CANTON ELECTRICAL WELFARE FUND

SUMMARY PLAN DESCRIPTION

FOR AULTCARE AND MEDICAL MUTUAL OF OHIO ENROLLEES, THEIR SPOUSES, AND OTHER COVERED DEPENDENTS

MAY 1, 2013

CANTON ELECTRICAL WELFARE FUND
SUMMARY PLAN DESCRIPTION ("SPD")
FOR ENROLLEES, THEIR SPOUSES,
AND OTHER COVERED DEPENDENTS

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January 1, 2013

Dear AultCare and Medical Mutual Enrollee:

We are pleased to distribute this revised Summary Plan Description detailing the benefits provided under the Canton Electrical Welfare Fund. This Summary Plan Description replaces and supersedes in its entirety your previous Summary Plan Description.

This Summary Plan Description summarizes the eligibility rules for participation in the Plan, the benefits provided to those who are eligible, and the procedures which must be followed when applying for a benefit. In addition, this Summary Plan Description contains important information concerning the administration of the Plan and your rights as a Participant.

Since there have been many plan changes, please take the time to read this Summary Plan Description and make yourself and your family familiar with the Plan benefits.

If you have any questions concerning your eligibility, the benefits provided, or the general provisions of the Plan, please contact the Fund Office. Please also note that the receipt of this booklet does not mean that you are eligible for benefits. Your eligibility will be determined by the Plan's Rules of Eligibility which are set forth in this Summary Plan Description.

Sincerely,

Board of Trustees
Canton Electrical Welfare Fund

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I. YOUR RESPONSIBILITIES AS A PARTICIPANT

**** SPECIAL NOTE ****

This SPD also operates as the Plan Document. Therefore, any reference to one is reference to the other.

The primary purpose of this Plan is to pay benefits to all those who are entitled to benefits. However, in order for the Trustees and the Fund Office staff to achieve this objective, we need your cooperation. There are certain responsibilities which you, as a Participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable. A list of your responsibilities under the Plan follows. As you review this list, you will notice that none of these responsibilities is extremely burdensome. In fact, just a little time and effort on your part will aid in protecting your best interests in the Plan.

1. Take Time to Read this SPD

This SPD contains information you need to know about how to qualify for benefits, the benefits which are available, and how to file a claim for benefits. We have tried to organize the SPD into sections dealing with specific aspects of the Plan and have tried to simplify the language where possible.

REMEMBER: You owe it to yourself and your family to become familiar with the details of this SPD which provides that information. Of course, if you have any questions that are not answered in the SPD, be sure to contact the Fund Office.

2. If You Have Not Filed an Enrollment Card -- Do it Now!

When you first became eligible for benefits under the Plan, you should have received enrollment cards for you to complete and return to the Fund Office. These cards request certain basic information needed for your records in the Fund Office, such as: your Social Security Number, Address, Birth Date, Name and age of Dependents and Name of Beneficiary. This information is vital. Without it, the Fund Office will have difficulty keeping you informed about Plan changes and you run the risk of not having a permanent record of your participation under the Plan. So, if you have not yet completed an enrollment card, do it now! Further, complete a new card if there has been any change in address, beneficiary, or dependent status since you first filed an enrollment card. If you are not sure whether you have filed these cards with the Fund Office, please contact the Fund Office staff. The staff will advise you whether or not your card is on file. If not, a card will be sent for your completion.

3. Notify the Fund Office Promptly Regarding Any Change in Address, Beneficiary or Dependents.

When there are Plan changes or benefit improvements, we advise you by first class mail. This means that in order to get in touch with you, we must have your current address. So, if you move, make sure the Fund Office has your new address.

Also, if your marital status changes, or if for some other reason, you wish to change the name of your beneficiary, do not forget to send the change in writing to the Fund Office. Unless you do, the latest enrollment card which we have on file will determine who receives any benefit which may be payable in the event of your death. Failure to change your beneficiary, even when you intend to, is often just an oversight, but such an oversight could be costly to your survivors.

Finally, if you add any dependents to your household, the Fund Office must be notified regarding the name and age of the new dependent(s). Since the Plan does provide certain benefits for dependents, the Fund Office must know who your dependents are.

4. Your Claims Payment Obligation

Deductibles: A deductible is the amount of covered medical expenses that you are required to pay each Calendar Year before benefits are paid by the Plan. A family deductible can be satisfied through any combination of individual deductibles. Deductibles are specified in the Schedule of Benefits which applies to you and your Dependents.

Co-Payments: A co-payment is an out-of-pocket charge paid by you directly to the Provider or Physician. A co-payment does not apply to your Calendar Year deductible or any co-insurance which may apply. The covered services which require a co-payment are specified in the Schedule of Benefits which applies to you and your Dependents.

Co-Insurance: A payment that represents the portion of the allowed amount that you are responsible to pay to any provider after you have met your deductible and made your co-payment. The covered services which require a coinsurance payment are specified in the Schedule of Benefits which applies to you and your Dependents.

Annual Maximum Benefit: The Plan has established an annual maximum benefit on certain benefits for you and for each Covered Dependent, as specified in the Schedule of Benefits which applies to you and your Dependents. Whenever benefits are paid, they are charged against the individual's annual maximum benefit.

Deductible Carryover: The Plan also contains a deductible carryover feature. This provision states that any expenses applied against your deductible in the last three months of a Calendar Year will also be applied against your deductibles for the next Calendar Year.

Usual, Customary and Reasonable Charges: This term is commonly called UCR, and refers to the prevailing or normal fees determined by the Claims Payor as payable to a healthcare provider in a particular geographic area. The UCR applies to the professional providers for AultCare. Medical Mutual uses the term "Traditional Amount".

For In-Network Providers and Physicians, charges for medical services that are established between the Claims Payor and the service provider. The Fund pays these charges at the established rate, so an In-Network doctor or hospital will not bill you for any charges that are above the UCR or the Traditional Amount.

For Out-of-Network Providers and/or Physicians, charges above UCR or Traditional Amount will normally not be covered by the Plan. You will be responsible for the charges exceeding UCR or the Traditional Amount, including co-payments, if the Claims Payor does not have a contract with the Out-of-Network Provider and/or Physician.

With regard to Out-of-Network Hospitals, many of these hospitals still have negotiated payment terms and methods with your Claims Payor in order to establish payment that will be accepted based upon the medical service you receive, so UCR or the Traditional Amount does not technically apply to a hospital.

