EXHIBIT A

AMENDMENT TO THE
INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
LOCAL NO. 150 WELFARE FUND

Effective January 1, 2022, the Plan document is amended as follows:

1. Section 3.1 of the Plan shall be amended and restated in its entirety as follows:

3.1 Eligible Status. Subject to the terms of the Plan, each individual who was a Covered Person immediately before the effective date will continue as such on and after the effective date. Each other individual will be eligible for coverage under the Plan and in an "eligible status" if he is an Employee, a Clerical Worker, an Apprentice, or a Retired Employee. A newly-organized Employee will enter an eligible status on the day the first letter of assent is signed on behalf of his Employer. A Retired Employee is not eligible for time loss weekly benefits. ~~In addition, a Retired Employee is not eligible for dental expense benefits or vision benefits except as permitted by rules established by the Trustees. Finally~~Also, subject to subsection 3.4, if a Member's Plan coverage stops for any reason, he may not become eligible as a Retired Employee unless he first becomes eligible as a Member.

Finally, upon attaining age 65, a Retired Employee and Dependents shall become eligible for medical and prescription drug benefits under the Plan's insured arrangement with UnitedHealthcare, or its successor ("MAPD Program"). In addition, upon attaining age 65, a Retired Employee and Dependents shall cease to be eligible for self-funded benefits hereunder except for the following designated benefits: (a) dental benefits outlined in Supplement B, (b) vision benefits outlined in Supplement C (excluding the annual vision examination benefit), and (c) medical expenses outlined in section 6.5 (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).

2. Section 3.4 of the Plan shall be amended and restated in its entirety as follows:

3.4 Waiting Period for Retired Employees. At the time of his or her retirement, a Retired Employee may elect no coverage, single coverage, or (if he or she has Dependents) family coverage. A Retired Employee may change his or her coverage status from time to time after retirement in accordance with administrative rules established by the Trustees. ~~A Retired Employee, however, may not change his or her coverage status after he or she attains age 65.~~ A Retired Employee's eligibility for such coverage is determined under Section 3.1.

3. Section 3.11 of the Plan shall be amended and restated in its entirety as follows:

3.11 Suspension of Retiree Eligibility. If a Retired Employee who has not yet attained age 65 ceases making self-payments for coverage under this Plan and elects coverage under the Health Insurance Marketplace (an exchange established pursuant to

the Patient Protection and Affordable Care Act), then such individual cannot again resume participation in this Plan ~~until on or after attaining age 65 and prior to attaining age 66~~. Furthermore, a Retired Employee who opts out of Plan coverage prior to age 65 for any other reason shall not be permitted to resume participation in the Plan unless he elects to resume participation hereunder prior to age 65~~6~~.

4. Section 5.2 of the Plan shall be amended and restated in its entirety as follows:

5.2. Self-Payment by Retired Employees. The medical expense benefits coverage of a Retired Employee may be continued through self-payment. Self-payment will commence on the first day of the month in which the Retired Employee's retirement occurs. A Retired Employee may elect single coverage or (if he has one or more Dependents) family coverage. The amount of a Retired Employee's self-payment contributions may be determined by multiplying the cost of the coverage elected (as such cost is determined from time to time by the Trustees) by 50% if the Retired Employee has attained age 63. In the case of a Retired Employee who has not attained age 63, the amount of his or her self-payment contributions will be determined by multiplying said cost of the coverage elected by the applicable percentage determined in accordance with the following table:

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

Notwithstanding the foregoing, the applicable percentage shall be 100% for a Retired Employee who has attained age 65 and elected coverage under the MAPD Program ~~the applicable percentage payable by a Retired Employee will be 50% beginning on the first day of the month next following the date he or she attains age 63, regardless of his or her age at the Retirement Date~~. The Trustees reserve the right to change the applicable contribution percentages and ages at any time and from time to time and no Covered Person shall have or acquire any right to coverage for any period except as provided under the Plan.

EXHIBIT A

AMENDMENT TO THE
INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
LOCAL NO. 150 WELFARE FUND

Effective August 11, 2022, Section 6.6 of the Plan is amended by adding the following paragraph to the end thereof to read as follows:

Notwithstanding the foregoing, prescription drugs purchased at an out-of-network pharmacy are not eligible for coverage under section 6.6.

EXHIBIT __

AMENDMENT TO THE
INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
LOCAL NO. 150 WELFARE FUND

1. Effective November 6, 2020, new section 7(q) is added to the Plan to read as follows:

(q) 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.

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND

[As Restated Effective October 1, 2009]

Including Amendments Adopted May 14, 2010
Including Amendments Adopted November 5, 2010
Including Amendment Adopted April 22, 2011
Including Amendments Adopted July 29, 2011
Including Amendments Adopted October 11, 2011
Including Amendments Adopted October 15, 2012
Including Amendments Adopted June 21, 2013
Including Amendments Adopted November 8, 2013
Including Amendments Adopted February 7, 2014
Including Amendments Adopted May 1, 2014
Including Amendments Adopted October 21, 2014
Including Amendments Adopted November 24, 2014
Including Amendments Adopted January 23, 2015
Including Amendments Adopted January 22, 2016
Including Amendments Adopted November 4, 2016
Including Amendments Adopted May 1, 2017
Including Amendments Adopted May 1, 2018

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INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND
[As Restated Effective October l, 2009]

SECTION 1

Introduction

1.1. The Plan and its Purpose. Pursuant to collective bargaining, INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL NO. l50 WELFARE FUND (the "Plan") has been established by LAKE COUNTY DIVISION, NORTHEASTERN ILLINOIS CHAPTER, INC., NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION, INC. (the "Association") and LOCAL UNION NO. 150 of the INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS (the "Union"). The purpose of the Plan is to provide comprehensive medical, life, accidental death and dismemberment, dental, vision, and time loss weekly benefits for Covered Persons. The Plan, as set forth below, is an amendment, restatement, and continuation of the Plan, as in effect on September 30, 2009.

1.2. Administration. The Plan will be administered by six Trustees (the "Trustees"), three of whom are appointed by the Union and three of whom are appointed by the Association. Funds contributed under the Plan will be held and invested until distributed by the Trustees pursuant to a Trust Agreement between the Union, the Association, and the Trustees. Copies of the Plan and the Trust Agreement, which implements and forms a part of the Plan, are on file at the offices of the Union where they may be examined by any Employee. The provisions of and benefits under the Plan are subject to the Trust Agreement.

1.3. Effective Date, Plan Year. The "effective date" of the Plan, as set forth herein, is October 1, 2009. The term "plan year" means the 12-calendar month period ending on each June 30.

l.4. Organization and Funding. For many years, medical expense, time loss weekly, vision, and dental expense benefits have been provided hereunder on an uninsured basis

with specific and aggregate stop loss insurance coverages provided through an insurance policy issued to the Trustees by an insurance company selected by them. Life and accidental death and dismemberment benefits, as described in Supplement A to the Plan, will be provided through a policy of group insurance issued by the insurance company. As of the effective date, the insurance company selected by the Trustees is ReliaStar Life Insurance Company.

l.5. Plan Supplements. The provisions of the Plan may be modified by Supplements to the Plan. The provisions of each Supplement are a part of the Plan and supersede the provisions of the Plan to the extent necessary to eliminate inconsistencies between the Plan and the Supplement.

1.6. Notices. Any notice or document required to be given to or filed with the Trustees may be delivered, or mailed by registered mail, postage prepaid, to the Trustees at 31290 North U.S. Highway 45, Unit B, Libertyville, Illinois 60048.

SECTION 2

Definitions

The following terms, when used in the Plan, shall have the following definitions unless the context expressly requires otherwise:

2.1. "Accident" means an unintentional or unexpected happening which: (1) causes Injury to the physical structure of the body, (2) results from an external agent or trauma, (3) is definite as to time and place and (4) happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences. "Accident" does not include a hernia of any kind, harm resulting from a disease, Illness or allergic reactions, with the exception of insect venom reactions.

2.2. "Active Work" or **"Actively at Work"** means (l) working or being available for work as an Employee; or (2) being on the job as required of an Apprentice or a Clerical Worker.

2.3. "Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a Hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and in which a patient is admitted and discharged within a 24-hour period. An office maintained by a Doctor for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an "Ambulatory Surgical Center."

2.4. "Apprentice" means a person enrolled in the Union's apprenticeship program.

2.5. "Birthing Center" means a place licensed as such by an agency of the state. If the state does not have any license requirements, a facility must meet all of the following tests: (l) it is primarily engaged in providing birthing services for low risk pregnancies; (2) it is operated under the supervision of a Doctor; (3) it has at least one licensed registered nurse certified as a nurse midwife in attendance at all times; (4) it has a written agreement with a licensed ambulance service to provide immediate transportation of the Covered Person to a

Hospital if an emergency arises; and (5) it has a written agreement with a Hospital located in the immediate geographical area of the birthing center to provide emergency admission of the Covered Person.

2.6. "Clerical Worker" means a person who, at a place other than his residence, works a full scheduled workweek of at least 25 hours as a member of the clerical support staff of the Union, International Brotherhood of Electrical Workers Local No. l50 Pension Fund (the "Pension Fund"), the Plan, or Lake County Joint Apprenticeship and Training Trust Fund (the "JATC"). Clerical Worker also includes a person who is employed by a Participating Lake County Employer (other than the Union, the Pension Fund, the Plan, or the JATC), including, if the Participating Lake County Employer is a sole proprietorship or partnership, its sole proprietor or partners, as the case may be, so long as any such person works a full scheduled workweek of at least 25 hours and the Participating Lake County Employer executes a participation agreement in a form satisfactory to the Trustees.

2.7. "Course of Treatment" means all treatment performed in the mouth during one or more sessions as the result of the same diagnosis, and includes all complications arising during such treatment.

2.8. "Covered Person" means a Member or a Dependent who is covered hereunder.

2.9. "Dentist" means a person who is licensed to practice dentistry or perform oral surgery and who is practicing within the scope of his license. A licensed denturist will also be considered a Dentist while practicing within the scope of his license. Dentist shall not include a Member, the Member's parent, or a person who is part of the Member's Immediate Family.

2.10. "Dependent" means any of the following individuals who is eligible for, has elected and has enrolled for Dependent Coverage under this Plan:

(a) The Member's legal spouse, of the opposite sex, who is a resident of the same country as the Member. Such spouse must have met all requirements of a valid marriage contract of the state in which they were married. This does not include common law marriage or any

other such arrangements which may be recognized by the state in which they reside.

(b) The Member's child who meets all of the conditions in items 1-2 below:

1. Is either (i) a natural child; or (ii) a legally adopted child; or (iii) a stepchild.

2. Is less than age 26; provided, however, that this requirement is waived for any mentally retarded or physically handicapped child, provided that the child is incapable of self-sustaining employment and is chiefly dependent upon the Member for support and maintenance. Proof of incapacity must be furnished to the Trustees and additional proof may be requested on an annual basis.

(c) A child who has been placed under the legal guardianship of the Member and who meets all of the conditions in items 1-4 below:

1. Is a resident of the same country as the Member.

2. Is unmarried.

3. Is in the legal custody of and financially dependent upon the Member. This requirement is waived if the Member is required to provide coverage, or is required to pay the cost of medical care due to court order or divorce decree of a child not in the custody of or not dependent on the Member.

4. Is less than age 20; provided, however, that this requirement is waived:

a. If the child is less than the age 24, a full-time Student, and dependent upon the Member for support.

b. For any mentally retarded or physically handicapped child, provided that the child is incapable of self-sustaining employment and is chiefly dependent upon the Member for support and maintenance. Proof of incapacity must be furnished to the Trustees and additional proof may be requested on an annual basis.

(d) Any child who is in the custody of a Member under an interim court order prior to finalization of adoption will be covered.

(e) Any children as required by a Qualified Medical Child Support Order.

Those situations specifically excluded from the definitions of a "Dependent" are:

(a) A spouse who is legally separated by a court order from the Member;

(b) A former spouse who is legally divorced from the Member;

(c) Any person on active military duty; and

(d) Any person covered under this Plan as an individual Member.

Notwithstanding the foregoing, if both a Member and a Member's spouse are eligible as Members, they will be covered both as Members and as Dependents, subject to the coordination of benefit rules of subsection 10.11.

2.11. "Doctor" means a person who is practicing within the scope of his license as (l) a doctor of medicine, (2) a doctor of osteopathy, (3) a Dentist, (4) a podiatrist, (5) a chiropractor, (6) an optometrist, or (7) a psychologist. Doctor does not include a Member, the Member's parent, or a person who is part of the Member's Immediate Family.

2.12. "During any Illness" means all periods of Illness arising from the same or related causes. A new Illness shall be deemed to start: (1) when a Covered Person who is an Employee, Apprentice, or Clerical Worker again becomes Totally Disabled after complete recovery or return to Active Work; or (2) for any other Covered Person, when such person again becomes Totally Disabled after resuming for at least six months the normal activities of a person in good health and of the same age and sex.

2.13. "Employee" means a person who, at a place other than his residence, works for a Participating Employer in a position for which contributions are required to be made to the Trustees under a collective bargaining agreement, a participation agreement, or otherwise.

2.14. "Experimental" or **"Investigational"** means one or more of the following is true of a treatment, procedure, device, drug or medicine:

(a) It cannot be lawfully marketed without U.S. Food and Drug Administration approval. Approval for marketing for the Condition treated has not been given at the time the device, drug or medicine is

furnished, or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

(b) Reliable evidence shows that the drug, device, medical treatment or procedure is:

(1) Part of a research project, protocol or study;

(2) Part of any phase of a clinical trial by the Food & Drug Administration, National Cancer Institute or other similar authority;

(3) Currently questionable or involved in on-going medical/legal debates; or

(4) Not commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the Illness or Injury.

