PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION FOR THE INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS

LOCAL UNION 306 SUPPLEMENTAL HEALTH BENEFIT FUND

Effective June 1, 2021[1]
Amended through December 31, 2021

[1] Except as Otherwise Noted

BOARD OF TRUSTEES

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL UNION 306 SUPPLEMENTAL HEALTH BENEFIT FUND

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OFFICE OF THE THIRD-PARTY ADMINISTRATOR

IBEW Local Union 306 Supplemental Health Benefit Fund c/o BeneSys, Inc.
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SPECIAL NOTICE

It is extremely important that you keep the Plan Office informed of any change in address, marital status, dependent status or beneficiary status. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility and/or benefits. If the Plan makes payments on behalf of a dependent that is no longer eligible, the Plan may pursue legal action against you in an attempt to recoup the benefit amounts wrongly paid. The important of a current, correct address on file in the Plan Office cannot be overstated! It is the ONLY way the Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan.

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I. GENERAL DEFINITIONS

(A) "Covered Employee"

The term "Covered Employee" means:

(1) All Employees represented for the purpose of collective bargaining by the Union and whose Employers make contributions to the Trust Fund in accordance with the Collective Bargaining Agreement with the Union.

(2) The term "Covered Employee" may also include employees of other Employers who participate as otherwise permitted by the terms of this Plan and make contributions to the Trust Fund, including Employees of the Union and the Akron Area Electrical Joint Apprenticeship Committee.

(3) The term "Covered Employee" shall not include partners or self-employed persons no matter how designated. Such persons are expressly excluded from the benefits provided in this plan.

(4) A Covered Employee shall still be eligible to participate in the benefits of the Fund even though he/she participates in a labor dispute or is absent from work due to such labor dispute or is being locked out by his/her Employer.

(B) "Covered Retiree" or "Eligible Retiree"

The term "Covered Retiree" or "Eligible Retiree" means:

(1) Any Covered Employee who is retired from active employment under the collective bargaining agreement and (1) is at least 57-1/2 years of age; (2) during at least 48 of the 60 months immediately prior to retirement has been eligible for benefits in the Fourth District IBEW Health Fund or Successor Fund; and (3) is eligible for benefits in the Fourth District IBEW Health Fund or Successor Fund in the month immediately preceding his/her month of retirement from active employment. A Covered Retiree shall also mean a disabled employee who meets the following conditions:

(a) Has received an award from the Social Security Administration for Disability Benefits; and

(b) On the date the award for Disability Benefits is received by the Covered Retiree from the Social Security Administration, the Covered Retiree was eligible for benefits in the Fourth District IBEW Health Fund or Successor Fund. No retroactive eligibility is permitted.

(2) A Covered Retiree who has participated in this Plan shall have the option to waive (decline) Fund coverage if covered as a dependent under his/her employed spouse's plan. Proof of the coverage under the spouse's group health plan is required and the Covered Retiree and the spouse would be required to complete and sign an Election

to Decline Coverage form.

(3) The Covered Retiree would then be permitted to reinstate coverage at a later date if:

(a) The other group health coverage ends, other than because the spouse failed to pay, or authorize the deduction of, any required contribution or for commission of fraud;

(b) The Covered Retiree acquires a dependent; or

(c) The Covered Retiree becomes entitled to Medicare benefits due to age or disability.

(4) If the Covered Retiree qualifies for Medicare before the Covered Retiree's spouse and the spouse continues to be covered under the employer group health plan, the spouse would be permitted to continue to defer Fund coverage until the spouse's group health coverage terminates. However, the spouse must also reinstate coverage through the Fund upon qualification for Medicare or termination of the employer group health coverage.

(5) Failure of the Covered Retiree and/or spouse to reinstate coverage through the Fund within 30 days of the earliest of the reinstatement conditions detailed above will result in the permanent termination of eligibility and reinstatement of coverage will not be permitted at a later date.

(6) The term "Covered Retiree" is used interchangeably in this Plan with the term "Eligible Retiree".

(C) <u>"Covered Dependents"</u>

The term "Covered Dependents" means:

(1) Your spouse, provided you are not divorced or legally separated. Your "dependent" also means your children who are less than age 26 or otherwise qualify because of a disability. An individual who is eligible for benefits with, or is a member of, the country's armed forces is not eligible as your Covered Dependent.

(2) The word "children" shall include your natural children and legally adopted children. Coverage for adopted children will commence at the beginning of the probationary period, regardless of whether the adoption becomes legally final. In addition, the word "children" shall also include stepchildren or any child named in a Qualified Medical Child Support Order satisfying all conditions outlined in the Omnibus Budget Reconciliation Act (OBRA) of 1994. Grandchildren, nieces, nephews, etc. are not eligible, even though the child may be wholly dependent upon you for support, unless they have been legally adopted by you and proof of the adoption is provided to the Fourth District IBEW Health Fund or Successor Fund and the IBEW Local Union 306 Supplemental Health Benefit Fund. (If a child is

not residing with you in a regular parent-child relationship, proof of dependent status must be furnished with any claim).