For example, if an Out-of-Network provider charges a fee of $125.00 for an office visit and the Usual, Reasonable and Customary charge or the Traditional Amount for this visit in the same area is $100.00, you will be responsible for the following payment assuming the deductible is met:

	In-Network Plans pay 85% after you pay $20.00 copay	Out-of-Network Plan pays 65% after deductible
Doctor's Office Visit Charge	$125.00	$125.00
UCR or Traditional Amount	$100.00	$100.00
Total Outstanding Amount	$25.00 (Provider writes off)	$25.00 (Provider balance bills)
Plans Payment	$68.00	$65.00
Member's Payment	$32.00 ($20.00 copay plus $12.00 coinsurance)	$60.00 ($35.00 coinsurance plus $25.00 balance bill amount)

Out-of-Pocket Expense Limit: The Out-of-Pocket expense limit applies to covered benefits and eligible charges of providers and physicians such as deductibles and coinsurance payments. These unpaid expenses are your responsibility until the annual out-of-pocket maximum limit is reached as specified in the Schedule of Benefits which applies to you and your Dependents.

5. How to Receive Benefits

A claim must be filed for you to receive benefits. Claim forms and instructions can be obtained from the Claims Payor or the Fund Office depending upon the benefit. The procedures to be followed to receive a specific benefit are set forth in Article XIV, Filing for Payment of Your Benefits on page 65. It is very important that you follow the established procedures in order to assure that your benefits are paid in a timely manner.

6. Medical Examination

No medical examination is required of any Eligible Participant or Eligible Dependent to become initially covered in the Plan. However, the Trustees have the right, through a physician, to examine you or your Dependents as often as they may reasonably require during the pendency of a claim. Additionally, the Trustees have the right and opportunity to require an autopsy in the case of death where it is not otherwise prohibited by law.

7. Enrollment with Claims Payor

Your Plan currently offers the choice of two (2) Claims Payors, Medical Mutual of Ohio and Aultcare. These Claims Payors both offer Preferred Provider Organizations (PPOs) which provide financial incentives to use the providers within the Medical Mutual and/or Aultcare Network. When you and your Dependents use the "In-Network" Providers and Physicians, the Fund may receive a discount or another form of cost reduction which is reflected in the co-insurance paid by the Participants. You and your Dependents will receive a higher level of Plan benefits when you utilize In-Network Providers and Physicians.

In comparison, you may be subject to charges above the UCR for AultCare or the Traditional Amount for Medical Mutual when you utilize Out-of-Network Providers and Physicians.

You are required to choose one Claims Payor – Medical Mutual of Ohio or Aultcare – and to use the In-Network Providers and Physicians offered by that chosen Claims Payor in order to receive the maximum Plan benefit payment. However, each Plan Year, the Plan offers an Open Enrollment period which allows you and your Eligible Dependents to switch Claims Payors.

The Open Enrollment Period will begin on April 15th of each Calendar Year. The Fund Office must receive your executed Enrollment Form by May 15th in order to affect a change in your Claims Payor. Whichever Claims Payor you select will also apply to your Eligible Dependents.

Before enrolling with a Claims Payor, you should find out if your current providers and physicians are members of the Claims Payor's Network and make sure that the Claims Payor you select best fits your medical needs.

If you fail to enroll with a Claims Payor during the Open Enrollment Period, you will remain with the same Claims Payor until you elect otherwise in the next enrollment period.

If you select a new Claims Payor, you will receive a new identification card and your new Claims Payor election will be effective on June 1st.

Each Claims Payor has a "Network" Directory which lists the Providers and Physicians which are part of their Network. You will receive a copy of this Directory when you enroll with your Claims Payor.

The Providers and Physicians which are part of the Network sign contracts with the Claims Payors. These providers and physicians also have the ability to terminate or refuse to sign new contracts. In order to be assured of the current status of your Provider or Physician in the Network, you should contact your Claims Payor directly and inquire. Additionally, please be aware that even though a hospital is contracting with your Claims Payor, each Provider and Physician who works with or in the hospital is not automatically part of the Network. You need to check on each Provider and Physician you use in order to be assured that they are part of your Network.

II. GENERAL INFORMATION

1. The Trustees Interpret the Plan

Only the Board of Trustees has the power to interpret and construe the Plan, determine all questions of eligibility and status under the Plan, determine all questions arising in the administration of the Plan, including the power to determine the rights of eligibility of employees, participants, and their dependents and beneficiaries, and to make factual determinations. No union or management representative, individual Trustee, business representative or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given that authority by the Board of Trustees and is acting on their behalf. However, the Board of Trustees has authorized the Administrative Manager, Claims Payors, and their staff to handle routine requests from Participants regarding eligibility rules, benefits and claims procedures. If there are questions involving interpretation of any Plan provisions, the Administrative Manager or Claims Payor will ask the Board of Trustees for the final determination.

2. Benefits Are Not Guaranteed; the Plan Can Be Changed

Benefits offered by the Plan are not guaranteed to the Eligible Participants and/or their Eligible Dependents, and the Board of Trustees reserves the right to make any changes to the benefits which the Fund currently provides.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. Achieving this goal may require Plan changes from time to time.

3. Right of Recovery

If we pay more for Covered Services than the provisions of this Plan requires, we have the right to recover the excess from anyone to or for whom the payment was made. The Participant agrees to do whatever is necessary to secure our right to recover the excess payment.

4. Subrogation

The Canton Electrical Welfare Fund will take advantage of its right to subrogation if you or your dependent is paid benefits by the Plan due to any injury or illness which arises out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage"), or medical payment coverage.

The term Covered Person as used hereinafter shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan.

The Plan shall be entitled to subrogation and reimbursement if you or your Dependent (claimant) are paid benefits under the Plan for claims due to injuries or illness for which a third-party may be obligated to pay you for any person.

Right to Subrogate

The Plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement, or otherwise, that may be liable for a claimant's injury or illness for which the Plan has paid or is obligated to pay benefits on the claimant's behalf.

Rights to Reimbursement With Source of Funds Specifically Identified

The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to the proceeds of any settlement, judgment, or payment from any source liable for making a payment relating to the claimant's injury, illness, or condition. A source includes, but is not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law, an individual policy of insurance maintained by a claimant, and organization, corporation, or government agency.

Rejection of Make-Whole Doctrine

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 the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. **This provision is intended to and does reject and superseded any "make-whole" rule/doctrine, which rule/doctrine might otherwise require that you be "made whole" before the Plan may be entitled to assert its subrogation right.**

Equitable Lien by Agreement
Once the Plan makes or is obligated to make payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the claimant or dependant from any source to the extent of payments made or to be made by the Plan on the claimant's behalf.

Claimant Must Set Aside Funds
The claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Plan immediately upon recovery. The claimant shall immediately notify the Plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. The claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the Plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement. The claimant shall assist and cooperate with representatives the Plan designates. The claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement. The claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

First-Dollar Recovery
The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise regardless of whether a claimant is made whole.

Disavowal of "Common-Fund" Doctrine
The Plan's subrogation and reimbursement rights apply to any recovery by the claimant without regard to legal fees and expenses of the claimant. The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses.

The Plan specifically disavows any claims that a claimant or dependant may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common-fund doctrine.

Cooperation
The Plan Administrator may require the claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement. **The completion and/or execution of any documents requested by the Plan Administrator shall be a condition to receiving payment for a claim. Further, the Plan shall have the right to suspend all benefit payments due to a claimant,**

the employee of whom a claimant is a dependent, and/or any other dependent of such an employee if the claimant fails to complete and/or execute such documentation.