Off-label use of drugs will be allowable under the Plan if such use of the drugs is supported by one or more citations in The American Hospital Formulary Service Drug Information, The American Medical Association Drug Evaluations, the United States Pharmacopoeia Drug Information, or any other compendia that is recognized by the industry as a valid standard, providing the use is not listed as "not indicated" in any one of the three compendia. The Trustees will rely on various sources to assist in determining "Investigational" or "Experimental" services. These sources may include, but are not limited to: The DATTA program of the American Medical Association, the Hayes Manual, the National Institute of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Health Technology Assessment and Congressional Office of Technology Assessment.

Notwithstanding the above, to the extent required under the Patient Protection and Affordable Care Act ("PPACA"), the Fund will not deny as Experimental or Investigational any qualified individual (as defined below) the right to participate in an approved clinical trial (as defined below); deny limit or impose additional conditions on the coverage of routine patient costs (as defined below) for items and services furnished in connection with participation in the approved

clinical trial; and will not discriminate against any qualified individual who participates in an approved clinical trial. For purposes of this section 2.14, the following definitions apply:

(a) "Routine patient costs" include items and services typically provided under the plan for a participant not enrolled in an approved clinical trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead are solely provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

(b) "Qualified individual" is a group health plan participant or beneficiary who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either the referring health care professional is a participating provider and has concluded that the participant's or beneficiary's participation in the approved clinical trial would be appropriate; or the participant or beneficiary provides medical and scientific information establishing that the individual's participation in the approved clinical trial would be appropriate.

(c) "Approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either:

1. Approved or funded by one of the following:

(i) The National Institute of Health,

(ii) The Centers for Disease Control and Prevention,

(iii) The Agency for Health Care Research and Quality,

(iv) The Centers for Medicare and Medicaid Services,

(v) A cooperative group or center of any of the above entities or the Department of Defense or Department of Veterans Affairs,

(vi) A qualified non-governmental research entity identified in the guidelines issue by the National Institutes of Health for center support grants, or

(vii) The Department of Veterans Affairs, the Department of Defense, or the Department of Energy if certain conditions are met.

2. Conducted under an investigational new drug application reviewed by the Food and Drug Administration, or

3. A drug trial that is exempt from having such an investigational new drug application.

(d) "Life-threatening condition" is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

If a PPO Provider is participating in an approved clinical trial and the PPO Provider will accept the qualified individual as a participant in the approved clinical trial, the qualified individual is required to use the PPO Provider instead of a Non-PPO Provider.

2.15 "Full-Time Student" means a Member's Dependent child who is enrolled in an accredited college, university, trade school or other accredited institution of higher learning at the beginning of the grading period for the minimum number of credit hours required by that accredited institution in order to maintain full-time status. The Full-time Student will be covered during school vacations if the intent is to return to full-time status during the next school term. Such coverage will then continue until the earlier of the date of graduation or the attainment of age 24 years. In addition, a Member's Dependent who is over age 19 who is a Full-Time Student at an accredited post-secondary educational institution who loses Full-Time Student status while covered under the Plan due to a "medically necessary leave of absence" which is certified by a Doctor will remain eligible under the Plan in accordance with ERISA section 714 and Internal Revenue Code section 9813, which is known as Michelle's Law.

2.16. "Health Care Provider" means any of the following that are engaged in providing medical care or diagnostic treatment to sick or injured persons:

(a) Home Health Agency

(b) Ambulatory Surgical Center

(c) Licensed Ambulance Service

(d) Practitioner

(e) Birthing Center

(f) Doctor

(g) Hospital

(h) Laboratory

(i) Nurse

(j) Nursing Home

(k) Hospice

(l) Substance Abuse Treatment Center

Additionally, to the extent required by PPACA and available guidance, if a service is covered under the Plan, the Plan will not discriminate based on the license or certification of the individual providing the service, if the individual is licensed to provide such services in the state in which the services are performed and the individual is acting within the scope of that license.

2.17. "Home Health Agency" means a public or private agency which: (l) is certified as a home health agency under Medicare or is licensed as a home health agency by a state; (2) is primarily engaged in providing skilled nursing and other therapeutic services; (3) has its policies set by a professional group which governs the services provided; and (4) maintains records for each patient.

2.18. "Hospice" means a public or private entity, or part of it, which is licensed or certified as a hospice by Medicare and by a state.

2.19. **"Hospital"** means an institution which meets all of the following conditions:

(a) It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;

(b) It is constituted, licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to Hospitals;

(c) It maintains on its premises all the facilities necessary to provide for the diagnosis and medical or surgical treatment of an Illness or an Injury, other than specialty Hospitals such as physical therapy and psychiatric Hospitals;

(d) Such treatment is provided for compensation by or under the supervision of Doctors with continuous 24-hour nursing services by Registered Nurses (R.N.'s);

(e) It is a provider of services under Medicare;

(f) It qualifies as a Hospital, a psychiatric Hospital, physical therapy Hospital or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Hospitals (JCAH [unless accreditation is limited by the jurisdiction of the JCAH due to the location of the Hospital or is accredited by the proper authority in the country in which the Hospital is located]); or a Substance Abuse Treatment Facility certified by the Division of Community Services and licensed by the Department of Health; and

(g) It is not, other than incidentally, a school, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

2.20. "Hospital Confined" or **"Hospital Confinement"** means confined in a Hospital as a registered bed patient.

2.21. "Illness" means a disorder or disease of the body or mind, or pregnancy as classified in the ICD.9.CM Manuals, as amended and in effect from time to time. All Illnesses due to the same cause, or to a related cause, will be deemed to be one "Illness."

2.22. "Immediate Family" means the spouse, Children, brothers, and sisters of a Covered Person.

2.23. "Injury" means a bodily condition caused, directly and independently of all other causes, by an accident that occurs while an individual is a Covered Person.

2.24. "Medical Necessity" or **"Medically Necessary"** means services or supplies provided by a Hospital or other covered provider which are not excluded under this Plan, which are provided to treat or diagnose an Illness or Injury, and which are determined by

the Trustees to meet the following criteria:

(a) They are consistent with the symptoms or diagnosis and treatment of the Illness or Injury;

(b) They are not primarily for the convenience of the Covered Person or any provider;

(c) They do not involve unnecessary or repeated tests;

(d) They are not of an Experimental, Investigational or educational nature, including drugs and drug treatment in one or more compendia qualifying for Medicare reimbursement, will not be considered Experimental or Investigational; and

(e) They are furnished by a provider with appropriate training and experience, acting within the scope of his license, and it is provided at the most appropriate level of care needed to treat the particular Condition.

The Trustees will analyze whether these requirements have been met based upon: 1) published reports in authoritative medical and scientific literature; 2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration and HCFA; 3) listings in the following compendia: The American Hospital Formulary Service Drug Information and the United States Pharmacopoeia Dispensing Information; and 4) other authoritative medical resources to the extent the Trustees determine them to be necessary.

2.25. "Medicare" means the Part A and Part B plans described in Title XVIII of the United States Social Security Act, as amended.

2.26. "Member" means a person who is eligible for coverage, or covered, under the Plan as an Employee, an Apprentice, a Clerical Worker, or a Retired Employee.

2.27. "Mental or Nervous Disorder" means a mental illness or functional nervous disorder.

2.28. "Nurse" means a Certified Registered Nurse Anesthetist, a Certified Nurse of the Operating Room, a Certified Surgical Technologist, a Certified First Assistant, a Licensed Nurse Practitioner, a Licensed Practical Nurse, a Nurse Midwife, and a Registered Nurse.

2.29. "Nursing Home" means a place which is operating legally to provide room and board for sick or injured persons under the supervision of a registered nurse or a Doctor, and along with the services of nurses at all hours, meets all of the following tests: (1) it has available at all times the services of a Doctor who is on the staff of a Hospital; (2) it keeps a daily medical record for each patient; and (3) it is not primarily a place for rest or custodial care, a place for the aged, a place for alcoholics or drug addicts, or a hotel.

2.30. "Participating Employer" means (a) the Union, the Pension Fund, the Plan, and JATC and (b) an employer within the jurisdiction of the Union that (1) is bound by a collective bargaining agreement between itself and the Union, or (2) through agreement with the Union, abides by the terms of the collective bargaining agreement, but is not a party to such agreement.

2.31. "Participating Lake County Employer" means a Participating Employer that maintains its principal office in Lake County, Illinois.

2.32. "Periodontal Disease" is the disease of tissues that surround, support, and nourish the teeth.

2.33. "Practitioner" means a person, other than one defined above as a Doctor, who: (l) upon referral by a Doctor, provides services which are covered under the Plan and (2) is practicing within the scope of his license. "Practitioner" also includes an individual who possesses a Master's Degree in Social Work or a Master's Degree in Counseling if such individual treats a Covered Person pursuant to a referral by a representative of an employee assistance plan with which the Plan has contracted.

2.34. "Prosthesis" means any full or partial removable denture, crown or fixed bridge.

2.35. '**Retired Employee'** means a person who:

(1) retires from active work on or after attaining age 55 years;

(2) has either:

(a) if he or she is a Clerical Worker employed by a Participating Employer (other than the Union, the Pension Fund, the Plan, or JATC) at the time of retirement, completed 10 years of employment with a Participating Employer and, on account of such employment, has had at least 120 months of contributions made on his or her behalf; or

(b) if he or she is not a Clerical Worker employed by a Participating Lake County Employer (other than the Union, the Pension Fund, the Plan, or JATC) at the time of retirement, qualified for a retirement or disability benefit under the Pension Fund; and

(3) has applied for coverage under the Plan as a retired employee; and

(4) was eligible for benefits under the Plan immediately prior to retirement; and

(5) was eligible for benefits under the Plan continuously for the 12 months immediately preceding retirement.

2.36. "Substance Abuse Treatment Center" means a facility (other than a Hospital) that has as its primary function the treatment of Substance Abuse and which is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

2.37. "Surviving Spouse" means a person to whom a Member is married on the date of his death.

2.38. "Totally Disabled" and **"Total Disability"** mean being unable, because of Illness:

(1) To work for pay, profit, or gain at any job for which one is suited by reason of education, training or experience; or

(2) To engage in one's regular and usual activities and not working at any job for pay, profit, or gain.

Item (1) applies to each person who is covered as an Employee. Serving as an instructor for the JATC, however, will not be considered as work of the type described in Item (1). Item (2) applies to all other Covered Persons.

2.39. "Trust Fund", as of any date, means all property of every kind then held by the Trustees in connection with the Plan.

2.40. "Usual and Customary Charge" means a charge that the Trustees determine (based on Medicode, the Claims Edit System, or otherwise) does not exceed the general level of charges being made by providers with similar training and experience in the locality where the charge is incurred when furnishing customary treatment for a similar Illness. The term "locality" means a zip code or such other geographically significant area as the Trustees deem necessary in order to establish a representative cross section of Doctors or other Health Care Providers regularly furnishing the type of treatment, services, or supplies for which the charge was made.

2.41. "Work-Related Illness or Injury" means an Illness or Injury which arises from or is sustained in the course of work for pay, profit, or gain.

SECTION 3

Eligibility

3.1. Eligible Status. Subject to the terms of the Plan, each individual who was a Covered Person immediately before the effective date will continue as such on and after the effective date. Each other individual will be eligible for coverage under the Plan and in an "eligible status" if he is an Employee, a Clerical Worker, an Apprentice, or a Retired Employee. A newly-organized Employee will enter an eligible status on the day the first letter of assent is signed on behalf of his Employer. A Retired Employee is not eligible for time loss weekly benefits. In addition, a Retired Employee is not eligible for dental expense benefits or vision benefits except as permitted by rules established by the Trustees. Finally, subject to subsection 3.4, if a Member's Plan coverage stops for any reason, he may not become eligible as a Retired Employee unless he first becomes eligible as a Member.

3.2. Resumption of Eligibility for Employees. If an Employee returns to eligible status after coverage has ceased, coverage will resume on the first day of the month which follows any three-month period in which the Employee works 375 hours for a Participating Employer.

3.3. Waiting Period for Apprentices, Newly-Organized Employees, and Clerical Workers. Subject to the following provisions of this subsection 3.3, an Apprentice, newly-organized Employee, or Clerical Worker will become a Covered Person on the first day of the month coincident with or next following the date he completes 60 days in an eligible status. If an Apprentice, newly-organized Employee, or Clerical Worker returns to an eligible status after coverage has ceased, his coverage will resume on the first day of the month coincident with or next following the date he again completes 60 days in an eligible status. In addition, unless a Clerical Worker is employed by the Union, the Pension Fund, or the JATC, he may not become a Covered Person unless his Participating Employer has entered into a participation agreement with the Trustees.

3.4. Waiting Period for Retired Employees. At the time of his or her retirement, a Retired Employee may elect no coverage, single coverage, or (if he or she has

Dependents) family coverage. A Retired Employee may change his or her coverage status from time to time after retirement in accordance with administrative rules established by the Trustees. A Retired Employee, however, may not change his or her coverage status after he or she attains age 65.