(3) While dependent coverage is in effect, newly acquired dependents automatically become Covered Dependents subject to any provisions applicable to the effective date of coverage for benefits in the Fourth District IBEW Health Fund or Successor Fund.

(4) When the Covered Retiree dies, benefits for his/her Covered Dependents shall be continued if permitted by the Fourth District IBEW Health Fund or Successor Fund. Any subsidy for such coverage from the IBEW Local Union 306 Supplemental Health Benefit Fund shall cease in the month of the Covered Retiree's death.

(5) Same-sex spouses shall be entitled to coverage as Dependents. This does not include individuals (whether of the opposite sex or the same sex) who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

(D) "Covered Spouse"

The term "Covered Spouse" means the legal spouse of the Covered Retiree at the time of his/her retirement who continues to be married to the Covered Retiree during his/her retirement.

Same-sex spouses shall be entitled to coverage as Spouses. This does not include individuals (whether of the opposite sex or the same sex) who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

(E) "Employer"

The term "Employer" means any corporation or other business entity with whom the Union has a collective bargaining agreement. The term "Employer" shall also mean an entity accepted for participation by the Trustees, including the Union and the Akron Area Electrical Joint Apprenticeship Committee.

(F) "ERISA"

The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

(G) "Fourth District IBEW Health Fund"

The term "Fourth District IBEW Health Fund" means the Trust Fund whose group health plan currently provides benefits to Covered Employees, Covered Retirees and their Covered Dependents.

(H) "Medical Reimbursement Account"

The term "Medical Reimbursement Account" means the accounts established by the Trustees from contributions and earnings for the use by Covered Employees, Eligible Retirees, and Covered Dependents for reimbursement of eligible medical expenses.

(I) "Medicare Supplemental Policy"

The term "Medicare Supplemental Policy" means a policy purchased through the Fourth District IBEW Health Fund which provides, according to its terms, supplemental benefits to policy holders after payment by Medicare or the same type of benefits which the Fourth District IBEW Health Fund elects to self- insure.

(J) "Plan Year"

The term "Plan Year" means the period running from June 1 through May 31.

(K) "Retiree Subsidy"

The term "Retiree Subsidy" means the amount that the Trustees of the IBEW Local 306 Supplemental Health Benefit Fund subsidize the premiums for Covered Retirees and/or their Covered Dependents for coverage through the Fourth District IBEW Health Fund or Successor Fund.

(L) "Successor Fund"

The term "Successor Fund" means a Trust Fund whose employee health benefit plan provides coverage for the IBEW Local Union 306 Supplemental Health Benefit Fund's Covered Employees, Covered Retirees and their Covered Dependents, which plan succeeds or replaces the Fourth District IBEW Health Fund.

(M) "Union"

The term "Union" means the International Brotherhood of Electrical Workers Local 306.

(N) "Plan" and "Summary Plan Description"

This booklet provides a description of those benefits available to eligible Participants, Retirees and Dependents and is the Plan Document, as well as your Summary Plan Description as provided in Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This booklet replaces and supersedes all previously published summary plan descriptions and plan documents.

II. ELIGIBILITY FOR RETIREE SUBSIDY

(A) Eligibility Requirements

Subject to the timely payment of premiums or other required amounts, eligible Covered Retirees, Covered Spouses and Covered Dependents may be eligible for benefits on the first day of the month following the date that he/she meets the eligibility requirements for participation, as detailed below:

(1) **Covered Retiree Under Age 65.** A Covered Retiree may be eligible for coverage in a group health plan offered by the Fourth District IBEW Health Fund or Successor Fund so long as those Funds provide benefits to such persons and subject to the eligibility rules of such Funds and their plans as those plans are not controlled by the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund.

(2) **Covered Retiree 65 and Over.** A Covered Retiree may be eligible for coverage through a Medicare Supplemental Policy, Medicare Advantage plan, or other Medicare retiree coverage provided by the Fourth District IBEW Health Fund or Successor Fund so long as those Funds provide such policies to such persons and subject to the eligibility rules of such Funds and their plans as those plans are not controlled by the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund.

(3) **Covered Spouse and Covered Dependents Under Age 65.** The Covered Spouse and Covered Dependents may be eligible for coverage through the Fourth District IBEW Health Fund or Successor Fund so long as those Funds provide benefits to such persons and subject to the eligibility rules of such Funds and their plans as those plans are not controlled by the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund.

(4) **Covered Spouse 65 and Over.** A Covered Spouse who is age 65 years or over may be eligible for coverage through a Medicare Supplemental Policy, Medicare Advantage plan, or other Medicare retiree coverage provided by the Fourth District IBEW Health Fund or Successor Fund so long as those Funds provide such policies to such persons and subject to the eligibility rules of such Funds and their plans as those plans are not controlled by the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund.

(5) **Qualified Medical Child Support Orders.** This Plan recognizes Qualified Medical Child Support Orders ("QMCSOs") and provides benefits for eligible Dependents, as determined by the order. A QMCSO is a court order or administrative order, which has the force of law pursuant to the state's administrative procedure, relating to child support that provides for a child's coverage under the Plan. A copy of the Plan's QMCSO qualification procedures and a sample is available, free of charge, upon request.