5. Limitation of Actions

No legal action may be taken against the Plan to recover benefits until all claim appeals have been exhausted. No such action may be taken later than three (3) years after expiration of the time within which proof of loss is required.

6. Your Plan is Tax Exempt

Your Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the Employer's contribution to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefit paid on your behalf is not taxable as personal income. Additionally, investments earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to Participants and their Eligible Dependents. Such tax exemption works to the benefit of both the Employer and the Employee, as it means that the money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses. The Trustees are well aware of these advantages and will take whatever measures are necessary to keep your Plan qualified as a tax-exempt trust under Internal Revenue Services rules.

7. In the Event of Plan Termination

In the event the Plan, in the opinion of the Trustee, is inadequate to carry out the intent and purpose under the Agreement and Declaration of Trust, or to meet the payments due or to become due to a Participant, the Plan may be terminated by the Trustees. Upon termination of the Plan, providing there are funds remaining, the Trustees shall:

(a) First pay the unpaid expenses and the expenses involved in terminating the Plan;

(b) Pay premiums on any policies existing at the time to provide one or more of the benefits authorized by the Trust Agreement, as the Trustees determine;

(c) Provide one or more of the benefits on a fully or partially self-funded basis authorized by the Trust Agreement, as the Trustees determine.

The Participants shall continue to receive such benefits as may be provided in the policies then in force and in such additional or substitute policies as the Trustee are able to secure by the assets then in the Fund. In the event of self-funding, the Participants shall continue to receive such benefits as the Trustees in their discretion are able to secure by use of the assets then in the Fund. If at any time there are insufficient funds to pay premiums on such policies or to provide self-funded benefits, the Trustees shall transfer such balance to charitable organizations as they may select. No portion of the assets of the Plan, directly or indirectly, shall revert or accrue to the benefit of any Employer or Union.

8. About Your Plan

The Canton Electrical Welfare Fund is maintained as a result of a Collective Bargaining Agreement between your Employer and the Union. Decisions on Plan operations and benefits are made by the Board of Trustees on which labor and management are equally represented. Working together, the Board of Trustees establishes rules of eligibility, strives constantly to improve benefits, supervises the investments of the Fund's money, and sees that the Fund is in compliance with all applicable federal and state laws. In carrying out these responsibilities, the Trustees are assisted by a team of professionals, including:

The Administrative Manager who handles the day-to-day business activities of the Fund, such as keeping the records of money received, crediting each Participant's account with the correct contributions received, paying certain claims, and answering Inquires from participants about their eligibility and benefits.

The Claims Payor(s) who handles the day to day business activities related to the payment of the medical benefits.

The Fund Attorney who advises the Trustees about what must be done to assure that all operations of the Fund comply with federal and state laws.

The Fund Consultant who assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on many other matters important to the Fund's operations.

9. Gender

In the construction of this SPD, the masculine shall also include the feminine and the use of singular will also include the plural where required in order being appropriate for your situation.

10. Definitions

You will notice that some of the terms in this SPD begin with capital letters. These terms have a special meaning under the Plan and most are listed in the Definitions beginning on page 115. Please refer to that section for a detailed explanation. There are certain definitions that apply only to Medicare Participants. These definitions are found on page 119-120.

11. Affordable Health Care Act of 2010

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

comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Compensation Programs of Ohio, Inc. 33 Fitch Blvd., Austintown, Ohio 44515, Phone: (800) 435-2388. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

III. RULES OF ELIGIBILITY

A. RULES OF ELIGIBILITY FOR ELIGIBLE EMPLOYEES

NOTE: It will be the responsibility of each Participant to ascertain his own eligibility status, and any notification of impending loss of eligibility will be considered a courtesy to the Participant.

1. Initial Eligibility

An Employee working under the terms of the Collective Bargaining Agreement between the Union and Employer or for a Participating Employer who is otherwise authorized to participate in the Plan by agreement of the Board of Trustees, who has accrued contributions of not less than 145 hours paid in his name by Participating Employers to the Fund Office for work performed by him within the preceding twelve (12) months period, is eligible for coverage the first day of the second month following the month in which contributions are received. For example, if you work 145 hours in January and the Fund Office receives the contribution for those hours in February, you will be eligible for coverage April 1.

A trainee/apprentice shall become initially eligible for benefits on the first day of the month the residential trainee completes the second step of training with the accrual of not less than the equivalent of one hundred forty-five (145) hours of contributions at the full journeyman contribution rate within a dollar bank but in no case later than twelve and a half (12.5) months from the date of the start of employment. Any contribution accrual that exceeds the equivalent of one hundred forty-five (145) hours of contributions at the full journeyman contribution rate shall be accumulated in his/her reserve hours bank for use by the trainee/apprentice upon his/her attainment of initial eligibility for benefits, including, but not limited to, providing for eligibility in months subsequent to his/her first month of eligibility.

2. Continuation Of Eligibility

An individual account of hours worked is maintained for you once you have one hour of contributions made on your behalf. Once you become an Eligible Employee because you fulfill the initial 145 hours paid eligibility requirements, you will remain an Eligible Employee provided you are credited with a minimum of 145 hours of contributions

received per calendar month with one or more contributing Employers or through reciprocal contributions.

Continuous coverage will commence on the first day of the second month following the work month reported to the Fund Office or the month in which Reserve Hours are applied to maintain your eligibility.

For Example: Once you reach your initial 145 hours, you will be eligible for coverage based upon 145 hours worked for which contributions are received as follows.

Contributions Received for the work month of:	Provides Coverage for:
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

a) Reserve Hours Bank

All contribution hours in excess of 145 hours per month are credited to your Hours Bank up to a maximum accumulation of 1,305 hours in reserve. This Reserve in your Hours Bank can be used to maintain eligibility until exhausted, provided you are actively seeking work through the Union. To be actively seeking work, you must meet one of the following conditions:

(i) maintain membership through the Union and register with the Union that you are available for work according to the Union rules; or

(ii) if not a member of the Union, register with the Union that you are available for work according to the Union rules.

In the event that your Hours Bank contains more than zero (0) hours, but less than the number of hours necessary to maintain one (1) month of eligibility, the hours remaining in the account shall be exhausted and you may preserve eligibility for only that month through a self-payment of the difference between the hours remaining in the Hours Bank and the hours required for eligibility times the contribution rate in effect at that time under the Inside Collective Bargaining Agreement between the Union and the Employer.

If a Participant did not elect to use reserve hours to make a self-payment, those hours will be used towards reinstatement eligibility under Section 6.

