payments due to such Individual or the Employee of whom such Individual is a Dependent or any other Dependent of such Employee by the amount of benefits paid by the Fund. The right of offset shall not, however, limit the rights of the Fund to recover such monies in any other manner described in this section 13.

Individual's Attorneys' Fees

The Fund's subrogation and reimbursement rights apply to any recovery by the Individual without regard to legal fees and expenses of the Individual. The Individual shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Injury, Illness, sickness, Work-Related Illness or Injury, accident or condition, and the Fund's recovery shall not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Fund's claim by an agreed-upon amount of such fees or expenses.

Disavowal of Common Law Defenses

The Fund specifically disavows any claims that an Individual may make under any federal or state common law defense, including, but not limited to, the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Fund's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Individual from any Source without regard to legal fees and expenses of the Individual and the Individual will be solely responsible for paying all legal fees and expenses. The Fund shall have a priority, first dollar security interest and a lien on any recovery received from any Source, whether by

suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Injury, Illness, sickness, Work-Related Illness or Injury, accident or condition.

Offset

In the event payment is made by the Fund to or behalf of an Individual who is not entitled to such payment, the Fund shall have the right to reduce any future payments due to such Individual or the Employee of whom such Individual is a Dependent by the amount of any such erroneous payment. Further, in event that the Fund is not able to apply the benefit reductions due to outpatient precertification, preadmission certification or concurrent review requirements because of agreements between the Fund and the service provider or facility, the Fund shall have the right to reduce any other benefit payments due to such Individual by the amount of such benefit reduction. This right of offset shall not, however, limit the rights of the Fund to recover such overpayments or benefit reductions in any other manner.

Coordination of Medical, Dental, and Vision Expense Benefits

Coverage under the Fund has been designed to help you pay your medical, dental, and vision expenses.

To the extent necessary to avoid duplicative payments and in accordance with applicable law and the rules established by the Trustees, you or your Dependent's benefits provided under the Fund (including supplements to the Fund) will be coordinated with:

(1) The benefits provided for under this Fund (in the case you or your Spouse who is entitled to benefits under this Fund both as Member and as a Dependent) and the benefits provided for you or your Dependent any other employer or government sponsored group medical plan or program; and

(2) Any amount that the Trustees deem to have been paid by or on behalf of any individual in the nature of damages for an Injury sustained by you or your Dependent.

(3) Coordination with Medicare. If you or your Dependent is eligible for Medicare the Fund will assume you or your Dependent have full Medicare coverage (*i.e.*, Part A and Part B). Therefore, if the Fund is not the primary payer of benefits, the Fund will coordinate its benefits with the full amount of Medicare benefits to which you or your Dependent is entitled, even if you or your Dependent are not enrolled. The benefits of Medicare and the Fund are combined to cover and pay for medical expenses up to, and not exceeding, 100% of the allowable expenses incurred. When Medicare is the primary payer of benefits, the allowable medical expense is limited to the Usual and Customary Charge approved by Medicare when the provider accepts Medicare assignment. This limitation will not apply if the service provider does not accept Medicare assignment.

In effecting the coordination of benefits payable to you or your Dependent, the Trustees may reduce the amount that otherwise would be payable to you or your Dependent or request that you or your Dependent reimburse the Fund in the amount of any overpayment of benefits made.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage under the Fund was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Fund when they otherwise would lose their group health coverage. The entire cost* (plus a reasonable administration fee) must be paid for such coverage. Coverage will end in certain instances, including if you or your Dependents fail to make timely payment of premiums. The Fund is administered by six individual trustees whose decisions are implemented by the Fund Office. You should check with the Fund Office at the following address to see if COBRA applies to you and your Dependents:

TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275
(517) 321-7502
(877) 478-4542
Fax: (517) 321-7508

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Fund coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and loss-of-time benefits are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Fund is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Fund), you will become a Qualified Beneficiary if you lose your coverage under the Fund because either one of the following Qualifying Events happens:

- Your hours of employment are reduced; or

* As of January 1, 2010, federal law provided for a temporary subsidy in an amount equal to 65% of the cost of coverage for some COBRA-eligible individuals. Please ask a Fund Office representative if you are entitled to such a subsidy.

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

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Fund because any of the following Qualifying Events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under 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 Fund because any of the following Qualifying Events happens:

- The parent-Covered Employee dies;
- The parent-Covered Employee's hours of employment are reduced;
- The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Fund as a "Dependent child."

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Fund Office with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

(1) Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her Spouse;

(2) Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent child under the terms of the Fund;

(3) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and

(5) Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

NOTE: A "Notice of Change" form is available, free of charge, from the Fund Office and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the date on which the relevant Qualifying Event occurs;

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Fund as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Fund's SPD or the general notice, of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Fund Office.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Fund's SPD or the general notice, of both the responsibility to provide the notice and the Fund's procedures for providing such notice to the Fund Office.

The notice must be postmarked (if mailed), or received by the Fund Office (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Fund will terminate on the last date for which you are eligible under the terms of the Fund, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice?

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice. *The notice must contain the following information:*

- Name and address of the Covered Employee or former employee;
- If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
- A description of the Qualifying Event (for example, divorce, legal separation, cessation of Dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
- In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and Dependent child(ren) covered under the Fund, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
- In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Fund;
- In the case of a Qualifying Event that is a Dependent child's cessation of Dependent status under the Fund, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age);
- In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Fund;
- In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es)

of other family members covered under the Fund, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

- In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Fund, the date the disability ended and the date of the SSA's determination; and

- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Fund Office may request additional information. If the individual fails to provide such information within the time period specified by the Fund Office in the request, the Fund Office may reject the notice if it does not contain enough information for the Fund Office to identify the Fund, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Fund Office within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. **If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.**

Each Qualified Beneficiary will have an in Dependent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children. In the event that the Fund Office determines that the individual is not entitled to COBRA Continuation Coverage, the Fund Office will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event; however, if the first Qualifying Event is the Covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for

Qualified Beneficiaries other than the Covered Employee ends on the later of (i) 36 months after the date the Covered Employee became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's 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 Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 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 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 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 COBRA Continuation Coverage

If you or anyone in your family covered under the Fund is determined by the SSA to be disabled and you notify the Fund Office as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18- month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA 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 properly is given to the Fund as set forth above. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, or gets divorced or legally separated, or if the Dependent child stops being eligible under the Fund as a Dependent child, or becomes entitled to Medicare benefits (under Part A, Part B, or both), **but only if the**

event would have caused the Spouse or Dependent child to lose coverage under the Fund had the first Qualifying Event not occurred.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period in the event of fraud or on the earliest of the following dates:

- The date the Fund terminates as to all employees;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Additional Information

Additional information about the Fund and COBRA Continuation Coverage may be available from the Fund Office.

Current Addresses

In order to protect your family's rights, you should provide **written notice** to the Fund Office of any changes in the addresses of family members.