(B) Conditions of Coverage

(1) Covered Retiree Under Age 65. The Covered Retiree may obtain coverage in the Fourth District IBEW Health Fund or Successor Fund through the payment of premiums or other self-pay amounts as determined by the Trustees of the Fourth District IBEW Health Fund or the Successor Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time and at their discretion, subsidize a portion of that premium or other required self-pay amount. In the event the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund elect to provide a subsidy, they may discontinue such subsidy in whole or part in their absolute and sole discretion.

(2) Covered Retirees 65 or Over. The Covered Retiree may purchase a Medicare Supplemental Policy, a Medicare Advantage plan or other Medicare retiree coverage offered through the Fourth District IBEW Health Fund or Successor Fund through the payment of premiums or other self-pay amounts as determined by the Trustees of the Fourth District IBEW Health Fund or the Successor Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time at their discretion, subsidize a portion of that premium. In the event the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund elect to provide a subsidy, they may discontinue such subsidy in whole or part in their absolute and sole discretion.

(3) Covered Dependents Under Age 65. In the event the Covered Retiree elects to cover his/her Covered Dependents through the Fourth District IBEW Health Fund or Successor Fund, the Covered Retiree shall pay the required premium or other self-pay amount to the appropriate Fund as determined by the Trustees of that Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time at their discretion, subsidize a portion of that premium. In the event the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund elect to provide a subsidy, they may discontinue such subsidy in whole or part in their absolute and sole discretion. The Trustees shall not pay any portion of the premium or other self-pay amount for any Covered Dependent other than the Covered Spouse if the cost of that coverage is greater than the cost of coverage for the Covered Spouse alone. In the event the Trustees determine to subsidize any portion of the premium or other self-pay amount required for the Covered Spouse or Covered Dependents, the subsidy shall not continue beyond the lifetime of the Covered Retiree.

(4) Covered Spouse Age 65 and Over. The cost of coverage for the purchase of Medicare Supplemental Policy, a Medicare Advantage plan or other Medicare retiree coverage provided by the Fourth District IBEW Health Fund or Successor Fund for the spouse of the Covered Retiree shall be determined by the Trustees of the Fourth District IBEW Health Fund or Successor Fund. The Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund may, from time to time at their discretion, subsidize a portion of the premium or other self-pay amount required for the spouse. In the event the Trustees of the IBEW Local Union 306

Supplemental Health Benefit Fund elect to provide a subsidy, they may discontinue such subsidy in whole or part in their absolute and sole discretion. In no event shall any subsidy for the Medicare Supplemental Policy by the IBEW Local Union 306 Supplemental Health Benefit Fund continue beyond the lifetime of the Covered Retiree.

(5) A Covered Retiree who returns to work and who, immediately before returning to work, was eligible for coverage through the retiree program of the Fourth District IBEW Health Fund or Successor Fund, and was eligible for any subsidy from this Plan, and is permitted by the Fourth District IBEW Health Fund or Successor Fund to continue to participate in the Covered Retiree portion of that Fund until he/she gains eligibility in that Fund's active program, shall continue to be eligible for a subsidy, if offered from this Plan, until he/she accumulates sufficient hours in the Fourth District IBEW Health Fund or Successor Fund, to be eligible to participate in that Fund's active program. At the time the Covered Retiree becomes eligible to be covered under the Fourth District IBEW Health Fund's active program, coverage for participation by the Covered Retiree and his/her dependents in this Plan shall immediately cease. To become again eligible in this Plan under the Retiree program, the former Covered Retiree must re-qualify as required in the Plan to be entitled to the subsidy if offered by this Plan.

(C) Premiums for Coverage

(1) Premiums or other self-payments required for coverage and eligibility paid by the Covered Retiree must be received by the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund no later than the first day of the month for each month of coverage. Premiums or other self-payments received after that date are delinquent.

(2) If a premium or other self-payment is not received within 15 days after the due date, the Fund will provide a notice to the Covered Retiree informing him/her of (1) the delinquent amount; (2) the Covered Retiree's obligation to pay all delinquencies in full within 30 days of the notice; and (3) that failure to pay within 30 days will cause eligibility to be terminated.

(3) Failure to timely remit premiums or other self-payments may affect coverage for benefits through the Fourth District IBEW Health Fund.

(D) Benefits for Covered Retirees and their Covered Dependents and other Conditions of Coverage

Please refer to the Plan and Summary Plan Description of the Fourth District IBEW Health Fund for the benefits provided to Covered Retirees and their Covered Dependents. In addition, please refer to the Fourth District IBEW Health Fund for other conditions of coverage, including, but not limited to, rights under the Employee Retirement Income Security Act, as amended, the Health Insurance Portability and Accountability Act (HIPAA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and

the Omnibus Budget Reconciliation Act of 1994 (OBRA).

(E) Rate of Subsidy

(1) For the purposes of this Section (E) only, the term "Covered Employee" means any individual who becomes a member of I.B.E.W. Local 306 on or after January 1, 2016.

(2) For the purposes of this Section (E) only, the term "Covered Employment" means:

(a) employment with an employer who is required to make contributions to this Plan pursuant to a collective bargaining agreement with I.B.E.W. Local 306 or a participation agreement with this Fund; and

(b) in a job classification requiring contributions under a collective bargaining agreement with I.B.E.W. Local 306 or a participation agreement with this Fund.