3.5. Exceptions to the Waiting Period Provisions. If an individual returns to an eligible status after coverage ceased because he entered full-time service in the armed forces, he will become a Covered Person on the first day of the month following discharge from the armed forces if he is available for Active Work at that time. If an individual was in an eligible status on the date he entered the armed forces, but had not yet qualified for coverage, the hours worked for a Participating Employer in the contribution quarter during which the individual 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 an individual worked for a Participating Employer in the contribution quarter during which he 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. A newborn Child of a Member will become a Covered Person at the moment of birth if the Member enrolls the Child within 31 days after the birth. A Member's adopted Child will be covered as of the earlier to occur of (i) the date the Member adopts the Child or (ii) the date as of which the Member acquires the legal obligation for total or partial support of the Child pursuant to a court order in anticipation of such adoption.

3.6. Continuation of Coverage for Employees and Apprentices. Subject to subparagraph 3.9(d), an Employee or an Apprentice will continue as a Covered Person until the last day of the eligibility quarter in which he or she ceases to be in an eligible status. In order to continue as a Covered Person for a succeeding eligibility quarter, an Employee or an Apprentice must work for a Participating Employer at least:

(a) 375 hours in the contribution quarter preceding the eligibility quarter;

(b) 750 hours in the two contribution quarters preceding the eligibility quarter;

(c) 1,125 hours in the three contribution quarters preceding the eligibility quarter; or

(d) 1,500 hours in the four contribution quarters preceding the eligibility quarter.

If an individual returns to an eligible status following a discharge from the armed forces, the hours worked in the contribution quarter during which he entered the armed forces and the three preceding contribution quarters may be applied towards meeting the work requirements specified in subparagraphs (a) through (d) above. In addition, an Apprentice's actual hours spent in the classroom, as reflected in written monthly reports prepared by the JATC and furnished to the Trustees, will be considered as hours of work for a Participating Employer for purposes of subparagraphs (a) through (d) above.

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.

3.7. Contribution Quarters and Eligibility Quarters. For purposes of this Section, the terms "contribution quarter" and "eligibility quarter" are three-month periods determined with reference to the following tables:

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

3.8. Eligibility of Dependents. Subject to the following provisions of this subsection 3.8, a Member's Dependent will become a Covered Person on the later of the date the Member becomes a Covered Person or the date the Member acquires his first Dependent. If a Member elects to cover a Dependent, he must cover all his Dependents. If a Member chooses not to cover a Dependent and later chooses to obtain coverage:

(a) If Dependents are enrolled within 31 days after they become eligible, they will become Covered Persons on the date of their enrollment.

(b) If Dependents are enrolled more than 31 days after they become eligible, their coverage will start on the first day of the month coincident with or next following the date of their enrollment. However, none of such Dependents shall have coverage for any loss which results from an Illness for which treatment was received or expense incurred during the six months which preceded the date of enrollment. This exclusion will cease to apply when the Dependent has been covered for a period of 12 months.

3.9. Termination of a Member's Coverage. Subject to Section 8, a Member's coverage will terminate on the earliest of the following dates:

(a) The date the Plan terminates;

(b) In the case of an Employee or an Apprentice, the date he or she no longer is in an eligible status under subsection 3.6;

(c) In the case of a Clerical Worker, the earlier to occur of (i) the last day of the month in which his or her employment terminates or (ii) the date of termination of the participation agreement entered into between the Trustees and his or her Participating Employer;

(d) In the case of an Apprentice, the last day of the month in which he or she ceases to be an Apprentice unless he or she ceases to be an Apprentice on account of becoming an Employee or a Clerical Worker; or

(e) The date a Member enters full-time service in the armed services.

Notwithstanding the foregoing, if a Member no longer is in an eligible status because of Total Disability, layoff or leave of absence, his coverage (and that of his Dependents) may be continued with self-payment:

(1) For not more than one year, beginning on the first day of the calendar month next following the date he or she becomes Totally Disabled on or after January 1, 2009, in the case of Total Disability;

(2) For the period his coverage would continue on account of the run-out of his hours plus 18 months in the case of a layoff or leave of absence.

3.10. Termination of a Dependent's Coverage. Subject to Section 8, a Dependent's coverage will terminate on the earliest of the following dates:

(a) The date the Plan terminates;

(b) The date as of which he no longer is a Dependent; or

(c) The last day of the month as of which the Covered Person with respect to whom an individual is a Dependent no longer is a Covered Person.

If an individual ceases being a Dependent because of the death of the Covered Person with respect to whom such individual is a Dependent, his coverage will terminate on the earliest of the following dates:

(1) The date the Plan terminates.

(2) The date the Covered Person's surviving spouse, if any, dies.

(3) The date that the Covered Person's coverage would have terminated after the run-out of his hours.

3.11. Suspension of Retiree Eligibility. If a Retired Employee who has not yet attained age 65 ceases making self-payments for coverage under this Plan and elects coverage under the Health Insurance Marketplace (an exchange established pursuant to the Patient Protection and Affordable Care Act), then such individual cannot again resume participation in this Plan until on or after attaining age 65 and prior to attaining age 66. Furthermore, a Retired Employee who opts out of Plan coverage prior to age 65 for any reason shall not be permitted to

resume participation in the Plan unless he elects to resume participation hereunder prior to age 66.

3.12 Special Enrollment. Notwithstanding anything herein to the contrary, an Employee who is eligible pursuant to the provisions of this Article 3 and who fails timely to enroll himself or his Dependent shall be entitled to enroll if either of the following requirements are satisfied.

(a) The Employee or Dependent experiences a special enrollment event described in the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), provided the Employee submits a written explanation of the event within 30 days of such event.

(b) The Employee or Dependent experiences a special enrollment event described in HIPAA as amended by the Children's Health Insurance Program Reauthorization Act of 2009, provided the Employee submits a written explanation of the event within 60 days of such event.

3.13 Crediting Hours for CWCE Employees. Due to the disparity in the contribution rate made on behalf of Employees in the CWCE category of employment who are covered by the provisions of the inside wireman collective bargaining agreement relative to other categories of employment, for purposes of determining eligibility under the Fund, an Employee in the CWCE category of employment who is covered by the provisions of the inside wireman collective bargaining agreement shall be credited with .72 hours for each hour for which contributions are made to the Fund on his behalf.

SECTION 4

Participating Employer Contributions

Subject to Sections 5 and 12, the Participating Employers expect and intend to contribute such amounts as, when combined with the contributions of Covered Persons and in accordance with accepted actuarial principles, are required under the collective bargaining agreement and any other agreements relating to the Plan to which they are parties and, in the opinion of the Trustees, necessary to fund the benefits provided, maintain reasonable supplemental reserves, and pay the administrative costs incurred, under the Plan; provided, however, that notwithstanding anything to the contrary in the foregoing or the Collective Bargaining Agreement, the Trustees will not accept any contributions on behalf of any Participant during any period in which such Participant is employed at a location that is outside the jurisdiction of the International Brotherhood of Electrical Workers ("IBEW"), as defined in the IBEW Constitution as amended and in effect from time to time. The Union, the Supplemental Pension Fund, the Pension Fund and the Apprenticeship Fund will contribute, respectively, an amount equal to 28 percent of the gross productive earnings of each Participant employed by such entity; provided, however, that, in the case of any such Participant who was hired before June 1, 2008, the contribution for each hour of service performed by each such Participant shall not be less than the greater of:

(a) $10.27; or

(b) 28 percent of such Participant's gross productive earnings.

SECTION 5

Employee Contributions

5.1. Self-Payment by Employees. Subject to Sections 8 and 9, an Employee whose medical expense benefits coverage otherwise would cease on account of his failure to meet the requirements of subsection 3.6 may continue such coverage through either self-payment or COBRA continuation coverage. The Employee may only choose one option. If the Employee chooses self-payment, the Employee cannot subsequently choose COBRA continuation coverage unless the Employee experiences an additional qualifying event. The amount of an Employee's self-payment contributions will be determined by the Trustees based on the difference between the number of hours the Employee was required to work to maintain coverage and the number of hours actually worked. An Employee's self-payment contributions must be made to the Trustees, in advance, on a quarterly basis. Notwithstanding the foregoing, an Employee's right to continue his medical expense benefits coverage through self-payment is subject to the following:

(a) Self-payment contributions may be made only while the Employee is available for Active Work.

(b) An Employee who performs zero hours of service during a period of unemployment may not continue coverage through self-payment for more than 18 months after the date his or her coverage otherwise would have ceased.

(c) If an Employee is Totally Disabled, his or her coverage will continue, with self-payment, for up to one year so long as he or she remains Totally Disabled. Thereafter, coverage will terminate unless the Employee returns to Active Work.

(d) The Trustees will not accept any self-payment from or on behalf of any Employee during any period in which such Employee is employed at a location that is outside the jurisdiction of the IBEW, as defined in the IBEW Constitution as amended and in effect from time to time.

An Employee whose medical expense benefits coverage ceased on account of his failure to meet the requirements of subsection 3.6 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 current hourly contribution rate payable by Employers (minus any WRA contribution), subject to periodic review by the Trustees.

5.2. Self-Payment by Retired Employees. The medical expense benefits coverage of a Retired Employee may be continued through self-payment. Self-payment will commence on the first day of the month in which the Retired Employee's retirement occurs. A Retired Employee may elect single coverage or (if he has one or more Dependents) family coverage. The amount of a Retired Employee's self-payment contributions may be determined by multiplying the cost of the coverage elected (as such cost is determined from time to time by the Trustees) by 50% if the Retired Employee has attained age 63. In the case of a Retired Employee who has not attained age 63, the amount of his or her self-payment contributions will be determined by multiplying said cost of the coverage elected by the applicable percentage determined in accordance with the following table:

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

Notwithstanding the foregoing, the applicable percentage payable by a Retired Employee will be 50% beginning on the first day of the month next following the date he or she attains age 63, regardless of his or her age at the Retirement Date. The Trustees reserve the right to change the applicable contribution percentages and ages at any time and from time to time and no Covered

Person shall have or acquire any right to coverage for any period except as provided under the Plan.

5.3. Self-Payment by Surviving Spouses. The medical expense benefits coverage of a Surviving Spouse may be continued through self-payment. A Surviving Spouse may elect single coverage or (if he or she has one or more Dependents) family coverage. The amount of a Surviving Spouse's self-payment contributions may be determined by multiplying the cost of the coverage elected (as such cost is determined from time to time by the Trustees) by 70% or, if the Surviving Spouse has attained age 65, 40%. The coverage of a Surviving Spouse will terminate on the first to occur of:

(a) The date the Surviving Spouse remarries or dies;

(b) The date the Surviving Spouse becomes eligible for coverage under another group medical plan sponsored by an employer; or

(c) The later to occur of (i) the date the Surviving Spouse no longer is entitled to receive benefits under the Pension Fund or (ii) the date that is five years after the date of the Member's death.

5.4. Termination of Coverage. The medical expense benefits coverage of an individual who is making self-payment contributions (and the coverage of his Dependents) will terminate on the last day of the calendar month for which such a contribution is made to the Trustees.

5.5. Time Loss Weekly Benefits. The coverage of an individual for time loss weekly benefits may not be extended through self-payment.

SECTION 6

Medical Benefits

6.1. Introduction. Subject to the terms and conditions of this Section 6 and Section 7, the Plan will pay 80% of a Covered Person's medical expenses (as defined in subsection 6.5) to the extent that such expenses exceed the deductible (as described in subsection 6.2). The Plan also will pay 50% of the charges for the treatment of infertility, subject to a lifetime maximum. Finally, the Plan will pay:

(a) 70% of the charges of 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 "PPN"); and

(b) 50% of the cost of a hearing aid prescribed by a Doctor and purchased once every third year for the use of a Covered Person; provided, however, that the Plan will not pay more than $1,000 (per ear) of the cost of such a hearing aid.

Notwithstanding subparagraph (a) above, if a Covered Person receives "emergency medical care" in a Hospital that is not a member of the PPN, 80% of the charges of the Hospital for such emergency medical care will be covered. "Emergency medical care" means treatment given in a Hospital emergency room for the sudden onset of a condition with acute symptoms requiring immediate medical attention. In no event, however, will the Plan pay any portion of a Covered Person's medical expenses that exceeds the Usual and Customary Charge for the service and/or supplies involved.

6.2. Deductible. The term "deductible", as used in subsection 6.l, means the first $500 of a Covered Person's medical expenses incurred in a calendar year. However:

(a) If two or more Covered Persons in the same Immediate Family sustain Injuries in the same accident, only one deductible must be satisfied in that calendar year for all comprehensive expenses incurred by such Covered Persons and resulting from that accident.

(b) If a Covered Person incurs medical expenses in the final three months of a calendar year that are applied to that Covered Person's deductible for that calendar year, such expenses also will be applied to that Covered Person's deductible for the following calendar year.

(c) No deductible is applicable in connection with routine pediatric care or a standard physical examination, as described in subparagraphs 6.5(g) and (h), respectively.

(d) If three or more Covered Persons in the same Immediate Family satisfy the deductible for a calendar year, no deductible need be satisfied by any other Covered Person in that Immediate Family for that calendar year.

(e) If a Covered Person is treated in the emergency room of a Hospital (as defined in subsection 2.19) and does not become Hospital Confined on account of the Illness or Injury for which he or she was treated in said emergency room, a special deductible in the amount of $200 must be satisfied by said Covered Person on account of such treatment.

6.3. Out of Pocket Maximums. The following out of pocket maximums apply:

(a) Medical Out of Pocket Maximum. Subject to the terms of the Plan, 100% of the eligible Usual and Customary Charges incurred by a Covered Person in the form of medical expenses will be paid by the Plan for the duration of a calendar year after the amount of medical expenses paid by such Covered Person or on his behalf (from a source other than the Plan) reaches $2,000 (in the case of a Covered Person who has single coverage) or $6,000 (in the case of Covered Persons who are members of an Immediate Family) for that calendar year.