If an Eligible Employee, as defined by the Plan, becomes the Training Director for the Canton Electrical Joint Apprenticeship and Training Fund, then that person's Reserve Bank Hours shall be maintained or "frozen" and shall be available for use, at the appropriate rate, if and when that person again becomes an Eligible Employee and/or if that person retires while in that position.

b) Self Payments

Once your Reserve Hours Bank is insufficient or exhausted, you are still entitled to preserve eligibility, other than through Reinstatement of Eligibility, by making a self payment of the required rate as set by the Trustees for each month up to a total of fifteen (15) consecutive months. Once you have exhausted your self payments or fail to make your self payments as required under the Plan, you may still be entitled to continue your eligibility under the provisions as set forth in the section entitled COBRA Continuation Of Coverage Option, and the amount required for payment to maintain eligibility under COBRA shall be the COBRA rate established by the Trustees.

3. Initial Eligibility For Newly Organized Employees

An employee who has never been eligible under the Plan prior to becoming eligible under the provisions of the Plan, may establish eligibility under the following conditions:

(a) The employee shall be certified by the Business Manager of IBEW Local 540 as an organized employee.

(b) The employee is not covered under any other medical plan.

(c) The employee is employed in covered employment or has been employed in covered employment and is available for work through the Union.

If the employee meets all of the above conditions, then the employee and his/her dependents will become initially eligible for coverage under this Plan on the first (1^{st}) day of the month following the month in which the employee first entered covered employment, provided:

(a) The employee, employer, or Union makes payment to the Fund on or before the thirtieth (30^{th}) day of the month prior to the month of coverage equal to seventy five (75) times the hourly contribution rate in effect at that time under the Collective Bargaining Agreement.

(b) Is employed in covered employment or available for work through the Union on the date payment is made.

4. Continuation of Eligibility For Newly Organized Employees

An employee who has become initially eligible for coverage under A(2) found on page 16 shall continue to be covered in the two month period immediately following the month of initial eligibility provided the employee meets the following conditions:

(a) The employee continues to be certified as an organized employee by the Business Manager of Local Union 540.

(b) The employee is employed in covered employment or is available for work in covered employment through the Union.

(c) For the employee's second and third month of eligibility, on or before the thirtieth (30^{th}) day of the month, prior to the month of coverage, the employee, employer or union pays to the Fund an amount which is equal to the number of hours multiplied by the hourly rate then currently in effect under the Collective Bargaining Agreement which is the difference between the hours received by the Fund for work performed by that employee in covered employment, prior to the due date of said payment and One Hundred Forty Five (145) hours of contributions.

For continued eligibility for the month immediately following the third month of eligibility, the employee shall have attained the initial eligibility requirements under the Plan which is required for all other employees based upon the contributions received for work performed in covered employment and the amount paid by the employee for eligibility in the first and/or second months of coverage. In the event that the employee fails to meet the eligibility requirement for coverage in the month immediately following the third month for which eligibility is provided or in the event the employee fails to make the required payments, the employee shall be notified of his rights available to him under COBRA.

Reserve Hours for Newly Organized Employees.

A newly organized Employee shall not earn reserve hours until such time after the first monthly accrual of at least 215 hours. Thereafter, all hours that are in excess of One Hundred Forty Five (145) received by the Fund for work performed in covered employment in a month shall be treated as reserve hours in the same manner as reserve hours are treated for all other employees.

5. Maintaining Eligibility - Eligible Employees Receiving Weekly Sickness Benefits

If you are an Eligible Employee who is receiving an Accident and Sickness Benefits under this Plan, or who is eligible and entitled to benefits under any Workers' Compensation or Occupational Disease Law, you will receive thirty-five (35) hours of contribution credits for each week you are entitled to or drawing such benefits. This credit contribution accumulation shall cease when said benefits cease or when such contribution credits total 910 hours, whichever occurs first. Disability credits will be

limited to twenty six (26) weeks per calendar year regardless of the number of disabilities during that year.

6. Reinstatement of Eligibility

If you were an Eligible Employee who fails to maintain your eligibility through work hours, use of your Reserve Hours Bank, or by making self-payments, other than through COBRA, you can become an Eligible Employee again on the first day of the second month following the month in which 145 hours of contributions are received from one or more contributing Employers within a period of twelve (12) consecutive months after termination of such eligibility. If you seek to become an Eligible Employee again after the lapse of this twelve (12) month period, you will be required to re-qualify as set forth under the Initial Eligibility requirements.

7. Delinquency Procedure for Self Payments

The Fund Office will calculate each month the number of hours necessary to maintain your eligibility in the Plan. If you do not have the proper hours paid by your Employer or in your Reserve Hours Bank, you will receive a self payment statement from the Fund Office. Your Self Payment is required to be paid on the due date reflected on the billing statement. If your self payment is not received by that date, your coverage will terminate on the termination date reflected on the billing statement. Once your coverage terminates due to the failure to make a self-payment, you will be required to reinstate your eligibility as provided in paragraph 6 above, or you may be eligible for COBRA Continuation Coverage depending upon your circumstances (see COBRA Continuation Coverage Option at page 84).

B. RULES OF ELIGIBILITY FOR RETIREES OVER AND UNDER AGE 65, EXCEPT AS OTHERWISE STATED

NOTE: It is the responsibility of each Eligible Retiree to ascertain his or her own eligibility status, and any notification of impending loss of eligibility will be considered a courtesy to the Retiree.

1. Eligibility Requirements

(a) Retirement of Eligible Employee

If an Eligible Employee has been continuously covered under the Plan for at least one (1) full year immediately prior to retirement, and if the Eligible Employee retires and is receiving either a Retirement Benefit from Social Security, the Local 540 Pension Fund, or a qualified retirement plan in which he is a participant as a result of his coverage under a Collective Bargaining Agreement with Local 540, he must notify the Fund Office in writing no later than sixty (60) days after his receipt of a retirement benefit as identified herein before. With that notice and payment of contributions as determined by the Trustees, the employee can be eligible to participate in the Plan as a retiree.

(b) Retirement of Special Class Former Eligible Employees

If you were an Eligible Employee for at least two (2) years and immediately following your coverage under the Welfare Fund, you became employed and remained continuously employed as:

(i) a full time construction electrical inspector in the State of Ohio,

(ii) as an instructor in the IBEW Local 540 Joint Apprenticeship Training Program, or

(iii) by a participating Employer , but not covered under the Collective Bargaining Agreement;

and then immediately following such employment, you retire and begin receiving either a Retirement Benefit from Social Security, the IBEW Local 540 Pension Fund or a qualified retirement plan in which you are a participant as a result of your coverage under a Collective Bargaining Agreement, you must notify the Fund Office, no later than sixty (60) days after your receipt of a retirement benefit as identified herein. With that notice and payment of contributions as determined by the Trustees, you can be eligible to participate in the Plan as a retiree.