(3) For the purposes of this Section (E) only, a "Year of Service" means a calendar year in which a Covered Employee, as defined in Section (E)(1) above, works at least three hundred (300) hours in Covered Employment, as defined in Section (E)(2) above.

(4) For Participants who become Covered Employees on or after January 1, 2016, the amount of the subsidy for Retiree Health Care self-premium payments will be based upon a Participant's Years of Service as follows:

Years of Service	Rate of Subsidy
0-4	**0%**
5	**10%**
6	**12%**
7	**14%**
8	**16%**
9	**18%**
10	**20%**
11	**22%**
12	**24%**
13	**26%**
14	**28%**
15	**30%**
16	**32%**
17	**34%**
18	**36%**
19	**38%**
20	**40%**
21	**42%**
22	**44%**

Years of Service	Rate of Subsidy
23	**46%**
24	**48%**
25	**50%**

(5) The Participant must also meet all eligibility conditions for coverage in the IBEW Local 306 Supplemental Health Plan as provided elsewhere in this Plan.

(6) A Participant who is totally and permanently disabled, as defined in Article I, Paragraph (B), will get the full subsidy regardless of the number of years of service.

(7) A Participant who was a Covered Employee, as defined in Section (E)(1) above, prior to January 1, 2016 will receive the full 50% subsidy upon reaching five (5) Years of Service.

(8) Discontinuance of Subsidy. In the event the Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund elect to provide a subsidy, they may discontinue such subsidy in whole or part at any time in their absolute and sole discretion.

(9) USERRA Military Time

Effective for those Covered Employees deployed into military service on and after January 1, 2021, for the limited purpose of determining whether such Covered Employee worked at least 300 hours in Covered Employment in a given calendar year in order to obtain a Year of Service pursuant to this Article II, Section (E)(3), the Plan will include hours during such calendar year spent deployed in qualified military service under the Uniformed Services Employment and Reemployment Rights Act (USERRA). However, the Covered Employee is expressly subject to an overall maximum of one (1) credit (i.e., only one (1) Year of Service) per calendar year. Further, any such credit is expressly conditioned upon the Covered Employee satisfying all notice and other requirements of USERRA. There will be no carry-over of hours, meaning that if the Covered Employee is deployed in 2021 for example, his military time hours will be combined with any other hours he worked and count for purposes of reaching the 300-hour threshold for calendar year 2021 only, but not for subsequent years. The Trustees retain the absolute discretion to discontinue this at any time as the Fund and Plan are not legally subject to the requirements of USERRA and are providing this military credit on a voluntary basis only.

III. MEDICAL REIMBURSEMENT ACCOUNTS

(A) Eligibility, Establishment, Maintenance, and Opt-Out of Medical Reimbursement Accounts

(1) If contributions are made to the IBEW Local Union 306 Supplemental Health Benefit Fund under the collective bargaining agreement or a participation agreement for Covered Employees and the Covered Employee has not opted out pursuant to paragraphs (4) and (5), Medical Reimbursement Accounts will be established for Covered Employees for use for reimbursement of eligible medical expenses of Covered Employees and their Covered Dependents.

(2) Medical expenses not covered elsewhere, if reimbursable, will be subtracted from the Covered Employee's Medical Reimbursement Account as provided herein.

(3) Covered Dependents of a deceased Covered Employee may continue to be reimbursed for medical care expenses up to an amount equal to the unused reimbursement amount remaining at the time of death of the Covered Employee.

(4) Covered Employees are permitted to permanently opt out of and waive future reimbursements from the Medical Reimbursement Account. This opt out availability shall be presented to Covered Employees at least annually.

(5) When contributions are no longer required on a Covered Employee's behalf due to retirement or ceasing to engage in employment covered by the collective bargaining agreement or participation agreement, Covered Employees are permitted to permanently opt out of and waive future reimbursements from his/her Medical Reimbursement Account.

(B) Eligible Medical Expenses

Reimbursable medical expenses are those medical expenses identified in Internal Revenue Code ("Code") §213 but which have not been paid under the Fourth District IBEW Health Fund or other qualified plan or arrangement. Unreimbursed medical expenses eligible for reimbursement under the Code include, but are not limited to:

(1) Deductibles and co-payments applied to covered medical expenses under the Fourth District IBEW Health Fund or a qualified plan of a Covered Spouse;

(2) Self-payments to maintain eligibility under the Fourth District IBEW Health Fund or other qualified plan or arrangement or premium or other payments required to maintain coverage under the Plan of Employee's Spouse;

(3) Unreimbursed prescription medicines (prescribed by a doctor) and insulin, including co-pays;

(4) Over the counter medicine that is prescribed by a physician;

(5) Unreimbursed medical services fees (from doctors, chiropractors, dentists, surgeons, registered nurses, specialists, and other medical practitioners);

(6) Unreimbursed special items (artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);

(7) Unreimbursed treatment at a drug or alcohol center (includes meals and lodging provided by the center);

(8) Unreimbursed dental expenses;

(9) Birth control pills;