(b) ACA Out of Pocket Maximum. Subject to the terms of the Plan, 100% of the eligible Usual and Customary Charges incurred by a Covered Person in the form of medical, dental, vision and prescription expenses will be paid by the Plan for the duration of a calendar year after the amount of in-network medical, dental, vision and prescription expenses paid by such Covered Person or on his behalf (from a source other than the Plan) reaches $6,600 (in the case of a Covered Person who has single coverage) or $13,200 (in the case of Covered Persons who are members of an Immediate Family) for that calendar year (and such dollar amount shall increase each calendar year based on the indexed amount announced by the IRS for the Plan Year ending within such calendar year).

6.4. Maximum Benefits. The maximum amount of medical benefits payable to or on behalf of a Covered Person under the Plan is as shown on the following table:

Benefits On Account Of:	Annual Maximum	Lifetime Maximum
Treatment By A Chiropractor	$1,500	
Treatment By A Naparath	1,500	
Infertility-General		12,000
Infertility-Prescription Drugs	3,000	
Impotence	2,000	

6.5. Medical Expenses. For purposes of this Section 6, a Covered Person's "medical expenses" means those covered expenses (not including expenses that exceed the Usual and Customary charge for the service or supplies involved) incurred for medically necessary treatment of an Illness or Injury in connection with the following:

(a) Services and supplies which are furnished by, and fall within the scope of the authorized practice of, a licensed Health Care Provider, including:

(1) Services and supplies when confined in a Hospital or Substance Abuse Treatment Center;

(2) Hospital services for medical care and surgery (including assisting surgeon when necessary) including home, Hospital, and office calls;

(3) Doctor's examination and reporting services for a second surgical opinion by a board certified specialist;

(4) Physical therapy; and

(5) Diagnostic tests and radioactive therapy; provided that:

(A) For room and board charges, medical expense for any day shall not exceed the Hospital's or Substance Abuse Treatment Center's most common semi-private room daily rate. However, this limit: (1) shall not apply to a unit for intensive or specialized care; and (2) shall be changed to the most common private room daily rate when a private room is used on order of a Doctor or because the Hospital or Substance Abuse Treatment Center is not equipped with semi-private rooms.

(B) Medical expense for any day of confinement in a Nursing Home shall not exceed 50% of the average semi-private room daily rate for Hospitals in the area in which the Nursing Home is located. Nursing Home confinement must start within seven days after Hospital confinement ends.

(C) Medical expense includes charges for a Birthing Center provided that such coverage shall cease at the end of a 48-hour period (in the case of a vaginal delivery) or a 96-hour period (in the case of a Caesarian section) following the birth of the Child.

(D) Medical expense includes charges for Hospice care made by a Hospice only if: (1) the expense is incurred by a Covered Person diagnosed by a Doctor as terminally ill with a prognosis of six months or less to live; and (2) the Hospice provides a plan of care which: (A) is prescribed by the Doctor; (B) is reviewed and approved by the Doctor monthly; (C) is not for any curative treatment; (D) states the belief of the Doctor and the Hospice that the Hospice care will cost less in total than any comparable alternative to Hospice care; and (E) is furnished to the Trustees.

(E) Hospice care may be provided: (1) In the Covered Person's home by a Home Health Agency or Hospice agency; or (2) In a Hospice inpatient facility. No amount will be paid for charges in a Hospice inpatient facility which exceed 150% of the average Hospital semi-private room daily rate in the geographical area in which the Hospice inpatient facility is located. Hospice care includes palliative and supportive medical and nursing services. For such Hospice care, the requirement that expenses will be covered only when incurred for diagnosis or treatment of an Illness is waived.

(F) Medical expense includes charges for home health care made by a Home Health Agency, provided that the plan of care by the Home Health Agency: (1) is prescribed by a Doctor; (2) is reviewed and approved by the Doctor every two weeks; (3) contains a statement expressing the belief of the doctor and Home Health Agency that: (A) the number of days of home health care does not exceed the number of days of

confinement in a Hospital or Nursing Home which would have been required; (B) the home health care will probably cost less per day than the daily rate for confinement in a Hospital or Nursing Home; and (C) confinement in a Hospital or Nursing Home would otherwise be required. A copy of this plan of care shall be provided by the Covered Person to the Trustees.

(G) Home health care includes: (1) skilled nursing care and home health aide services; and (2) any other services and supplies provided in lieu of the services which would have been covered if the Covered Person were confined in a Hospital or Nursing Home. Home health care does not include housekeeping or custodial care.

(H) Medical expense for licensed ambulance service is limited to expense incurred to transport a Covered Person to the nearest facility able and willing to treat the Illness or Injury of such person.

(I) Medical expense for a diabetes instruction program which is: (1) designed to teach the Covered Person and his family about the disease process and the daily management of diabetic therapy; and (2) supervised by a Doctor.

(b) Costs incurred for drugs or medicines may be covered under the Plan, as described in subsection 6.6, but will not be considered "medical expenses" for purposes of Sections 6 and 7.

(c) Oxygen, blood or blood plasma.

(d) Artificial limbs or eyes, custom-fitted orthotics, and other non-dental prosthetic devices, which include breast implants only when incidental to a mastectomy.

(e) Rental, and with the approval of the Trustees, purchase of Durable Medical Equipment. Durable Medical Equipment means equipment which meets all of the following tests: (1) it can withstand repeated use; (2) it is designed and used only to treat an Injury or Illness; (3) it is appropriate for medical treatment in the home; (4) it has no value to the Covered Person or the Covered Person's family in the absence of the Injury or Illness being treated; (5) it is not an item commonly found in the household; and (6) it is not sporting or athletic equipment.

(f) Required immunizations for Covered Persons as required under the preventive care guidelines outlined in section 6.5(p).

(g) Routine medical care (including physical examinations) for a child who has not attained age two.

(h) A standard physical examination performed once each calendar year. A standard physical examination may include (A) up to two Doctor visits in a calendar year; and (B) one or more of the following tests and no others:

(l) Blood pressure;

(2) Heart and chest examination;

(3) Urinalysis;

(4) Fecal occult blood test;

(5) Eye, ear, nose, and throat examination;

(6) Blood count and cholesterol level test;

(7) Breast examinations, mammograms, and Pap tests for females; and

(8) Proctologic examinations for males.

(9) In the case of a Covered Person who has attained age 50, an initial screening colonoscopy will be covered and one or more follow-up screening colonoscopies for such Covered Person will be covered provided that, in the case of each such follow-up screening colonoscopy, at least 60 months have elapsed since the date of his or her previous colonoscopy.

(i) Anesthetics and its administration by a Doctor, a Dentist, or a professional anesthetist as part of the treatment of a medical or dental Illness or Injury.

(j) Services and supplies provided for the treatment of impotence.

(k) 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.

(l) Services and supplies (other than prescription drugs, which are covered, if at all, under subsection 6.6) prescribed to male or female Covered Persons for the purpose of birth control.

(m) Organ and tissue transplants to the extent that they are Medically Necessary and are not Experimental or Investigational, subject to the following:

(A) **Mandatory Second Opinion**. A second opinion (record review or physical exam) must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must be by a Physician qualified to render such a service either through experience, specialized training, education or such similar criteria, and who is not affiliated in any way with the Physician who will be performing the actual transplant procedure.

(B) **Donor Expenses**. Eligible expenses incurred by the donor will be considered for benefits only if the recipient is covered by this Plan. Charges for the donor are considered as part of the recipient's claim and not the donor's.

(C) **Other Charges**.

(i) Acquisition, Storage and Transportation. The Usual and Customary costs of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and the Hospital's charge for storage or transportation of the organ, will be considered an Eligible Expense.

(ii) Transportation-Recipient. Transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual or, in the case of a minor, two other individuals, and all reasonable and necessary lodging expenses incurred, up to a maximum of $10,000.

(n) initial purchase of custom-fitted orthotics, artificial limbs and eyes, or similar appliances.

(o) casts, splints, braces, trusses, and crutches.

(p) Preventive Services. This Plan provides coverage for certain Preventive Services as required by PPACA and interpretive guidance. Preventive Services are paid for based on the Fund's payment

schedules for the individual services. Coverage is provided on a PPN basis (i.e., through Blue Cross/Blue Shield of Illinois) with no cost sharing (for example, no deductibles, coinsurance, or copayments), and on a non PPN basis with normal cost sharing as reflected in the Plan document for other non PPN services. However, if the Plan does not have a PPN provider to provide a particular Preventive Service or item, the Plan will cover the service or item provided by a non PPN provider without cost sharing, upon receipt of substantiating documentation. The Preventive Services covered by the Plan 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.

Covered Preventive Services are also subject to the following:

- For all purposes of the Plan, an expense is deemed to be incurred on the date the service is performed or the supply is obtained.

- The Plan will use reasonable medical management techniques to control costs of Preventive Services under the Plan.

- The Plan covers the following tobacco cessation Preventive Services: two tobacco cessation interventions per year, each consisting of four counseling sessions and one 90 day supply of any FDA-approved tobacco cessation drug.

For all purposes of the Plan, an expense is deemed to be incurred on the date the service is performed or the supply is obtained.

6.6. <u>Prescription Drug Card Program</u>. Prescription drugs are covered under the terms of a program maintained for Covered Persons pursuant to an agreement entered into between the Trustees and CVS Caremark ("Caremark").

The prescription drug benefit is separate from the medical benefit. Prescription drug copays do not apply to the medical deductible and out-of-pocket maximum (although prescription drug copays will apply to the out-of-pocket maximum starting July 1, 2015).

For a 30-day supply of prescribed drugs and medications from a retail pharmacy, the Fund pays 100% after the Covered Person makes 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.

For mail order prescriptions through Caremark, a Covered Person pays 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), or (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.

Notwithstanding the foregoing, Covered Persons will be required to fill prescriptions for maintenance medications in 90-day supplies either at a CVS pharmacy or through use of Caremark's mail order service.

SECTION 7

Exclusions

For purposes of the Plan, "medical expenses" as described in Section 6, will not include expenses incurred in connection with the following:

(a) Supplies or services for which no charge is made or for which the Covered Person is not required to pay.

(b) Supplies and services for which the Covered Person receives payment from:

(i) The Uniformed Services Medical Care Facilities (unless applicable law requires the Plan to pay); or

(ii) Under the prescription drug card program maintained for Covered Persons under the terms of a contract entered into between the Trustees and Caremark.

(c) Expense for which the Covered Person receives payment under: (1) a worker's compensation or similar law; or (2) a program of a government or plan established by law, except: (A) Medicare; (B) the Civilian Health and Medical Program of the Uniformed Services (TRICARE); and (C) where the law does not permit this type of exclusion.

(d) Expense for a Work-Related Illness or Injury.

(e) Expense for cosmetic surgery unless performed to repair: (1) a birth defect; or (2) damage due to an accident.

(f) Expense for the services of a private duty nurse when the Covered Person is Hospital Confined. A "private duty" nurse means a nurse who is not an employee of the Hospital in which the Covered Person is confined.

(g) Expense for the services of a person who normally lives in the Covered Person's household, or who is a member of the Covered Person's Immediate Family.

(h) Expense for services or supplies that are for educational, experimental, or research purposes (except as expressly provided herein for clinical trials required by PPACA).

(i) Expense for the purchase of exercise equipment.

(j) Expense incurred by an individual while he is not a Covered Person.

(k) Expense for any of the services listed below unless, and except to the extent that, specific provisions dealing with such services are included in the Plan:

(1) Dental x-rays; treatment on or to the teeth whether done for medical or dental reasons; treatment of the gums other than for tumors; or treatment of other structures mainly involved in the treatment or replacement of teeth. This exclusion does not apply to:

(i) Treatment received by a Covered Person to repair the damage to his natural teeth caused by an accident if such treatment is provided while the individual involved is a Covered Person.

(ii) Dental procedures that are required and incidental in conjunction with the treatment of a pre-existing, unrelated, and purely medical condition, as certified by a physician.

(iii) Services and supplies provided in connection with the administration of general anesthetics as part of the treatment of teeth or gums.

(2) 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.

(3) Expense for radial keratotomies or other procedures for surgical correction of myopia and/or other refractive errors, except as may be permitted under Supplement C to the Plan.

(4) Except as provided in subsection 6.5(p), expense for immunizations, routine examinations or check-ups, and other preventive care.

(5) Expense for custodial care, except when provided by a Hospice.

(6) Except as provided in subsection 6.5(p), 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 expense must be incurred on account of Injury or Illness does not apply during such confinement.

(l) Expenses for services or supplies for which no claim is filed as of the date that is one year after the date such expenses were incurred.

(m) Services rendered and/or supplies provided to a Member or Dependent during any period in which the Member is employed outside the jurisdiction of the IBEW, as defined in the IBEW Constitution as amended and in effect from time to time.

(n) 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 the Covered Person or his authorized representative shall agree to cooperate fully with the Plan, and agree in writing as requested by the Plan, to protect the Plan's rights to subrogation and reimbursement as described in Section 13.

(o) Services or supplies that are not Medically Necessary.

SECTION 8

Continuation of Coverage

8.1. COBRA Continuation. Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and in effect from time to time ("COBRA"), coverage for medical expense benefits may be continued beyond the date such coverage otherwise would stop, subject to the provisions set forth below.

(a) Continuation benefits will be available to any Covered Person whose coverage otherwise would stop due to any of the following qualifying events:

(1) Reduction in the number of hours of the Member's Employment;

(2) The death of the Member;

(3) The termination (other than by reason of gross misconduct) of the Member's employment;

(4) The divorce or legal separation of the Member;

(5) The Member becomes entitled to Medicare; or

(6) A dependent Child ceases to be a Dependent for purposes of the Fund.