(c) Retirement of Special Terminated Eligible Employees

In addition, any Eligible Employee who ceased employment after working continuously for a period of at least one (1) year under a Collective Bargaining Agreement between the Union and the Employer and becomes immediately employed by a Participating Employer in a position not covered under the Collective Bargaining Agreement will become eligible to participate in the Retiree Program if he continues with that Employer until the date of his retirement and actually retires, and, upon retirement, begins receiving either a Retirement Benefit from Social Security, the IBEW Local 540 Pension Fund or a qualified retirement plan in which he is a participant as a result of his coverage under a Collective Bargaining Agreement with Local 540. He must also notify the Fund Office in writing no later than sixty (60) days after his receipt of a retirement benefit as identified herein. With that notice and payment of contributions as determined by the Trustees that employee can be eligible to participate in the Plan as a retiree.

(d) Total and Permanently Disabled Under Age 65

If an Eligible Employee has been covered under this Fund for a period of five (5) years out of the previous seven (7) years which preceded his retirement and if he is receiving a Total and Permanent Disability Benefit from either Social Security, the IBEW Local 540 Pension Fund or a qualified retirement plan in which he is a participant as a result of his coverage under a Collective Bargaining Agreement

with Local 540, he must arrange within sixty (60) days of the notification that his Disability Benefit has been approved to join the Retiree Program and remit timely contributions as determined by the Trustees.

2. Application of Reserve Hours and the Delinquency Procedure for Retiree Contributions

As of the day before you receive the initial Pension Benefit from either Social Security, or the IBEW Local 540 Pension Fund, or a qualified retirement plan, the hours in your hour bank will be converted to dollars at the contribution rate in effect under the Inside Working Agreement on that date. Monthly thereafter, all dollars that the Fund receives on your behalf will be added to your account and the amount of your monthly retiree premium will be subtracted from that account. Your account will be limited to a maximum amount which is equal to 1,305 hours multiplied by the current contribution rate specified in the Inside Working Agreement between the Union and the Employer. When there is not a sufficient balance in your account (i.e. the difference between the amount in your account and the premium necessary for coverage) you will be required to pay the balance. If you decide to go back to work in Local 540's jurisdiction and hours are reported to the Fund Office, you may elect to return to eligibility under Article IV and your welfare account balance will be converted back to an hour bank at the then current rate per hour in effect under the Inside Working Agreement. At that time, you will be an eligible employee with all of its associated benefits, e.g. life insurance and weekly sickness benefits. Under no circumstances will your account balance be paid directly to you. Your account balance can only be used to pay your monthly insurance premium.

For example, if on April 25, 2004, you retire and receive your first pension payment from the Local 540 Pension Fund on May 1, 2004, on April 30, 2004, your bank hours will be converted to a dollar amount by multiplying the number of hours by the contribution rate then in effect under the Inside Working Agreement, and you will be considered a retiree with the Canton Electrical Welfare Fund. In other words, if you had 1,000 reserve hours and the contribution rate under the Inside Working Agreement was $3.00 per hour, $3,000.00 would be credited to your account. If, for example, the Fund received under a reciprocity agreement 100 hours at a contribution rate of $2.40 per hour, $240.00 would be credited to your balance. If the amount for your health insurance coverage is $399.10 per month, that amount would be charged to your account and thus decrease the balance. As long as you have a balance in your account, which is equal to or greater than the monthly payment for insurance coverage, you do not have to make any payment for retiree coverage. If your account balance is less than the monthly payment for insurance coverage you will be billed the difference. Your account will be limited, however, to an account which is equal to 1,305 hours multiplied by the current contribution rate specified in the Inside Working Agreement.

If you have an account, the Fund Office will send you a Retiree Premium Billing Statement each month based upon the premium which applies to you and your eligible dependents. Your Self Payment is required to be paid on the due date reflected on the billing statement. If your self payment is not received by that date, your coverage will

terminate on the termination date reflected on the billing statement. Once your coverage terminates due to the failure to make a self-payment, you will not be entitled to reinstate your eligibility. However, you or your Eligible Dependent may be eligible for COBRA Continuation Coverage depending upon your circumstances (see COBRA Continuation Coverage Option on page 84).

3. Retiree Medical Benefit.

A retired participant and his dependents who are eligible for Medicare Part A and Part B may elect during a period not to exceed twenty four (24) months to enroll in a retiree medical plan which provides supplemental Medicare benefits. During such period, such retired participant and dependent may continue to receive Vision, Dental and Prescription Benefits as provided in Articles VII through IX, subject to the limitations set forth in that Section. Such participant and dependent may elect to return to the Plan no later than twenty four (24) months after enrolling in the Supplemental Medicare Coverage. The failure to return to the Supplemental Medicare Coverage within a period of twenty four (24) months after enrolling in the Supplemental Medicare Coverage will restrict the participant and/or such dependent from reentering such basic supplemental coverage in the future. In such event, however, the Participant and/or dependent may be able to continue prescription, vision and dental coverage, at a rate determined by the Board of Trustees, provided that coverage was initially elected at the time of the enrollment in the Supplemental Medicare Coverage.

4. Re-entry in the Plan.

A Retired Participant who has previously elected limited coverage under this Section may elect to opt back into the Plan under Article III only under the occurrence of one of the following qualifying circumstances:

- When the Retired Participant has enrolled in all or limited benefits provided under Article III but his/her dependent declined coverage due to other coverage and then loses that coverage, the Retired Participant and the dependent may enroll in any option provided under Article III;

- When the Retired Participant has enrolled in an optional benefit and subsequently obtains a new dependent, both the Retired Participant and the dependent may enroll in any option available under Article III;

- When the Retired Participant's marital status changes due to death of a spouse, divorce, legal separation, annulment or marriage both the Retired Participant and the dependent may enroll in any option available under Article III;

- When the Retired Participant's status is changed due to imposition of Court judgment(s), decree(s), and/or orders which directly affect the Participant the Retired Participant and the dependent may enroll in any option provided under Article III; or

- When the Retired Participant's spouse becomes eligible for Medicare and is not employed the Retired Participant and the dependent may enroll in any option provided under Article IIV.

The election to opt back into participation in the Plan under one of the above qualifying circumstances must be exercised within 30 days following the circumstance which gives rise to decision to re-enter into the Plan and must be approved by appropriate proof of the occurrence of such circumstance.

C. RULES OF ELIGIBILITY FOR OFFICE AND SALARY PARTICIPANTS

NOTE: It is the responsibility of each Office and Salary Participant to ascertain his or her own eligibility status, and any notification of impending loss of eligibility will be considered a courtesy to the Participant.

1. Eligibility Requirements

Salary and other office personnel working a minimum of thirty (30) hours per week for Participating Employers but who do not work under the terms of the Collective Bargaining Agreement, may be eligible for benefits at a monthly rate which is determined by the Board of Trustees. All Participating Employers who wish to have their non-bargaining unit employees participate in the Office and Salary Program must execute an Assent of Participation and be approved by the Board of Trustees. Coverage for the Office and Salary Participants will begin on the first day of the month for which the Participating Employer pays the proper rate. An invoice for the monthly contributions on behalf of Office and Salary Participants will be sent out each month for the coverage in following month.

> *Example:* On January 1, 2004, the Fund Office will send out an invoice to the Participating Employer for coverage beginning on February 1, 2004 which requires payment in the amount equal to the monthly contribution rate times the number of covered Office and Salary Participants.