(10) Capital expenses for equipment or improvements to the Covered Employee's home needed for medical care;

(11) Cost and care of guide dogs or other animals aiding the blind, deaf, and disabled;

(12) Cost of lead-based paint removal;

(13) Expenses of an organ donor;

(14) Oxygen equipment and oxygen;

(15) Part of life-care fee paid to retirement home designated for medical care;

(16) Psychiatric care at a specially equipped medical center (includes meals and lodging);

(17) Hospital services fees (lab work, therapy, nursing services, surgery, etc.);

(18) Legal abortion;

(19) Legal operation to prevent having children;

(20) Meals and lodging provided by a hospital during medical treatment;

(21) Special school or home for mentally or physically disabled persons;

(22) Unreimbursed transportation for needed medical care;

(23) Wages for nursing services; or

(24) Any other medical expenses identified in the Internal Revenue Code Section 213.

(C) **Non-Eligible Medical Expenses**

The following expenses are not eligible for reimbursement:

(1) Expenses for which the Covered Employee claimed or will claim a medical expense deduction on the Covered Employee's tax returns;

(2) Expenses incurred before the Covered Employee became initially eligible for medical benefits under this Plan, unless permitted by Internal Revenue Code Section 213;

(3) Expenses incurred after termination of employment and eligibility, unless permitted by Internal Revenue Code Section 213;

(4) Over the counter medicine unless prescribed by a physician;

(5) Bottled water;

(6) Diaper service;

(7) Expenses for general health (even if following doctor's advice) such as—

(a) Health club dues;

(b) Household help (even if recommended by a doctor);

(c) Social activities, such as dancing or swimming lessons;

(d) Trip for general health improvement; or

(e) Non-legend drugs for smoking cessation;

(8) Funeral, burial or cremation expenses;

(9) Illegal operation or treatment;

(10) Life insurance or income protection policies, or policies providing payment for loss of life, limb, sight, etc.

(11) Maternity clothes;

(12) Medical insurance included in a car insurance policy covering all persons injured in or by the Covered Employee's car;

(13) Nursing care for a healthy baby;

(14) Surgery for purely cosmetic reasons;

(15) Toothpaste, toiletries, cosmetics;

(16) Medical services in a U.S. Government Hospital;

(17) Medical services provided at no cost through any public program;

(18) Medical expenses for which reimbursement is available under another plan or program; or

(19) Expenses related to cosmetic surgery.

Medical Expenses will be reimbursed only to the extent that reimbursement for such Medical Expenses is not available to the Covered Employee under any health insurance policy or plan provided through any employer of the Covered Employee. If there is such a policy or plan in effect, providing for reimbursement or payment in whole or in part, then to the extent of the coverage under such other policy or plan, the Plan shall be relieved of any liability hereunder.

(D) How to Obtain Reimbursement

(1) **Benny Cards.** The Fund will provide Participants with a Benny Card, which may be used to pay for Eligible Medical Expenses. The Benny Card acts similarly to a debit card and can be used to pay for Eligible Medical Expenses at certain providers/merchants that accept MasterCard or Visa prepaid cards. Generally, Participants may use the Benny Card at freestanding pharmacies and health care providers (such as hospitals, doctors, and dentists). The Benny Card will not be accepted at discount stores, department stores, and supermarkets that cannot identify HRA-eligible items at checkout. The Participant will be responsible for repayment of any charges incurred on the Benny Card that are not Eligible Medical Expenses. Participants can track account balances by logging onto www.mybenny.com, or by calling the Fund Office.

(2) **Submission of Claim.** When a Covered Employee or Covered Dependent has unreimbursed medical expenses and a balance in the Covered Employee's MRA, the Covered Employee should submit proof of such out-of-pocket expenses on forms available from Benesys, Inc. (Third-Party Administrator), 3660 Stutz Drive, Canfield, OH 44406; 800-435-2388. Separate bills may be itemized on the same claim form. Forms must be accompanied by receipt for bills.

(3) **Reimbursement Payment.** The Third-Party Administrator will send reimbursement checks quarterly (example: expenses submitted in January, February and March will be reimbursed in April and so on) or sooner if premium payments are necessary to maintain eligibility under the Fourth District IBEW Health Fund or other qualified plan.

(4) **Limitations.** Claims for medical expense reimbursement must be filed no later than 18 months following the end of the Plan Year in which the claims were incurred.

(5) **Administrative Fee.** The Plan may assess a monthly administrative fee against the Covered Employee's MRA for any account activity (i.e., contributions received or claims paid).

(6) **Carry Over.** Any unused balances in the Covered Employee's MRA will be carried over to the next Plan Year, subject to provisions below about "Cancellation of

Account" and "Changes."

(E) Net Earnings and Losses in Excess of Operating Expenses

(F) If the Fund and/or Plan has a surplus due to accumulation of interest income or other earnings, or if the Fund and/or Plan incurs a loss, the Trustees shall have discretion on how to allocate such earnings/losses within the Fund and Plan. Cancellation of Account

If the Covered Employee's MRA has no activity for a period of two (2) years (i.e., no contributions received to the account or claims made from the account), and the balance in the account is less than $50, such account will be canceled, and any remaining account balance shall be permanently forfeited and revert to the Trust Fund.