(b) The Covered Person must notify the Trustees of any change in family status (divorce, separation or ineligibility of a child) within 60 days from the date of such change. Within 14 days of the date the Trustees receive notice of the event, they will notify the Covered Person of the right to continue medical expense benefits coverage, the cost thereof, and the timing and manner of paying such cost.

(c) In order to continue coverage, election must be made within 60 days after the later of: (A) the date the Covered Person is notified of the continuation right; or (B) the date coverage would stop. In addition, the first payment for the cost of continuation coverage must be made to the Trustees within 45 days of the election. Thereafter, monthly payments must be made in advance.

(d) Continuation coverage will cease on the earliest of:

(1) The date 36 months (18 months in the case of termination of employment, 29 months in the case of total disability) after the occurrence of a qualifying event, as described above.

If a second qualifying event occurs during the period of a Covered Person's continuation coverage, the maximum period of coverage shall not exceed:

(A) 18 months from the date of termination of employment for a Member; or

(B) 36 months from the date of the first event for covered Dependents affected by the second event.

(2) The end of the period for which coverage has been paid.

(3) The date the Covered Person becomes covered under any other group health plan or entitled to Medicare.

(4) The date the Plan terminates.

(5) The date the Plan ceases providing health care benefits.

(6) This continuation coverage shall run concurrently with any continuation period which may be mandated by state law.

A Covered Person may elect to continue coverage for medical expense, dental, and vision benefits or only for medical expense benefits. If a Covered Person is entitled to have health care benefits coverage continued under both Section 5 and this Section 8, such Covered Person shall elect which, if any, continuation coverage he desires. If, following a qualifying event, a Covered Person elects to continue coverage under the Fund's self-payment provisions described in Section 5, rather than under COBRA continuation coverage, COBRA continuation coverage shall not be available at the end of the self-payment coverage period, unless the Covered Person experiences a new qualifying event.

A General Notice of COBRA rights will be furnished to each Participant and spouse no later than the earlier of (1) 90 days from the date the Participant first becomes covered

under the Plan or (2) the date on which the Trustees are required to furnish an election notice. The General Notice also will form a part of the summary plan description of the Plan.

8.2 USERRA Continuation. When an Employee or Clerical Worker enters uniformed service as defined by the Uniformed Services Employment and Reemployment Rights Act, as amended ("USERRA") benefits shall continue as usual if the service is for a period of less than 31 days. If the uniformed service is for a period of greater than 30 days, all benefits will terminate the date on which the Employee or Clerical Worker enters full-time military, naval or air service, unless sooner terminated in accordance with this article. Notwithstanding the above, an Employee or Clerical Worker who enters uniformed service may continue coverage in accordance with the provisions of USERRA except that the maximum coverage period shall be 24 months. USERRA continuation coverage will run concurrently with COBRA continuation coverage. In the event there is any inconsistency between the provisions of this Plan and the provisions of USERRA the Employee or Clerical Worker and his eligible dependents shall be entitled to the protection of the more beneficial provisions. Upon discharge from uniformed service, benefits will be reinstated on the day he returns to active employment following uniformed service, provided the Employee or Clerical Worker returns to active covered employment within the period during which reinstatement rights are guaranteed by law.

SECTION 9

Conversion Privilege

The Trustees do not provide conversion policies for individuals who cease to be Covered Persons under the Plan.

SECTION 10

Miscellaneous

10.1. **Plan Records**. The records of the Plan relating to a Covered Person will be conclusive unless determined to the Trustees' satisfaction to be incorrect.

10.2. Information Furnished by Covered Person. Covered Persons must furnish to the Trustees such evidence, data, or information as the Trustees consider necessary to carry out the Plan. The benefits of the Plan for each Covered Person are on the condition that he furnish promptly true and complete evidence, data, and information requested by the Trustees.

10.3. **Interests Not Transferable**. Except as may be required by application of the tax withholding provisions of the Internal Revenue Code or of a state's income tax act and except to the extent that the Trustees may consider it advisable so that Plan benefit payments may be made on behalf of Covered Persons, the interests of Covered Persons under the Plan are not subject to the claims of their creditors and may not be transferred or encumbered.

10.4. Facility of Payment. When, in the Trustees' opinion, a Covered Person is under a legal disability or incapacitated in any way so as to be unable to manage his financial affairs, the Trustees may make payments to the Covered Person's legal representative, or to a relative or friend of such Covered Person for his benefit, or the Trustees may apply the payment for the benefit of the Covered Person in any way they consider advisable.

10.5. No Guaranty of Interests. Neither the Trustees nor any Participating Employer in any way guarantees the trust fund from loss or depreciation nor do they guarantee any payment to any person. The right of anyone to receive any payment under the Plan is limited to the available assets of the Trust Fund.

10.6. Employment Rights. The Plan is not a contract of employment and coverage under the Plan will not give any person the right to be retained in a Participating Employer's employ, nor any right or claim to any benefit under the Plan unless the right or claim has specifically accrued under the Plan.

10.7. Evidence. Evidence required of anyone under the Plan may be by certificate, affidavit, document or other information which the person acting on it considers pertinent and reliable, and signed, made, or presented by the proper party or parties.

10.8. Uniform Rules. In administering the Plan, the Trustees will apply uniform rules to all persons who are similarly situated.

10.9. Gender and Number. Where the context admits, words in the masculine gender include the feminine and neuter genders, the plural includes the singular, and the singular includes the plural.

10.10. Trustees' Decision Final. To the extent permitted by law, an interpretation of the Plan and a decision on any matter within the Trustees' discretion made by the Trustees in good faith is binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known and the Trustees shall make such adjustment on account thereof as they consider equitable and practicable.

10.11. Coordination of Benefits. To the extent necessary to avoid duplicative payments and in accordance with applicable law and the rules established by the Trustees, a Covered Person's benefits provided under the Plan (including Supplements to the Plan) will be coordinated with:

(a) The benefits provided for him under this Plan (in the case of a Covered Person who is entitled to benefits under this Plan both as Member and as a Dependent) and the benefits provided for such Covered Person any other employer- or government-sponsored group medical plan or program; and

(b) Any amount that the Trustees deem to have been paid to him by or on behalf of any individual in the nature of damages for an Injury sustained by the Covered Person. In the case of any such payment made on or after December 1, 1994, the Trustees will determine the percentage (if any) of such payment that the Covered Person must pay as attorneys' fees (the "applicable percentage"). Then, the Trustees will relinquish the Plan's claim to the lesser of:

(i) The applicable percentage of such payment; or

(ii) 33-1/3% of such payment.

(c) C**oordination with Medicare**. Each Covered Person who is eligible for Medicare will be assumed to have full Medicare coverage (i.e., Part A and Part B). Therefore, if the Plan is not the primary payer of benefits, the Plan will coordinate its benefits with the full amount of Medicare benefits to which a Covered Person is entitled, even if he or she not enrolled. The benefits of Medicare and the Plan 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 a Covered Person, the Trustees may reduce the amount that otherwise would be payable to such Covered Person or request that such Covered Person reimburse the Plan in the amount of any overpayment of benefits made to him or her.

10.12. Controlling Laws. To the extent not preempted by federal law, the internal laws of Illinois will be controlling in all matters relating to the Plan.

10.13. Waiver of Notice. Any notice required under the Plan may be waived by the person entitled to notice.

10.14. Plan Not an Insurance Program. The Plan is not an insurance program and, accordingly, neither the Participating Employers nor the Trustees nor any other person guarantees that any payment will be made to any person.

10.15. Notices. Any notice or document required to be given to or filed with the Trustees may be delivered, or mailed by registered mail, to the following address:

Fund Administrator
International Brotherhood of
Electrical Workers Local No. l50 Welfare Fund
31290 North U.S. Highway 45, Unit B
Libertyville, Illinois 60048

The Fund Administrator will automatically mail a certificate of creditable coverage to an individual when he or she ceases to be a Covered Person. Any such individual may request a certificate of creditable coverage by contacting the Fund Administrator.

10.16. Release of Information. Subject to the terms of the Health Insurance Portability and Accountability Act of 1996, the Trustees, without the consent of anyone, may release to, or obtain from, any insurance company (or service provider) or any other person any information the Trustees consider appropriate or helpful in administering the Plan.

10.17. Rights in Recovery. Whenever a payment has been made under the Plan in excess of the amount necessary to satisfy the intent of the Plan, the Trustees shall have the right, exercisable alone and in their sole discretion, to recover such excess payment. Further, the Trustees reserve the right to deduct the amount of any excess payment from future benefits to which a Member or any of his covered Dependents may become entitled. This right of recovery also applies when a Covered Person, or any plan that pays benefits for which benefits also are paid by the Plan, receives duplicate payments under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

10.18. Claim Procedures.

(a) Claim Filing Deadline. To be paid, a Covered Person (or provider) must file a claim within one year of the date the Covered Person incurred an expense or suffered a loss.

(b) Initial Decision on Claim.

1. Health Claims.

(i) Urgent Care Claims. The Fund will inform a Covered Person 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, the

Covered Person 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 the Covered Person 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 a Covered Person or subject a Covered Person 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 the Covered Person's condition.

(ii) Pre-Service Claims. The Fund will inform a Covered Person of the decision on a Pre-Service claim within 15 days of the date the claim is filed. Within that 15-day period, the Covered Person 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 the Covered Person can expect to receive a decision.

If during the review, additional information is required, a Covered Person will be so notified within the required time period for notice of a decision detailed above. The Covered Person 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 the Covered Person 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.

(iii) Post-Service Claims. The Fund will inform a Covered Person of the decision on a Post-Service claim within 30 days of the date the claim is filed. Within that 30-day period, the Covered Person 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 the Covered Person can expect to receive a decision.

If during the review, additional information is required, a Covered Person will be so notified within the required time period for notice of a decision detailed above. The Covered Person 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 the Covered Person to provide the additional required information.

(iv) Concurrent Care Claims. Any request by a Covered Person to extend the duration or number of treatments previously approved through a Pre-Service claim is a Concurrent Care claim. The Fund will inform the Covered Person 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. The Covered Person 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).

2. Time Loss Weekly Benefit Claims. If the Covered Person's claim for Time Loss Weekly Benefits is denied in whole or in part, the Fund will inform the Covered Person of the denial within 45 days of the date the initial claim was

received, regardless of whether the claim included all the necessary information.

(i) 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.

(ii) Additional Information. If, during the review, additional information is required, the Fund Office will notify a Covered Person within the required time periods noted above. The Covered Person shall have at least 45 days to provide such information. Following receipt of the additional information the Covered Person provides 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.

3. Content of Denial Notice on a Health Claim. If a Covered Person's Health Claim is partially or wholly denied, the Covered Person will receive a notice:

(i) 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;

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

(iii) describing and explaining any additional material or information required of the Covered Person in order to make the Covered Person's claim valid;

(iv) explaining the Fund's appeal procedure and the Covered Person's right to appeal the initial decision;

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

(vi) detailing the Covered Person's right to bring a civil action under ERISA section 502(a), or to request an external review with an independent review organization as described in section 10.18(d), following an adverse benefit determination on an appeal;

(vii) notifying the Covered Person that, if a specific rule or guideline was relied upon, a copy of such rule or guideline is available free of charge upon request;

(viii) notifying the Covered Person that, if the determination is based upon a medical necessity, experimental treatment, or similar exclusion or limitation, a copy of an explanation of the scientific judgment supporting the determination is available free of charge upon request; and

(ix) describing the expedited review process for Urgent Care claims, if applicable.

4. Content of Denial Notice on a Time Loss Weekly Benefit Claim. If a Covered Person's Time Loss Weekly Benefit claim is partially or wholly denied, the Covered Person will receive a notice:

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

(ii) describing and explaining any additional material or information required of the Covered Person in order to make the Covered Person's claim valid;

(iii) explaining the Fund's appeal procedures and the Covered Person's right to appeal the initial decision;

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

(v) notifying the Covered Person that, if the determination is based upon a medical necessity, experimental treatment, or similar exclusion or

limitation, a copy of an explanation of the scientific judgment supporting the determination is available free of charge upon request; and

(vi) detailing the Covered Person's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on an appeal.

For Time Loss Weekly Benefit claims submitted on or after April 1, 2018, the claim denial notice shall also contain the following:

(i) 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 the claimant;

[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;

(ii) 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

(iii) A statement that the Covered Person is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim upon request, free of charge.

(c) Appeal Procedure. A Covered Person has the right to appeal a claim denial 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 a Covered Person receives a notice denying a claim for benefit payment which the Covered Person feels is incorrect, the Covered Person must 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) the Covered Person feels 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 the Covered Person submits, 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.

For Health Claims and Time Loss Weekly Benefit claims submitted on or after April 1, 2018, the Covered Person shall 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 rationale will be provided as soon as possible and sufficiently in advance of the final decision in order to give the Covered Person a reasonable opportunity to respond.

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

1. Urgent Care Claims. The Fund will inform a Covered Person of the decision on the review of an Urgent Care claim within 72 hours of the Fund's receipt of the request for review.

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

3. Post-Service Claims. The Trustees or Claims Appeal Committee shall meet quarterly to render a determination on appeals of Post-Service 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 the Covered Person's 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 the Covered Person of the reasons for the delay prior to any extension. The Fund will

notify the Covered Person of the decision within five days of the date the decision is made.

4. Concurrent Care Claims. The Fund will inform a Covered Person 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 the Covered Person 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.