The monthly contributions shall be remitted to the Fund Office by the fifteenth (15th) day of each month in order to pay for coverage for the following calendar month. Changes in coverage or Eligible Office and Salary Participants can be noted on the contribution reports at the time the reports are submitted to the Fund Office.

2. Delinquency Procedure for Office and Salary Contributions

As a participant under the Office and Salary Program, you are eligible in this Plan based upon the timely remittance of your contribution by your Employer to the Fund Office. In the event that your Employer fails to pay a premium for your coverage by the 15th day of the month PRIOR to the coverage month, your coverage will terminate on the last day of the month. Once your coverage terminates due to the failure of your Employer to make the proper premium payment, you will not be entitled to reinstate your eligibility or to make a self payment to continue your coverage. However, you and/or your Eligible Dependent(s) may be eligible for COBRA Continuation Coverage

depending upon your circumstances (see COBRA Continuation Coverage Option on page 84).

3. Participation by Office and Salary Employees in Any Retiree Program

Office and Salary Participants are eligible to participate in any retiree program under the Plan if the Participant is receiving a Pension Benefit from either Social Security, IBEW Local 540 Pension Fund or a qualified retirement plan in which he is a participant as a result of his coverage under a Collective Bargaining Agreement with Local 540. To be so eligible, the Participant must be at least age 55 with at least 30 years of service with any signatory Employer or at least age 62 with 10 years of service with any signatory Employer; must have been a participant in the 7 years immediately preceding retirement; and did not have had a break in service for prior service credit of more than 5 years. A year of "service credit" requires the individual shall be employed with any signatory Employer throughout the calendar year and regularly work for any of those Employers at least 30 hours per week.

4. Waiver of Coverage

An Active Eligible Office and Salary Participant who is otherwise eligible to participate in the Plan as a result of the Employer's proper execution of an authorized "Assent of Participation and Acceptance" form may elect to waive coverage under the Plan by signing and returning an authorized "Waiver of Coverage" form to the Plan Administrator.

5. Re-Entry Into the Plan

An Active Eligible Office and Salary Participant who has waived participation in the Plan as provided in Paragraph 4 above may opt back into participation in the Plan only on the occurrence of any one of the following qualifying circumstances:

a. a change in the Participant's legal marital status due to death of spouse, divorce, legal separation, or annulment;

b. the termination of Participant's spouse's employment or strike or lockout of Participant's spouse where such event affects the eligibility of Participant's spouse;

c. due to imposition of court judgment(s), decree(s), and/or orders which directly affect Participant; or

d. the Participant's retired spouse becomes eligible for Medicare and is not employed.

The election to opt back into participation in the Plan under one of the above-cited qualifying circumstances must be accompanied by appropriate proof of the occurrence of such circumstance.

D. RULES OF ELIGIBILITY FOR DEPENDENTS

NOTE: It is the responsibility of each Participant to ascertain his own Dependent's eligibility status and any notification of impending loss of eligibility will be considered a courtesy to the Eligible Participant and their Dependents. For the definition of an eligible dependent please refer to pages 117-118.

1. Eligibility for Dependent Coverage

In order to be covered for dependent benefits offered by this Plan, the Eligible Participant must be covered for benefits. In the event that you meet the eligibility provisions for Eligible Employees, Eligible Retirees Over 65, Eligible Retirees Under 65 and Office and Salary Participants, the coverage for your Eligible Dependents will become effective on the latest of the following dates:

(a) on the date the Trustees determine;

(b) on the date that your coverage as an Eligible Participant becomes effective; or

(c) on the date you, as the Eligible Employee or Office and Salary Participant, first acquire an Eligible Dependent.

If you acquire a dependent while you are covered in this Plan, such Eligible Dependent will automatically become covered with respect to that Eligible Dependent, except for the following provision with regard to adopted children and hospitalized spouse and children. In the case of an adopted child, the child will be covered as an Eligible Dependent from the date of birth, if the child is placed in the home of the Eligible Employee or Office and Salary Participant by a state agency or order of a court with competent jurisdiction within thirty (30) days of birth. In all other cases, the adopted child will be covered as an Eligible Dependent from the date the child is placed with the Eligible Employee or Office and Salary Participant.

Effective Date Of Dependent Benefits - Generally, coverage for your legal spouse and dependent children starts when your coverage begins. If you marry while covered under this Plan, coverage begins for your spouse on the day you were married. If you have a child while covered under this Plan, his or her coverage begins at birth. NOTE: From time to time, the Fund may require proof of your legal spouse's eligibility.

2. Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order made pursuant to a state domestic relations law (including community property law) that relates to the provision of support for a child of a participant and which:

(a) Creates or recognizes the existence of the child's right to or assigns to the child the right to receive benefits for which a Participant, Dependent or Beneficiary is eligible under this Plan; and

(b) Specifies (i) the name and last known mailing address (if any) of the Participant and each child covered by the Order, and (ii), a reasonable description of the type of coverage to be provided by the Plan or the manner in which the coverage is to be determined; and

(c) Does not require the Plan to:

(i) Provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of any law relating to medical child support as described in Section 1908 of the Social Security Act.

(ii) Upon receipt of any judgment, decree, or order (including approval of a property settlement agreement) relating to the provision of payment by the Plan to a child pursuant to a state domestic relations law, the Trustees shall promptly notify the affected Participant and any child of the receipt of such judgment, decree or order and shall notify the affected Participant and any child of the Trustees' procedures for determining whether or not the judgment, decree, or order is a Qualified Medical Child Support Order.

(iii) The Trustees shall establish procedures to determine the status of a judgment, decree, or order as a QMCSO and to administer Plan benefits in accordance with Qualified Medical Child Support Orders. Such procedures shall be in writing, shall include a provision specifying the notification requirements enumerated in the preceding paragraph, and shall permit a child to designate a representative for receipt of communications from the Trustees and shall include such other provisions as the Trustees shall determine, including provisions required under regulations promulgated by the Secretary of the Treasury. A copy of such procedures is available without charge, upon request, from the Office of the Administrative Manager.

3. Surviving Spouse of Eligible Participant

(a) Rules for Eligibility

If you are an Eligible Participant upon the date of your death, your spouse will be eligible to continue coverage under the Surviving Spouse Program offered by this Plan until the earlier of when:

(i) your spouse first becomes eligible after the Participant's death to participate in a group hospitalization program offered by his or her employer and in which the spouse was not eligible to participate in and/or had not been participating in at the time of the participant's death; or

(ii) your spouse first becomes covered under another group program, excluding Medicare, and in which the spouse was not eligible to participate in and/or had not been participating in at the time of the participant's death; or

(iii) your spouse remarries.

In the event that the benefits of the group hospitalization program offered by surviving spouse's employer are, in the judgment of the Trustees, significantly less than the benefits offered by this Plan, the Trustees, at their discretion, may permit the surviving spouse to continue to participate in this Plan, provided timely contributions established by the Trustees are remitted.