(G) Changes

This MRA program is based on existing law, as currently interpreted. If there are legislative changes, governmental announcements or financial considerations which affect this program, the Trustees reserve the right to change or cancel the program, including cancellation of existing MRAs. If the program is to be discontinued or changed, the Trustees will provide Covered Employees with notice.

All MRA contributions shall become and are general assets of this Fund. The Covered Employee may not make contributions to his MRA. A contribution to the MRA is not a vested benefit. Thus, the Trustees can rescind it in whole or in part at any time, within their absolute discretion.

IV. CLAIMS AND APPEALS PROCEDURE

(A) Determination of Eligibility and Claims

(1) The Third-Party Administrator shall initially determine the eligibility of Covered Employees and/or their Covered Dependents for the Retiree Subsidy and the MRA. In addition, the Third-Party Administrator will initially determine whether claims for medical expenses are reimbursable and/or payable from the MRAs of Covered Employees or Covered Dependents.

(2) **Eligibility for Retiree Subsidy.** Determinations concerning eligibility for coverage or payment of Retiree Subsidies shall generally be made within 30 days after the request for coverage is submitted.

(3) **Eligibility for Determination for Payment of Medical Reimbursement.** Eligibility for medical reimbursement of claims shall generally be made within 30 days following the end of each calendar quarter in which the claim is submitted.

(4) **Notice of Adverse Determination.** In the event that an adverse determination is made by the Third-Party Administrator, in whole or in part, the Covered Employee, Covered Retiree or Covered Dependent, where applicable, will receive a written notice which shall include the following:

(a) The specific reason for the denial;

(b) The sections of the Plan and/or SPD upon which the denial was based;

(c) A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

(d) A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;

(e) If applicable, an explanation of the scientific or clinical judgment for the determination; and

(f) A notice of your right to file an appeal to the Benefits Committee of the IBEW Local Union 306 Supplemental Health Benefit Fund as outlined below.

(B) Appeal to the Benefits Committee of the IBEW Local Union 306 Supplemental Health Benefit Fund

(1) You or your authorized representative may appeal the decision of the Third-Party Administrator denying any eligibility or claim in whole or in part. An "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

(2) You may file a written notice of appeal to the Benefits Committee at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination by the Third-Party Administrator. The written notice only needs to state your name, address, social security number and the fact that you are appealing from the decision of the Fund Office, giving the date of the Notice. The Appeal should be addressed as follows:

Benefits Committee
IBEW Local Union 306 Supplemental Health Benefit Fund c/o Benesys, Inc.
3660 Stutz Drive
Canfield, OH 44406

(3) During the appeals process, you will also be afforded with access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

(4) If an appeal requires medical judgment, the Benefits Committee shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

(5) The Benefits Committee will consider your appeal at its next regularly scheduled quarterly meeting. If your appeal is received less than 30 days prior to the next regularly scheduled quarterly meeting, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You may be notified of the decision of the Benefits Committee within 5 days after the decision is made.

(6) In the event that the denial is upheld, you will receive a written Notice which includes the following information:

(a) The specific reason for the denial;

(b) The sections of the Plan and/or SPD upon which the denial was based;

(c) A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

(d) A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;

(e) A notice of your right to file a voluntary appeal to the Board of Trustees as outlined below;

(f) If applicable, an explanation of the scientific or clinical judgment for the determination; and

(g) A notice of your right to file suit under ERISA Section 502(a).

(h) The decision of the Benefits Committee is final and binding.

(C) **Voluntary Appeal to the Board of Trustees.**

(1) Once you have filed your appeal through the Benefits Committee as detailed above, you have the right to file a lawsuit in federal court. However, you can also file a voluntary appeal to the full Board of Trustees. If you decide to file a voluntary appeal to the full Board of Trustees, you must file it within 60 days of the mailing of the Notice of Final Decision by the Benefits Committee.

(2) The Appeal should be addressed as follows:

Board of Trustees
IBEW Local Union 306 Supplement Health Benefit Fund c/o Benesys, Inc.
3660 Stutz Drive
Canfield, OH 44406

(3) The Board of Trustees will consider your appeal of a claim at its next regularly scheduled quarterly meeting. If your appeal is received less than 30 days prior to the next regularly scheduled quarterly meeting, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You may be notified of the decision of the Board of Trustees within 5 days after the decision is made.

(4) In the event that you file a voluntary appeal with the Board of Trustees:

(a) The Fund will not assert a failure to exhaust administrative remedies;

(b) The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;

(c) The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);

(d) You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

(i) A statement that using this procedure will have no effect on your right to receive other benefits under this Fund

(ii) A statement that you have the right to have a personal representative with regard to your claim;

(iii) A notice of any circumstances which may impair the impartiality of the Board of Trustees.

(5) The Fund will not impose any fees or costs on you as part of this voluntary appeal

process.

(6) The Plan's Claim Procedure is furnished automatically, without charge, as a separate document, upon the request of a Participant or Beneficiary.