5. Loss of Time Benefits Claims. 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 a Covered Person's 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 the Covered Person of the reasons for the delay prior to any extension. The Fund will notify the Covered Person of the decision within five days of the date the decision is made.

6. Content of Health Claim Denial Notice on Review. The Trustees will notify the Covered Person of their decision in writing. Written notice of denial of a Health Claim on appeal will:

   (i) include 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;

   (ii) explain the reasons for the decision and if your appeal has been denied, a discussion of the decision making;

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

   (iv) include a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents,

records and other information relevant to the Covered Person's claim for benefits;

(v) include 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 free of charge upon request;

(vi) if the determination is based on a medical necessity, experimental treatment, or similar exclusion or limitation, include notice that a copy of an explanation of the scientific judgment supporting the determination is available free of charge upon request;

(vii) include notice informing the Covered Person of any additional voluntary appeal procedures offered by the Fund; and

(viii) include notice of the Covered Person's 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.

7. Content of Time Loss Weekly Benefit Claim Denial Notice on Review. Written notice of denial of a Time Loss Weekly Benefit claim on review will:

(i) state the specific reason(s) for the denial;

(ii) include reference to specific Fund provision(s) on which the decision is based;

(iii) if the determination is based on a medical necessity, experimental treatment or similar exclusion or limitation, include notice that a copy of an explanation of the scientific judgment supporting the determination is available free of charge upon request;

(iv) include a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Covered Person's claim for benefits;

(v) include 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 free of charge upon request;

(vi) include notice informing the Covered Person of any additional voluntary appeal procedures offered by the Fund; and

(vii) inform the Covered Person of the right to bring a civil action under ERISA section 502(a).

For Time Loss Weekly Benefit claims submitted on or after April 1, 2018, the written notice of denial for a Time Loss Weekly Benefit claim shall also contain the following:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

[a] The views of a health care or vocational professional who treated or evaluated the claimant;

[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;

(ii) Copies of any internal rule, guideline, protocol or similar criteria relied on by the Trustees, or a statement that no such rule, guideline, protocol or similar criteria was considered; and

(iii) If the Fund's decision is based on a medical necessity, experimental treatment, or similar exclusion or limitation, a statement that the Covered Person may receive, free of charge, upon request, an explanation of the scientific or clinical judgment for the denial applying the terms of the Fund to the claimant's medical circumstances; and

(iv) A statement indicating any applicable contractual limitations period by which the Covered Person must bring an action against the Fund, including the

calendar date on which such contractual limitations period expires.

(d) External Review of a Denied Health Claim.

1. Right to Request External Review. A Covered Person has the right to request an external review of his denied Health Claim if the denial involved medical judgment. The Fund offers this right in accordance with and to the extent required by available guidance issued by the Departments of Health and Human Services and Labor and the Internal Revenue Service.

2. Claims Eligible for External Review. Only Health Claims are eligible for external review. Time Loss Weekly Benefits and all other welfare benefit claims are not eligible for external review.

3. How to Request an External Review. If a Covered Person wants his denied Health Claim reviewed by an independent review organization, the Covered Person must send a written request for an external review of the claim denial to the Fund no later than four months after the date the Covered Person receives the notice of denial or appeal. The Covered Person may submit additional information for consideration or review, including a written explanation and comments on the issues.

(e) Further Action. No lawsuit or other action against the Fund or its Trustees may be filed until a Covered Person exhausts 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 the Covered Person or the Covered Person's beneficiary has been given written notice of the Trustees' decision on the appeal (or, if later, 180 days after written notice is provided by the external review firm, if applicable). 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.

SECTION 11

No Interest in Participating Employers

No Participating Employer shall have any right, title, or interest in the Trust Fund nor will any part of the Trust Fund at any time revert or be repaid to a Participating Employer, directly or indirectly, except that if any contribution is made by a Participating Employer as the result of a mistake of fact, such contribution will be returned to such Participating Employer within one year after the date the contribution was made.

SECTION 12

Amendment or Termination

12.1. Amendment. The Plan may be amended from time to time by majority vote of the Trustees except as follows:

(a) No amendment will reduce a Covered Person's Plan benefits to less than an amount equal to the amount he would be entitled to receive if he had resigned from the employ of all the Participating Employers on the day of the amendment.

(b) Except as provided in Section 11, under no condition shall an amendment result in the return or repayment to the Union, the Association, or a Participating Employer of any part of the Trust Fund or result in the distribution of the Trust Fund for the benefit of anyone other than persons entitled to benefits under the Plan.

12.2. Termination. The Plan will terminate on the first to occur of the following:

(a) The date it is terminated pursuant to agreement entered into between the Union and the Association if at least 30 days' advance written notice of the termination is given to the Trustees.

(b) The date all Participating Employers completely discontinue making contributions under the Plan.

12.3. Notice of Amendment or Termination. Covered Persons will be notified of an amendment or termination within a reasonable time.

12.4. Allocation and Distribution on Termination. On termination of the Plan, the Trustees will pay, subject to the terms of the Plan, such unpaid claims as may have been incurred by Covered Persons prior to the date of the termination of the Plan. The Trustees, in their discretion, then shall be authorized to apply the remainder of the Trust Fund (as adjusted from time to time to reflect the investment experience attributable thereto): (i) to pay the amount of any Plan benefits to which the Covered Persons are entitled as of the date the Plan terminates, (ii) to purchase from an insurance company (or service provider) individual policies of hospital, surgical, and medical insurance issued to or on behalf of one or more of the Covered Persons,

(iii) by a transfer of the amount involved to another trust that constitutes an organization described in Section 501(c)(9), and is entitled to tax exemption under Section 501(a), of the Internal Revenue Code of 1986, as amended, or (iv) by a combination of the foregoing media.

SECTION 13

Subrogation and Reimbursement

13.1. Plan's Right to Subrogation and Reimbursement. The Plan 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 Plan 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 Plan 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 Plan makes or is obligated to make payments on behalf of an Individual on account of the claim, the Plan 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.

13.2. <u>Action Required of Individual</u>. 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 Plan 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 Plan to be paid to the Plan 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 Plan to recover payments made by the Plan and shall do everything that may be necessary to enable the Plan 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 Plan's request, or if the Agreement is modified in any way without the consent of the Plan, the Plan may suspend all benefit payments due a Covered Person or Dependents. However, in its sole discretion, if the Plan advances claims in the absence of an Agreement, or if the Plan advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan'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 Plan. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Plan. In this regard, the Individual agrees that out of any Source, as described in subsection (13.1) above, the identified amount that the Plan has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the

Plan's benefit and that the Plan 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 Plan's subrogation and reimbursement rights shall apply regardless whether the Individual executes an Agreement.

13.3. Enforcement of Rights. The Plan has the right to recover amounts representing the Plan'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 Plan 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 Plan'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 Plan'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 Plan 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 Plan 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 Plan. The right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner described in this section 13.

13.4. Individual's Attorney's Fees. The Plan'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 Plan'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 Plan's claim by an agreed upon amount of such fees or expenses.

13.5. Disavowal of Common Law Defenses. The Plan 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 Plan'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 Plan 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.

13.6. Offset. In the event payment is made by the Plan to or behalf of an Individual who is not entitled to such payment, the Plan 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 Plan is not able to apply the benefit reductions due to outpatient precertification, preadmission certification or concurrent review requirements because of agreements between the Plan and the service provider or facility, the Plan 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 Plan to recover such overpayments or benefit reductions in any other manner.

SUPPLEMENT A
TO
INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND
[As Restated Effective October 1, 2009]

A-1. Introduction. The purpose of this Supplement A to the Plan is to describe the life and accidental death and dismemberment ("AD&D") insurance provided under the Plan. The provisions of this Supplement are a part of the Plan and supersede the provisions of the Plan to the extent necessary to eliminate inconsistencies between the Plan and this Supplement.

A-2. Amount of Insurance. The amount of a Covered Person's life and AD&D insurance is $20,000.

A-3. Effective Date of Insurance Coverage. A Covered Person's life and AD&D insurance coverage begins on the later of the following dates:

(a) The date he enters an eligible status; or

(b) The date he returns to Active Work if he is not Actively at Work on the date insurance coverage otherwise would begin; provided, however, that a Covered Person's insurance coverage will begin on a nonworking day if he was Actively at Work on his last scheduled working day before the nonworking day.

A Covered Person's life and AD&D insurance coverage terminates on the date he ceases to be Actively at Work; provided, however, that if he ceases to be Actively at Work on account of Total Disability, such insurance coverage will continue for the period described in subparagraph 3.9(l).

A-4. Life Insurance. The insurance company pays a death benefit to a Covered Person's beneficiary if written proof is received that the Covered Person died while this insurance is in force. The insurance company pays the death benefit for all causes of death.

A-5. Designation of Beneficiaries. Subject to the following provisions of this subsection A-5, each Covered Person from time to time, by signing a form furnished by the insurance company, may designate any person or persons (who may be designated concurrently, contingently, or successively) to whom benefits under this Supplement A are to be paid. A

beneficiary designation form will be effective only when the form is filed in writing with the insurance company while the Covered Person is alive and will cancel all beneficiary designation forms previously signed and filed by the Covered Person. If a deceased Covered Person failed to designate a beneficiary as provided above, or if a designated beneficiary dies before the Covered Person, the insurance company, in its discretion, may pay the Covered Person's benefits to the Covered Person's spouse, children, parents, or estate. The term "designated beneficiary" means the person or persons designated by a Covered Person as a beneficiary in the last effective form filed with the insurance company and to whom a deceased Covered Person's benefits are payable. The term "beneficiary" means the person or persons to whom a deceased Covered Person's benefits are payable under this subsection.

A-6. Missing Participants and Beneficiaries. Each Covered Person and each designated beneficiary must file with the insurance company from time to time in writing his post office address and each change of post office address. A communication, statement, or notice addressed to a Covered Person or beneficiary at his last post office address filed with the insurance company, or if no address is filed with the insurance company then at his last post office address as shown on the Trustees' records, will be binding on the Covered Person and his beneficiary for all purposes of the Plan.

A-7. Accidental Death & Dismemberment (AD&D) Insurance. The insurance company pays this benefit if a Covered Person loses his life, a limb, or sight due to an accident. Both the following conditions must be met:

(a) Loss occurs within 180 days of the date of the accident.

(b) The cause of the loss is not excluded.

The insurance company pays the benefit shown below if a Covered Person suffers any of the losses listed. The insurance company pays only one "full amount" ($20,000) while the group policy is in effect. If a Covered Person has a loss for which the insurance company paid one-half

of the full amount, the insurance company pays no more than one-half of the full amount for the next loss:

Schedule

For Loss of	The benefit is:
Life	Full Amount
Both hands, both feet or sight of both eyes	Full Amount
One hand and one foot	Full Amount
One hand or one foot and sight of one eye ..	Full Amount
One hand or one foot or sight of one eye	1/2 of Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. The insurance company does not pay a benefit for loss of use of the hand or foot. Death benefits are paid to a Covered Person's beneficiary. All other benefits are paid to the Covered Person.

A-8. Accidental Death and Dismemberment Exclusions. The insurance company does not pay benefits for loss directly caused by any of the following:

(a) Physical or mental illness.

(b) Bacterial infection or bacterial poisoning.

Exceptions:

- Infection from a cut or wound caused by an accident.
- Accidental ingestion of a poisonous food substance.

(c) Riding in or descending from an aircraft as a pilot or crew member.

(d) Any armed conflict, whether declared as war or not, involving any country or government.

(e) Injury suffered while in the military service for any country or government.

(f) Injury which occurs during the commission or attempted commission of a felony.

(g) Use of any drug, narcotic or hallucinogenic agent --

- unless prescribed by a Doctor.
- which is illegal.
- not taken as directed by a Doctor or the manufacturer.

(h) 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.

A-9. Conversion Rights. The life insurance provided under this Supplement may be converted to an individual life insurance policy if all or any part of a Covered Person's life insurance under the group policy terminates for any of the following reasons:

(a) He no longer is Actively at Work.

(b) He no longer is in an eligible status under the Plan.

(c) The Plan or the group policy is changed or cancelled and a Covered Person's life insurance under the group policy has been in effect for at least five years in a row.

A Covered Person may convert his insurance by applying to the insurance company for an individual policy within 31 days after any part of his life insurance terminates. The insurance company will supply conversion forms to be completed and returned to it. Premiums must be paid for the individual policy within 31 days after any part of a Covered Person's life insurance coverage terminates.

A-10. Booklet. The insurance company has prepared a booklet that serves as the summary plan description of the life and AD&D insurance coverage provided under the Plan. The booklet, as amended and in effect from time to time, constitutes a part of the Plan.

A-11. Miscellaneous. Except as otherwise expressly provided, all provisions of the Plan will apply to the benefits provided under this Supplement. Unless the context clearly implies or indicates the contrary, a word, term, or phrase is used or defined in this Supplement.

SUPPLEMENT B
TO
INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND
[As Restated Effective October 1, 2009]

B-1. Introduction. The purpose of this Supplement B to the Plan is to describe the dental expense benefits provided under the Plan. The provisions of this Supplement are a part of the Plan and supersede the provisions of the Plan to the extent necessary to eliminate inconsistencies between the Plan and this Supplement.

B-2. Dental Expense. Subject to subsection B-5, a Covered Person's "dental expenses" means those expenses (not including expenses that exceed the Usual and Customary Charge for the services or supplies involved) incurred for the following expenses:

(a) **Diagnostic and Preventive Services and Supplies:**

(1) Cleaning and scaling of teeth, but not more often than twice in 12 months.