(b) Eligibility Date

If you are an Eligible Employee or an Office and Salary Participant, and your spouse is eligible under the rules above, your spouse will become eligible to elect coverage in the Surviving Spouse Program upon the last day of the month that coverage was paid on your behalf prior to your death and your spouse will receive credit for the Surviving Spouse Program until your Reserve Hours Bank is exhausted.

If you are an Eligible Retiree Over Age 65 or Under Age 65, and your spouse is eligible under the rules above, your spouse will become eligible to elect coverage in the Surviving Spouse Program upon the date of your death.

Your spouse will be required to make application for coverage in the Surviving Spouse Program within sixty (60) days of the eligibility date listed above and remit timely monthly contributions at the rate established by the Trustees.

4. Surviving Dependent of an Eligible Participant or Surviving Spouse

An Eligible Dependent of an Eligible Employee, Eligible Retiree Over Age 65, Eligible Retiree Under Age 65, Office and Salary Participant, and Surviving Spouse will be eligible to participate in the Surviving Dependent Program as long as he or she remains a Dependent as the term is defined by the Plan and provided he or she:

(a) remits the timely monthly contributions at the rate established by the Trustees; and

(b) Elects to participate in the Surviving Dependent Program by making application within sixty (60) days of the date of the death of the Eligible Participant or Surviving Spouse.

IV. PRE-EXISTING CONDITIONS LIMITATIONS OF COVERAGE

1. Pre-existing Condition Exclusion

A pre-existing condition is a condition for which you incurred medical expenses, received medical treatment, used prescription drugs, or were advised by a physician or other professional provider to receive treatment prior to your effective date of initial eligibility in the Plan. A pre-existing condition does not apply to pregnancy. Additionally, a pre-existing condition exclusion does not apply to newborn children or children who have been continuously covered by a group health plan within thirty (30) days of the birth or adoption.

Your Plan does not have a pre-existing condition exclusion so you and your Eligible Dependents will be covered for all medical benefits which are payable under this Plan from the first day of coverage. Please note that all deductibles and co-payments must be met prior to receiving payment from the Plan for covered services.

2. Certificate of Creditable Coverage Required to Waive Pre-existing Condition Exclusion

While this Plan does not impose a pre-existing conditions exclusion, you may terminate your coverage under this Plan and enter into other health insurance coverage which does impose a waiting period. For other plans, pre-existing condition limitations will not be permitted after the start of the plan's 2014 plan year. Until then, a health coverage provider cannot impose a pre-existing condition exclusion upon you or your Eligible Dependents for a condition that this Plan covered.

> *For example.* You were treated for a heart condition under this Plan for two years and terminated coverage. Your new health coverage provider imposed a twelve (12) month pre-existing condition limitation which denies coverage for any condition that you were treated for in the 12 months prior to joining the new health plan. Since you were treated for this heart condition for over twelve months, this Plan will issue you a Certificate which states the time period that you were covered under this Plan and that treatment for this heart condition was covered. If you present this Certificate of Creditable Coverage to your new health coverage provider within sixty three (63) days after coverage ended in this Plan, your new health coverage provider cannot impose a pre-existing condition limitation.

You will be provided a Certificate of Creditable Coverage free of charge from the Administrative Manager when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to twenty four (24) months after losing coverage. Prior to another Plan's start of its 2014 plan year, without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion after your enrollment date in your coverage in a plan other than the Canton Electrical Welfare Fund.

If you have any questions with regard to the obtaining a Certificate of Creditable Coverage from the Plan, contact the Fund Office.

V. SCHEDULE OF BENEFITS

A. ELIGIBLE EMPLOYEES, OFFICE & SALARY PARTICIPANTS, ELIGIBLE RETIREES UNDER AGE 65 AND THEIR DEPENDENTS UNDER AGE 65

	In-Network benefits*	Out-of-Network benefits*
General Plan Provisions		
Annual Deductibles	$200 Single $400 Family	$400 Single $800 Family
Co-Insurance	85%	65%
Your out-of-pocket limit[1]	$1,500 Single $3,000 Family	$3,000 Single $6,000 Family
Your annual maximum benefit limit on essential health benefits	$2,000,000 effective November 1, 2012 through October 31, 2014. There will be no maximum benefit limit effective November 1, 20141`.	
Dependent Age Limit	Up to age 26, for so long as the dependent is not eligible for health insurance coverage by his/her employer.	
Pre-existing conditions	There is not a pre-existing condition clause	
Preventive Care		
Physician's Office Visit	The Plan pays 85% after you pay the $20.00 co-pay/visit	The Plan pays 65% after deductible
Well-baby, child care, immunizations up to age 26 [2]	The Plan pays 85% after you pay the $20.00 co-pay	The Plan pays 65% after deductible
Adult Routine Physical	The Plan pays 85% after you pay the $20.00 co-pay	The Plan pays 65% after deductible
Routine Mammography and PAP (limit one test per calendar year)	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Physician's Services		
Second and Third surgical opinions	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Surgery	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Allergy Testing	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Allergy Injections	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Emergency Services: Accident related, Medical	The Plan pays 85%	
Diagnostic tests including routine Comprehensive Metabolic Panel, CBC, urinalysis	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Diagnostic x-ray and laboratory	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Anesthesia	The Plan pays 85% after deductible	The Plan pays 65% after deductible

[1] Excludes deductibles, copayments, and amounts over usual, customary and reasonable (UCR) charges for AultCare or over the Traditional Amount for enrollees in the Medical Mutual Network.

[2] Call your Claims Payor (either Aultcare or Medical Mutual) for a listing of covered immunizations.

Physical Therapy[3]	The Plan pays 80% after deductible	The Plan pays 60% after deductible
Inpatient medical care visits	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Maternity Care (Maternity Care for Dependent Children is not covered)		
Physician care and delivery	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Initial Newborn Exam	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Hospital Services	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Abortion Services[4]	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Hospital Services		
Pre-admission testing	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Post-discharge testing	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Organ transplant (bone marrow, cornea, lung,heart, heart-lung, kidney, liver, pancreas, pancreas/kidney)	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Emergency Services: Accident related, Medical	The Plan pays 85%	
Non-emergency accident/illness	The Plan pays 85% after you pay a $35.00 co-pay	The Plan pays 65% after you pay a $35.00 co-pay
Skilled Nursing Facility	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Home Health Care	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Physical Therapy	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Private Duty Nursing	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Hospice Care		
Up to six months of life expectancy	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Mental Health and Nervous Disorders		
Inpatient and outpatient coverage	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Drug and alcohol abuse treatment		
Inpatient and outpatient coverage	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Other Services		
Immunizations[5]	The Plan pays 85% after	The Plan pays 65% after