(D) Time Limitation on Legal Actions

No legal action regarding an applicant's benefit may be commenced or filed against the Board of Trustees or the Plan more than one (1) calendar year after the date of the Board of Trustees' decision on appeal as specified in Article IV, Appeal Procedure, Sections (A), (B) or (C), whichever is later.

(E) Governing Law and Venue

This Plan and Summary Plan Description shall be governed by and construed in accordance with the laws of the United States of America. In the event state law applies, the laws of the State of Ohio shall apply in all such cases. Anyone asserting any rights or claims, however characterized, under this Plan and Summary Plan Description, including but not limited to a Covered Retiree, Covered Employee, Covered Dependent, or any other individual or entity, or hereby bound directly or indirectly or with rights or obligations hereunder, shall only bring an action in connection with this Trust and/or Plan exclusively in the United States District Court for the Northern District of Ohio at Akron, Ohio.

V. TRUSTEE DISCRETIONARY AUTHORITY OF PLAN INTERPRETATION

The decisions of the Trustees in all matters pertaining to the administration of the Trust shall be final. The Board of Trustees, as the administrator of the Trust, shall have complete control of the administration of the Trust, subject to the provisions hereof, with all powers necessary to enable it to properly carry out its duties in that respect. Not in limitation, but in amplification of the foregoing, the Trustees shall have full authority and discretion to construe, interpret and apply all provisions of the Trust and to determine all questions that may rise hereunder, including all questions relating to the eligibility of Covered Employees and Covered Dependents to participate in the Plan, the amount of any benefit to which any Covered Employee or Covered Dependent may become entitled hereunder and to determine all appeals subsequent to any application for eligibility or benefits. Specifically, the Trustees shall have full and complete authority and discretion to make any determinations or findings of fact regarding any claims and appeals of any benefit determinations. Its decision upon all matters within the scope of its authority shall be final.

VI. NOTICE OF PRIVACY PRACTICES

(A) Purpose of This Notice and Effective Date

This Notice Describes:

(1) How medical information about you may be used and disclosed; and

(2) How you may obtain access to this information.

Please review this information carefully.

Effective date. The effective date of this updated Notice is June 1, 2021.

(B) Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

(1) Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

(2) Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

(3) Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

(4) Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it

would affect your care.

(5) Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

(6) Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

(7) Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

(8) File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us the Privacy Official, I.B.E.W. Local Union 306 Supplemental Health Benefit Fund, BeneSys, Inc., 3660 Stutz Drive, Canfield, OH 44406 or calling 1-800-589-8041.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

(C) Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

We will not use or disclose psychotherapy notes about you from your therapist without your written permission. However, we may use and disclose such notes when needed to defend against litigation filed by you.

(D) Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Help manage the health care treatment you receive.** We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
- **Run our organization.** We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.
- **Pay for your health services.** We can use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.
- **Administer your plan.** We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.
- **How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

  www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues.** We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- **Do research.** We can use or share your information for health research.
- **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director.**
    - We can share health information about you with organ procurement organizations.
    - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

(E) <u>Our Responsibilities</u>

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the

privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

(F) Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

(G) For Information On or to Exercise Your Individual Privacy Rights

For information on or to exercise your Individual Privacy Rights, contact:

Privacy Official
I.B.E.W. Local Union 396 Supplemental Health Benefit Fund
BeneSys, Inc.
3660 Stutz Drive
Canfield, OH 44406

VII. ADDITIONAL INFORMATION REQUIRED BY ERISA

(A) Name of Plan

I.B.E.W. Local 306 Supplemental Health Benefit Fund

(B) Plan Established and Maintained by Board of Trustees

I.B.E.W. Local 306 Supplemental Health Benefit Fund c/o BeneSys, Inc.
3660 Stutz Drive
Canfield, OH 44406
Phone: (800) 435-2388

(C) Employer Identification Number

34-0308380

(D) Plan Number

501

(E) Type of Plan

This Plan is maintained for the purpose of providing a subsidy for premiums or self-payments required to be paid by Covered Retirees who are covered by the IBEW Local Union 306 Supplemental Health Benefit Plan who are eligible to participate in the Fourth District IBEW Health Fund or Successor Fund.

The benefits to be provided to the Covered Retirees and their Covered Dependents shall be determined exclusively by the Fourth District IBEW Health Fund.

This Plan is also established for the purpose of establishing and maintaining Medical Reimbursements Accounts for Covered Employees and Covered Retirees for the payment of eligible medical expenses for the Covered Employees and Covered Retirees, and their Covered Dependents.

(F) Type of Administration of the Plan

Although this Plan technically is administered and maintained by the joint Board of Trustees of the IBEW Local Union 306 Supplemental Health Benefit Fund, the Trustees have delegated certain administrative functions to a professional Third-Party Administrator, BeneSys, Inc.

Address all communications with the Board of Trustees to: Board of Trustees, IBEW Local Union 306 Supplemental Health Benefit Plan, 3660 Stutz Drive, Canfield, OH 44406, Phone: (800) 435-2388.

(G) Agent for Service of Legal Process

Board of Trustees, IBEW Local Union 306 Supplemental Health Benefit Fund, 3660 Stutz Drive, Canfield, OH 44406, Phone: (800) 435-2388.