(2) Diagnostic services to determine necessary care, but:

(i) for full mouth x-rays, not more than once in two years.

(ii) for bite-wing x-rays, not more often than twice in 12 months.

(iii) for routine oral examinations, not more often than twice in 12 months.

(3) The application of fluoride and/or sealant to teeth, but not more often than twice in 12 months.

(4) Space maintainers and their fitting.

(b) **Restorative and Surgical Services and Supplies:**

(1) Oral surgery that is not covered under subparagraph 6.5(k) of the Plan, including: (a) extractions; (b) cutting procedures in the mouth; and (c) treatment of fractures and dislocations of the jaw.

(2) Treatment of the gums and supporting structures of the teeth.

(3) Root canal therapy and other endodontic treatment.

(4) General anesthetics and their administration.

(5) Antibiotics and therapeutic injections given by a Dentist.

(6) Emergency dental treatment for relief of pain on a day for which no other benefit, other than for x-rays, is payable.

(7) Restorations (fillings) for teeth broken down by decay or injury.

(c) **Replacement Services and Supplies:**

(1) Full, temporary full or partial denture, fixed bridge, or the addition of teeth to a denture.

(2) Repair and rebasing of a denture which has not been replaced by a new one.

(3) Crowns and inlays for a tooth broken down by decay or injury.

(d) **Orthodontic Services and Supplies:** Diagnostic procedures and appliances for straightening of teeth.

B-3. Covered Dental Expenses. All or a portion of a Covered Person's dental expenses for a calendar year will be paid after the dental cash deductible for that year has been satisfied. A Covered Person's dental cash deductible for each calendar year is $25, subject to the following:

(a) If two or more Covered Persons in the same Immediate Family satisfy the $25 dental cash deductible for a calendar year it will be deemed to have been satisfied for that year by all Covered Persons in that Immediate Family;

(b) If a Covered Person incurs dental expenses in the final three months of a calendar year that are applied to his dental cash deductible for that year, such expenses also will be applied to his dental cash deductible for the following calendar year;

(c) In the case of expenses incurred for orthodontic services and supplies [as described in subparagraph B-2(d)], each Covered Person must satisfy a $25 lifetime deductible instead of the $25 dental cash deductible for a calendar year; and

(d) The dental cash deductible is waived for dental expenses incurred by a Covered Person on account of diagnostic and preventive services and supplies.

B-4. Payment Rates and Limits. Subject to the terms of the Plan and this Supplement, the Plan will pay (a) 100% of a Covered Person's dental expenses incurred on account of diagnostic and preventive services; and (b) 75% of his other dental expenses. Notwithstanding any other provisions of the Plan, not more than $1,500 of a Covered Person's lifetime orthodontic expenses, nor more than $1,500 of a Covered Person's other dental expenses incurred in a calendar year, will be paid by the Plan. The $1,500 annual limit on non-orthodontic dental expenses does not apply to a Covered Person who is less than age 18, provided, however, the Plan will cover no more than four visits to a dentist per calendar year for non-orthodontic dental services for such Covered Persons.

B-5. Exclusions. A Covered Person's dental expenses shall not include expenses incurred on account of:

(a) Adjustment or relining of a denture within six months after placement.

(b) Which the Covered Person receives payment under: (1) a workers' compensation or similar law; or (2) a program of a government or plan established by law, except (A) Medicare; (B) the Civilian Health and Medical Program of the Uniformed Services (TRICARE); and (C) where the law does not permit this type of exclusion.

(c) A work related Illness or Injury.

(d) Any supplies or services: (1) for which no charge is made; or (2) for which the Covered Person is not required to pay.

(e) Supplies and services which the Covered Person receives from the Uniformed Services Medical Care Facilities.

(f) Any procedure which began before the date an individual's dental coverage starts (provided this exclusion will not apply to a Covered Person under age 19). X-rays and prophylaxis shall not be deemed to start a dental procedure.

(g) More than two routine oral exams in any 12 month period.

(h) Treatment for cosmetic reasons except for treatment which is needed for repair of damage which results from an accident.

(i) Orthodontics, unless the procedure starts before the Covered Person's 19th birthday.

(j) Any procedure, other than minor spot grinding, which is for the purpose of or relates to the correction of the bite.

(k) Treatment of temporomandibular joint disturbances except for (1) a diagnostic examination and x-rays; (2) injections; and (3) one non-orthodontic appliance.

(l) Any procedure whose main purpose is to change vertical dimension.

(m) Diet planning, or training in oral hygiene or preventive care.

(n) A temporary full denture.

(o) Replacement of a prosthesis which in the Dentist's opinion can be repaired or does not need repair.

(p) The replacement of a prosthesis within 5 years after it was first placed, except for:

- A crown which is needed for restoration only.

- Replacement which is needed because of the first time placement of an opposing full denture or the extraction of natural teeth.

- A permanent prosthesis which replaces a stayplate or other temporary prosthesis.

- Replacement of a prosthesis which, while in the mouth, has been damaged beyond repair as a result of an accident.

(q) Services or supplies for which no claim is filed as of the date that is one year and 90 days after the date such expenses were incurred.

B-6. <u>Extension of Benefits</u>. No benefits will be paid for dental expenses incurred after an individual has ceased to be a Covered Person, except as set forth below:

(a) If such an individual incurs dental expenses within one month after the date his coverage ceases, benefits will be paid, to the same extent as if he were still covered, if: (i) the treatment, not B-5 including x-rays and prophylaxis, began prior to the date the person ceased to be a Covered Person; and (ii) the Plan had not terminated as of the date the expense is incurred.

(b) If, on the date the Plan terminates, an individual is Totally Disabled as a result of an accident which occurred while he was a Covered Person, benefits will be paid for dental expenses 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.

B-7. Miscellaneous. Except as otherwise expressly provided, all provisions of the Plan will apply to the benefits provided under this Supplement. Unless the contest clearly implies or indicates the contrary, a word, term, or phrase used in the Plan is similarly used or defined in this Supplement.

SUPPLEMENT C
TO
INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND
[As Restated Effective October 1, 2009]

C-1. Introduction. The purpose of this Supplement C to the Plan is to describe the vision expense benefits provided under the Plan. The provisions of this Supplement are a part of the Plan and supersede the provisions of the Plan to the extent necessary to eliminate inconsistencies between the Plan and this Supplement.

C-2. Vision Expense Benefits. Subject to the following provisions of this subsection and subsection C-3, the Plan will pay 90% of a Covered Person's "vision expenses". Vision expenses are those expenses (not including expenses that exceed the Usual and Customary Charge for the services or supplies involved) incurred for eye refractions and sub-normal vision care. Sub-normal vision care includes the use of contact lenses, telescopic lenses, and other vision aids, including the professional services required to fit, administer, and prepare such vision aids. Expenses incurred for sub-normal vision care are covered vision expenses only if: (1) such care is needed after cataract surgery; or (2) vision in one or both eyes can be corrected to at least 20/70 with sub-normal vision aids only. Notwithstanding the foregoing provisions of this subparagraph:

(a) Subject to subsection C-3, the Plan will pay 50% (but not more than $350 in any calendar year) of a Covered Person's expenses (not including expenses that exceed the Usual and Customary Charge) incurred for frames and lenses. The $350 limit on expenses incurred for frames and lenses does not apply to any Covered Person who is less than age 18, provided, however, for such Covered Persons, the Plan will only cover one set of frames/lenses or contacts every 24 months;

(b) The Plan will not pay more than $600 of a Covered Person's vision expenses incurred in any calendar year for sub-normal vision care; and

(c) The Plan will pay 50% of the cost of corrective eye surgery, subject to a lifetime maximum of $600 per eye.

C-3. Exclusions. A Covered Person's vision expenses shall not include expenses incurred on account of:

(a) More than one eye refraction during any 12-month period.

(b) More than one frame in any 12-month period (24-month period for Covered Persons under age 18).

(c) More than one pair of lenses, or set of contact lenses (other than disposable contact lenses), during any 12-month period (24-month period for Covered Persons under age 18).

(d) Surgical or medical care for treatment of eye disease or Injury, except as provided in subparagraph C-2(c).

(e) Sunglasses, safety lenses, or goggles, unless prescribed by a Doctor.

(f) Orthoptics, vision training, or aniseikonia.

(g) 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.

(h) Expense for which the Covered Person receives payment under: (1) a workers' compensation or similar law; or (2) a program of a government or plan established by law, except: (a) Medicare; (b) the Civilian Health and Medical Program of the Uniformed Services (TRICARE); and (c) where the law does not permit this type of exclusion.

(i) Expense for a work related Illness or Injury.

(j) Any supplies or services: (1) for which no charge is made; or (2) for which the Covered Person is not required to pay.

(k) Supplies and services which the Covered Person is entitled to receive from the Uniformed Services Medical Care Facilities.

(l) Expense for the services of a person who normally lives in a Covered Person's household, or who is a member of the Covered Person's Immediate Family.

(m) Expense for services or supplies that are for educational, experimental, or research purposes.

(n) Expenses for services or supplies for which no claim is filed as of the date that is one year and 90 days after the date such expenses were incurred.

C-4. Extension of Benefits. No benefits will be paid for vision expenses incurred after the date an individual ceases to be a Covered Person, except benefits payable for frames and lenses prescribed before such date and received within 30 days after such date.

C-5. Miscellaneous. Except as otherwise expressly provided, all provisions of the Plan will apply to the benefits provided under this Supplement. Unless the context clearly implies or indicates the contrary, a word, term, or phrase used in the Plan is similarly used or defined in this Supplement.

SUPPLEMENT D
TO
INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND
[As Restated Effective October 1, 2009]

D-1. Introduction. The purpose of this Supplement D to the Plan is to describe the time loss weekly benefits provided under the Plan. The provisions of this Supplement are a part of the Plan and supersede the provisions of the Plan to the extent necessary to eliminate inconsistencies between the Plan and this Supplement.

D-2. Time Loss Weekly Benefit. If an Employee, Clerical Worker, or Apprentice becomes Totally Disabled on or after January 1, 2010, he or she will receive $475 for each full week that he or she is Totally Disabled, starting with the next day after the end of the time loss waiting period (that is, seven days in the event the Total Disability is caused by Illness and zero days if it is caused by Injury). Payment of a Covered Person's time loss weekly benefits will be made for no longer than the "maximum term" (that is, 26 weeks in any 12-month period and/or than 39 weeks in any 24-month period). If any period for which benefits are payable is less than a full week, the Covered Person will receive one-fifth of the amount of his or her weekly benefit for each day in such period. The maximum term applies to each period of Total Disability, whether due to one or more causes. A new period will be deemed to start when the Covered Person again becomes Totally Disabled after returning to employment with an Employer:

(a) For two weeks or more if the cause or causes are related in any way to those of the prior Total Disability; or

(b) For one day or more if the cause or causes are not so related.

No time loss weekly benefits will be paid for or on account of any period of Total Disability:

(1) For which the Covered Person is not under the regular care of a Doctor.

(2) For which the Covered Person receives payment under any workers compensation law or occupational disease law.

D-3. <u>Miscellaneous</u>. Except as otherwise expressly provided, all provisions of the Plan will apply to the benefits provided under this Supplement. Unless the context clearly implies or indicates the contrary, a word, term, or phrase used or defined in the Plan is similarly used or defined in this Supplement.

SUPPLEMENT E
TO
INTERNATIONAL BROTHERHOOD OF
ELECTRICAL WORKERS LOCAL NO. 150 WELFARE FUND
[As Restated Effective October 1, 2009]

E-1. Introduction. The purpose of this Supplement E to the Plan is to describe the welfare reimbursement account program maintained under the Plan (the "WRA Program"). The provisions of this Supplement are a part of the Plan and supersede the provisions of the Plan to the extent necessary to eliminate inconsistencies between the Plan and this Supplement. A Participant in the CWCE category of employment shall not be eligible to participate in the WRA Program (unless participating hereunder pursuant a collective bargaining agreement subject to the Davis-Bacon Act).

The WRA Program is intended to qualify as a self-funded medical expense reimbursement plan under Internal Revenue Code ("Code") section 105 and regulations thereunder and to comply with guidance issued by the Internal Revenue Service ("IRS") on health reimbursement arrangements in order that benefits paid to Members and their Family Unit will be excludible from their gross income for federal income tax purposes. The WRA Program is also intended to meet the requirements of Code section 106 in order that Employer contributions on behalf of Members will be excludable from gross income for federal income tax purposes.

E-2. Participating Employer Contributions. Effective for work performed on and after June 1, 2004, a portion of each Participating Employer's contributions to the Plan under the collective bargaining agreement will be allocated to Members' Account established and maintained under this WRA Program. The applicable portion may be changed from time to time pursuant to collective bargaining between the Union and the Association or otherwise. Contributions also may be made to a Member's Account by an Employer that is not a Participating Employer through reciprocity. If a contribution is made on behalf of a Member through reciprocity, the amount credited to his or her account will be that portion (if any) of the contribution that exceeds an amount equal to 23% (22% for residential) of his or her gross earnings in the period for which the contribution is made. In any case, the actual amount of a Participating Employer's contribution will be determined in accordance with the collective

bargaining agreement to which such Participating Employer is a party. Under no circumstances will benefits under the WRA Program be funded directly or indirectly with salary reductions or other conditions under a Code section 125 plan. Notwithstanding any other provisions of the Plan, North Shore Sign Co., Northern Lights Sign and Lighting LLC, and Sign Effects, Inc. will not be Participating Employers for purposes of this Supplement E.

E-3. Definitions.

(a) Account. The term "Account," as used in this Supplement, means the account established under this WRA Program pursuant to section E-6 on behalf of a Member.