(H) Name, Title and Address Principal Place of Business of Each Trustee

Management Trustees

John Kellamis, Secretary
Lake Erie Electric/Loomis Div.
1888 Brown St.
Akron, OH 44301

Christeen Speelman-Parsons
Speelman Electric, Inc.
235 Northeast Avenue
Tallmadge, OH 44278

Jason Walden
North Central Ohio Chapter NECA
9050 Sweet Valley Drive
Valley View, OH 44125

Kari Heimbrock (Alternate Trustee)
North Central Ohio Chapter NECA
9050 Sweet Valley Drive
Valley View, OH 44125

Union Trustees

Michael Might, Chairman
I.B.E.W. Local 306
2650 South Main St., Suite 200
Akron, OH 44319

Benjamin Bovard
99 Forest Hill Rd.
Munroe Falls, OH 44262

James Deckert
I.B.E.W. Local 306
2650 South Main St., Suite 200
Akron, OH 44319

David Hickel (Alternate Trustee)
1469 Stoney Pointe Drive
North Canton, OH 44720

(I) Collective Bargaining Agreement

This Plan is maintained pursuant to a Collective Bargaining Agreement between the International Brotherhood of Electrical Workers Local Union No. 306 and the National Electrical Contractors Association and various other Participating Employers. You may obtain a copy of the Collective Bargaining Agreement from the Fund Office, the Union, or you may examine the Agreement at either of these locations.

(J) Participating Employers

Upon written request to the Fund Office, you may receive information as to whether a particular employer is a sponsor of the Plan. If the employer does participate, the Fund Office will furnish the address.

(K) Plan Year/Fiscal Year

The Plan Year is the same as the Fiscal Year and begins June 1 of each year.

(L) Funding Medium for the Accumulation of Plan Assets

Contributions are received from Participating Employers and deposited into the Trust Fund. Such assets are invested at the discretion of the Board of Trustees. The Board of Trustees is responsible for establishing and carrying out the Fund's funding policy.

(M) Plan Amendment and Termination

This Plan may be amended, changed, or discontinued at any time. An amendment may be effective prospectively or retroactively. If the Plan is modified or terminated, you will be notified in writing or as required by law.

The Trust may be terminated because of the expiration of all Collective Bargaining Agreements requiring payment of contributions to the Fund, or for any other reason that the Trustees deem necessary. If the Plan is terminated and assets remain after paying all obligations and expenses, the Trustees will adopt and follow a dissolution plan to continue providing benefits in accordance with the existing Plan, or in a manner that will best serve the Fund's purposes, until exhausting any and all assets. In no event will assets be paid to, or recoverable by, any contributing employer, association, or labor organization.

(N) Legal Counsel

Faulkner Hoffman & Phillips, LLC
One International Place
20445 Emerald Parkway Dr., Suite 210
Cleveland, Ohio 44135

(O) Investment Manager

Ancora Advisors
606 Parkland Blvd., Suite 200
Cleveland, OH 44124

(P) Custodian

Fifth Third Institutional Service
MDOWBS1
One Woodward, Suite 2500
Detroit, MI 48226

(Q) Auditor

Yurchyk & Davis, CPA's
3701 Boardman-Canfield Rd., Suite 2
Canfield, OH 44406

VIII. STATEMENT OF YOUR RIGHTS UNDER ERISA

ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974, and as amended since that time.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the I.B.E.W. Local Union 306 Supplemental Health Benefit Fund. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken steps necessary to assure full compliance with ERISA.

ERISA requires that Plan Participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this combined Plan and Summary Plan Description.

ERISA also requires that Participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan.

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

(1) ERISA provides that all Plan Participants shall be entitled to:

(a) Examine, without charge, at the Fund Office and at other specific locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the Third-Party Administrator or Board of Trustees, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Trustees or the Third-Party Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this Summary Annual Report.

(d) Obtain a complete list of employers sponsoring the Plan upon written request to the Third-Party Administrator which list is available for examination by Participants and Beneficiaries.

(2) In addition, Participants and Beneficiaries may obtain from the Administrative Manager, upon written request, information as to whether a particular employer or employee organization is a sponsor to the Plan and if the employer or employee

organization is a plan sponsor, the sponsor's address.

(3) In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries.

(4) No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit to which you may be entitled, or exercising your rights under ERISA.

(5) If you have a claim for a welfare benefit denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

(6) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(7) If you have any questions about your Plan, you should contact the Third-Party Administrator or the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trustees, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor or the Pension and Welfare Benefits Administration, whose offices are located at:

1730 K Street
Suite 556
Washington, DC 20006
Tel: (202) 254-7013

or

1885 Dixie Highway
Suite 210
Ft. Wright, Kentucky 41011-2664 Tel: (606) 578-4680

or

Division of Technical Assistance and Inquiries Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W. Washington, D.C. 20210.

NOTE: **Unwritten communications such as personal conversations with a Trustee, the Union, an Employer, or Plan employees should not be relied upon to change the terms of the written documents.**

The Trustees reserve the right to interpret, amend, and/or terminate the Fund and Plan at any time. The benefits provided by this Fund and Plan are not vested and can be modified and/or eliminated by the Board of Trustees at any time.

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