(b) Accounting Date. The term "Accounting Date," as used in this Supplement, means the last day of each calendar quarter.

(c) Family Unit. The term "Family Unit," as applied to any Member, means the Member, his or her spouse, and such of his or her children as are Dependents within the meaning of Section 2.10 of the Plan. Following the Member's death, "Family Unit" includes the Member's surviving spouse to whom he was married at the time of his death and his children who continue to qualify as Dependents of his surviving spouse under Section 2.10 of the Plan (regardless of the eligibility rules in Article 3).

(d) Qualifying Medical Expenses. The term "Qualifying Medical Expenses," as used in this Supplement, means amounts incurred on behalf of a Member or a Member's Family Unit for:

(1) Diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body, including, by way of example but not limitation, amounts paid for:

(i) operations or treatments affecting any portion of the body, including obstetrical expenses and expenses of therapy or X-ray treatments;

(ii) the prevention or alleviation of a physical or mental defect or illness;

(iii) hospital services, nursing services (including nurses' board where paid by the Participant), medical laboratory, surgical, dental and other diagnostic and healing services,

X-rays, medicine and drugs, artificial teeth or limbs, and ambulance hire;

(iv) eye glasses, a seeing-eye dog, artificial teeth and limbs, wheel chair, crutches, an inclinator, or an air conditioner which is detachable from the property and purchased only for the use of a sick person, etc., and permanent improvement or betterment of property to the extent that the expenditure exceeds the increase in value of the related property, if the particular expenditure is related directly to medical care;

(v) in-patient hospital care (including the cost of meals and lodging therein);

(vi) care in an institution other than a hospital where an individual is in an institution because his or her condition is such that the availability of medical care in such institution is a principal reason for his or her presence there, and meals and lodging are furnished as a necessary incident to such care, including the entire cost of institutional care for a person who is mentally ill and unsafe when left alone; except that where an individual is in an institution and his or her condition is such that the availability of medical care in such institution is not a principal reason for his or her presence there, only that part of the cost for care in the institution which is attributable to medical care or nursing attention will be considered an amount paid for medical care; meals and lodging at the home are not considered a cost of medical care;

(vii) attendance at a special school for a mentally or physically handicapped individual if such individual's condition is such that the resources of the institution for alleviating such mental and physical handicap are a principal reason for his or her presence there, including the cost of meals and lodging if supplied, and the cost of ordinary

education furnished which is incidental to the special services furnished by the school;

(viii) care and supervision, or of treatment and training, of a mentally retarded or physically handicapped individual at an institution;

(ix) prescription medicine (excluding those for cosmetic purposes) and insulin which are legally procured and which are generally accepted as falling within the categories of medicine and drugs. Over-the-counter medicines (except for insulin) cannot be reimbursed without a prescription.

(2) Transportation primarily for and essential to medical care referred to in subparagraph (a) next above.

In no event shall Qualifying Medical Expenses be provided in the form of cash other than reimbursement or include the following items:

(1) Any item which is not included within the meaning of "medical care," as defined in Section 213(d) of the Code, or any comparable provision of any future legislation that amends, supplements, or supersedes said Section 213(d).

(2) Any item not required to be paid by the Member or Family Unit;

(3) Any item previously taken as a tax deduction by the Member or Family Unit; and

(4) Any item that is an expenses for long-term care services.

(e) Qualifying Premium Expenses. The term "Qualifying Premium Expenses," as used in this Supplement, means amounts paid for: self-payments (including retiree self-payments) required to maintain and/or continue coverage under the Plan (exclusive of this Supplement) for COBRA continuation coverage and substantiated premiums payments for qualified long-term care insurance. Expenses do not include premiums for accident or health insurance as defined in Code Section 213(d); fixed indemnity, cancer or hospital indemnity insurance premiums paid by an Employer or premiums that are or could be deducted pre-tax

through a Section 125 cafeteria plan (including a spouse's plan). Notwithstanding the above, Qualifying Premium Expenses shall include premiums for Medicare Parts B and D, Medicare supplemental policies, group Medicare Advantage premiums and group health plan premiums (unless the premium is paid or could have been paid pre-tax from another source) for the Family Unit of deceased Members or for retired Members.

In no event shall a Qualifying Premium Expense have been previously taken as a tax deduction by the Employee or Dependent and in no event shall Qualifying Premium Expenses be provided in the form of cash other than reimbursement.

E-4. Access to Funds.

(a) Members. A Member shall have access to the funds accumulated in his individual Account to obtain reimbursement for out-of-pocket expenses incurred by the Member after becoming eligible to participate in, and while covered under, the Plan and the WRA Program or by a Member's Family Unit covered under the Plan (on either a primary or secondary basis) and the WRA Program for Qualifying Medical Expenses and Qualifying Premium Expenses.

(b) Family Unit. A Member's Family Unit shall have access to the funds accumulated in the Member's Account upon the Member's death, provided they were covered as Dependents under the Plan and the WRA at the time of the Member's death and they remain covered under the WRA Program. The balance in the Member's Account will be available for use by the Member's Family Unit to reimburse out-of-pocket expenses incurred for Qualifying Medical Expenses and Qualifying Premium Expenses until the earliest of when the Member's Account balance is zero, the Account is forfeited under the Plan's rules, or the Plan ends.

E-5. Medical Reimbursement Payments. At least once during each calendar quarter, the Trustees shall reimburse each Member (or after a Member's death, his Family Unit), from the balance in his or her Account, for the portion of his or her Family Unit's Qualifying Medical Expenses or Qualifying Premium Expenses incurred that qualifies for reimbursement; provided that, prior to such reimbursement, the Trustees receive: (i) written evidence acceptable to them that such Qualifying Medical Expenses or Qualifying Premium Expenses have been incurred by the Member or another member of the Family Unit; (ii) confirmation that the amount of such Qualifying Medical Expense or Qualifying Premium Expense to be reimbursed is at least $50; (iii) the request for reimbursement is received by the Fund Office no later than two years after

the date the Qualifying Medical Expense or Qualifying Premium Expense was incurred and (iv) the request for reimbursement on a form prescribed by the Trustees. Any such reimbursement form must be received by the Trustees by the 15th day of the month in which payment is to be made.

If a Member accumulates less than the $50 in Qualifying Medical Expenses or Qualifying Premium Expenses during the calendar year, the Member may request reimbursement at the end of the calendar year for the amount of Qualifying Medical Expenses or Qualifying Premium Expenses that the Member has accumulated.

If the Member does not have the sufficient amount in his Account to cover the reimbursement for a Qualifying Medical Expense or a Qualifying Premium Expense at the time the reimbursement form is submitted to the Fund Office, the Fund Office will reimburse the Member the entire remaining balance in the Account. The Member may not resubmit a request for the unpaid balance related to any Qualifying Medical Expense or Qualifying Premium Expense previously submitted.

A Member may receive reimbursement from his Account only for Qualifying Medical Expenses or Qualifying Premium Expenses that are incurred while the Member or Family Unit is eligible for coverage under the WRA Program. An expense is "incurred" when the Member or Family Unit is furnished the medical care or services giving rise to the claimed expense. The determination of whether an individual is a Member or Family Unit whose Qualifying Medical Expenses and Qualifying Premium Expenses are covered by the WRA Program shall be made at the time such expenses are incurred. A Member or Family Unit cannot be reimbursed for any medical expenses that he incurred before the WRA Program was established or before the Member became a participant in the WRA Program.

Following the death of a Member, the Member's Family Unit may continue to seek reimbursement of Qualifying Medical Expenses and Qualifying Premium Expenses from the Member's Account pursuant to the procedure described in the foregoing paragraph.

E-6. Non-duplication of Benefits. A Member shall not be reimbursed for Qualifying Medical Expenses or Qualifying Premium Expenses under this WRA Program to the extent that

such costs have been paid, or are payable, to or for the benefit of the Member or any individual included in his Family Unit under the provisions of the Plan (exclusive of this Supplement) or by any other insurance or group health benefits available to the Member or any individual included in his Family Unit.

E-7. Accounts. The Trustees will maintain a separate Account in the name of each Member. Each Account will reflect the Member's share of Employer contributions and the income, losses, appreciation, and depreciation attributable thereto. The Trustees may maintain such other accounts, in the names of Member or otherwise, as they may deem advisable. Except as expressly modified, reference to a Member's "Account" includes all accounts maintained for him or her by the Trustees. The Trustees will provide each Member with a report on the status of his or her Account as of each Accounting Date. If there is any balance remaining in the Account after all reimbursements have been paid for the calendar year, such balance shall be carried over to a subsequent calendar year. The Member, Family Unit or any other individual may not assign, transfer or alienate any interest in the Accounts.

E-8. Contributions Considered Made on Last Day of Accounting Period. For purposes of this Supplement, Employer contributions for any accounting period will be considered to have been made on the last day of that accounting period, regardless of when paid to the Trustees. On and after January 1, 2009, no interest will be credited to Members' Accounts.

E-9. Adjustment of Accounts. As of each Accounting Date, the Trustees shall:

(a) First, charge to the proper Accounts all payments made since the last preceding Accounting Date that have not been charged previously; and

(b) Then, charge any amounts to reflect distributions to or for the Member and his Family Unit or forfeitures that are to be charged as of that date in accordance with subsection E-11.

The "adjusted net worth" of the assets held under this Supplement as of any Accounting Date means the then fair market value of all assets held hereunder, as determined by the Trustees, less an amount equal to the sum of any Employer contributions paid to the Trustees for the period elapsed since the last preceding Accounting Date.

E-10. Crediting of Employer Contributions. As of each Accounting Date, the Employer contributions under the Plan made during the accounting period ending on that date will be credited to Members' Account. After such crediting, each Member's Account will reflect an amount equal to the product of (i) the number of hours he or she worked or his or her gross productive earnings (whichever is applicable) during such period multiplied by (ii) the contribution rate specified in the collective bargaining agreement for that period. The total amount of Employer contributions for an accounting period, and the amount to be credited to each Member's Account, will be determined on the basis of the monthly payroll reports submitted by the Employers for that period or on the basis of such other evidence as the Trustees consider appropriate.

E-11. Opt-Out of Account.

(a) Members. A Member will be given the opportunity to opt-out of this WRA Program and waive all future reimbursements from his Account annually. Additionally, the Plan will offer a one-time opt-out of the WRA Program upon the occurrence of the following events:

(1) Loss of Plan eligibility;

(2) Becoming eligible for Retiree coverage;

If a Member elects to opt-out of his Account, any amounts remaining in his Account will be forfeited consistent with section E-13(b) of this Supplement and will not be reinstated in the event the Member subsequently elects to reenroll in the WRA Program.

(b) Member's Family Unit. A Member's Family Unit will be given the opportunity to opt-out of the WRA Program and waive future reimbursements from the Member's Account upon the death of the Member. If a Family Unit elects to opt-out of the Member's Account, any amounts remaining in the Account will be forfeited consistent with section E-13(b) of this Supplement.

E-12. Charging Payments and Forfeitures. All payments made to or for the benefit of a Member or a member of his Family Unit and any amount forfeited by the Member will be charged to the Member's Account.

E-13. Forfeiture.

(a) Upon Death. If a Member dies, his entire Account balance becomes immediately available to the Member's Family Unit. The balance in the Account will be available for use by the Family Unit until the earliest of: (A) when the Account balance is zero, (B) the Account is forfeited under the Plan's rules, or (C) when the Plan ends.

A Member's Account balance will be forfeited upon the death of the Member and all members of his Family Unit provided, however, that the amount, if any, forfeited upon the death of a Member and all members of his Family Unit will be the Account balance remaining after any claims for the Qualifying Medical Expenses and Qualifying Premium Expenses of the Member and his Family Unit prior to his or her death have been properly filed and paid.

(b) Upon Opt-Out. A Member's Account balance is subject to forfeiture if the Member elects to opt-out of the WRA Program consistent with section E-11 of this Supplement. Any forfeited amount will become part of the general assets of the Plan.

E-14. Miscellaneous. Except as otherwise expressly provided, all provisions of the Plan will apply to the benefits provided under this Supplement. Unless the context clearly implies or indicates the contrary, a word, term, or phrase used or defined in the Plan is similarly used or defined in this Supplement.

(a) Coordination of Benefits.

(1) General. The WRA Program shall not be considered a group health plan for coordination of benefits purposes under the Plan, and its reimbursement benefits shall not be taken into account when determining other benefits payable under this Plan or benefits payable under any other health plan except for Medicare. The use of benefits under the WRA Program may be restricted under some circumstances for active employee Members or their Family Unit who are enrolled in Medicare pursuant to the Medicare Secondary Payer Rules.

(2) Coordination with Other Plans Benefits under this WRA Program are intended to pay benefits solely for Qualifying Medical Expenses and Qualifying Premium Expense not previously reimbursed or

reimbursable elsewhere. To the extent that an otherwise eligible Qualifying Medical Expense or Qualifying Premium Expense is payable or reimbursable from another source, that other source will pay or reimburse prior to payment or reimbursement from the WRA Program. Without limiting the foregoing, if the eligible person's Qualifying Medical Expenses are covered by both the WRA Program and by a health flexible spending account ("FSA"), then the WRA Program is not available for reimbursement of such Qualifying Medical Expenses until after amounts available for reimbursement under the health FSA have been exhausted.

(b) COBRA. Qualified Beneficiaries shall be entitled to continue coverage under the WRA Program to the extent required by applicable law.

(c) Expenses. The Trustees may assess a reasonable fee for Account maintenance and for expenses related to the processing of reimbursements.