[3] Treatments will be reviewed for medical necessity

[4] Elective abortions are not covered

	deductible	deductible
Ambulance	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Durable medical equipment	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Oral surgery and oral accident	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Routine hearing exams and hearing aids	The Plan pays 80%	
Speech therapy[6]	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Chemotherapy	The Plan pays 85% after deductible	The Plan pays 65% after deductible
Podiatry	The Plan pays 85% after deductible	The Plan pays 65% after deductible

*** In-Network and Out-Of-Network Benefits are reimbursed based upon PPO contractual obligations and no benefits are paid for services over UCR for AultCare or over the Traditional Amount for Medical Mutual.**

Prescription Drug Benefits $25.00 Annual Deductible Per Person (retail only)[7]	
Brand Name	20% of billed amount subject to a $10 minimum co-pay/maximum 34 day supply
Generic	10% of billed amount subject to a $5 minimum co-pay/maximum 34 day supply
Mail Order	Same as over the counter with maximum 90 day supply (Not subject to annual deductible)

Weekly Sickness Benefits			
	Eligible Employees	**Eligible Retirees Under Age 65**	**Eligible Retirees Over Age 65**
Maximum Weekly Benefit Amount	$300.00 per week	Not Available	Not Available
Office and Salary and Apprentices	$300.00 per week or 66 2/3% of weekly pay whichever is less	Not Available	Not Available
Maximum Duration	26 weeks in any 12 consecutive months	Not Available	Not Available
Maximum Duration for Alcohol / Drug Abuse or Chemical Dependency	30 days in 12 consecutive months	Not Available	Not Available
Coverage limitations	See page 49	Not Available	Not Available

[5] Call your Claims Payor (either AultCare or Medical Mutual) for a listing of covered immunizations
[6] Treatments will be reviewed for medical necessity.
[7] The Fund has a mandatory generic substitution policy.

	Eligible Employees	Eligible Retirees Under Age 65	Eligible Retirees Over Age 65
Vision Care Benefits[1]			
Frames	Once every two calendar years per person		
Lenses & Exam	Once every calendar year per person		
Safety Glasses	Once every calendar year for Eligible Employees Only	Not Covered	Not covered
Dental Care Benefits [1]	100% for first $400.00 of Billed Charges per family, 75% of next $600.00 of Billed Charges per Family. However, essential pediatric oral care (excluding orthodontia) under the Patient Protection and Affordable Care Act of 2010 (PPACA) will be paid at 80% of the UCR fee per child under age 19. These services are not limited by the family annual maximum but will apply towards that maximum. Root Canals – 85% of billed charges limited to one root canal per individual per year.		

B. MEDICARE PARTICIPANTS AND ELIGIBLE DEPENDENTS OVER AGE 65 (Rates to be determined by Trustees).

[1] Vision Care Benefits and Dental Care Benefits are available to Retirees Over and Under Age 65 if elected upon entering the Retiree Program.

**** SPECIAL NOTE ****

Medicare

All Eligible Retirees and Eligible Dependents Over Age 65 (and Eligible Retirees under Age 65 but who are Medicare eligible) must be enrolled in both parts A and B of Medicare. Medicare will be your primary insurance coverage. The Fund will only pay what Medicare considers a Covered Expense under the Medicare Rules, and then we only pay the balance which Medicare does not pay, subject to the limitations set forth elsewhere in this SPD. The Fund is secondary on all claims. See the Article on Coordination of Benefits in this SPD at page 81 for more information on coordination with Medicare. Please submit all medical claims directly to Medicare and any remaining balances to Canton Electrical Welfare Fund, 33 Fitch Boulevard, Austintown, Ohio 44515 for payment consideration.

Summary of Benefits

Basic Benefits (Rates to be established by Trustees)

Only offered at time of initial eligibility into this class or at return from HMO as provided hereinafter.

Part A Benefit:

100% of the Part A Deductible each Benefit Period.
100% of the Coinsurance Amount for Days 61-90.
100% of the Coinsurance Amount for Days 91-150 (Lifetime Reserve Days).
100% of Medicare Eligible Expenses after Lifetime Reserve Days Used (Maximum – 365 Days).
100% of the Coinsurance Amount for Skilled Nursing Facility for Days 21-100.
100% of the cost of the first three (3) pints of blood.

Part B Benefit:

100% of the Part B Deductible.
20% of Medicare Approved Charge (After Part B Deductible).
100% of the cost of the first three (3) pints of Blood.

Hearing Aids: 80% of billed charges (subject to limitation on page 47.

Medical Supplies and Equipment: 80% of billed charges (subjection to limitation on page 47).

Prescription Drug Benefit (subject to limitation on page 55).

Optional Benefits (Rates to be established by Trustees)

Vision and Dental Benefits (subject to the limitation on pages 52-55).

Optional Benefits for those electing to participate in HMO (rates to be established by the Trustees)

Prescription Drug and/or Vision and Dental Benefits (subject to the limitation on pages52-58).

C. SUPPLEMENTAL BENEFITS FOR ALL ELIGIBLE PARTICIPANTS AND DEPENDENTS

	Eligible Employees	**Eligible Retirees Under Age 65**	**Eligible Retirees Over Age 65**
Life Insurance Benefits (Benefits provided under contract with Amalgamated Life)			
Life Insurance Coverage	Eligible Participant Only	Eligible Participant Only	Eligible Participant Only
Amount	$25,000.00	$10,000.00	
Accidental Death & Dismemberment Benefits			
Coverage	Eligible Participant Only	Not Available	Not Available
Accidental Death	$25,000.00	Not Available	Not Available
Loss of Both Hands	$25,000.00	Not Available	Not Available
Loss of Both Feet	$25,000.00	Not Available	Not Available
Loss of Both Eyes	$25,000.00	Not Available	Not Available
Loss of One Hand and One Foot	$25,000.00	Not Available	Not Available
Loss of One Hand and One Eye	$25,000.00	Not Available	Not Available
Loss of One Foot and One Eye	$25,000.00	Not Available	Not Available
Loss of One Hand	$12,500.00	Not Available	Not Available
Loss of One Foot	$12,500.00	Not Available	Not Available
Loss of One Hand	$12,500.00	Not Available	Not Available
Loss of One Eye	$12,500.00	Not Available	Not Available

VI. EXPLANATION OF MEDICAL BENEFITS

A. EXPLANATION OF MEDICAL BENEFITS FOR ELIGIBLE EMPLOYEES, ELIGIBLE RETIREES UNDER AGE 65, ELIGIBLE OFFICE AND SALARY PARTICIPANTS OR ELIGIBLE DEPENDENT

If you are an Eligible Employee, Eligible Retiree Under Age 65, Eligible Office and Salary Participant or Eligible Dependent of any of these Participants, then your covered Medical Benefits are explained in this Section. If you are a Retiree over Age 65 your Medical benefits may differ depending upon Medicare Rules. These Medical Benefits are explained beginning on page 50.

Your Plan has contracted with two separate Claims Payors in order to provide improved services and benefits for you and your Dependents. Accordingly, there are situations in which you may be responsible for the costs of your Medical Benefits even though they are otherwise covered under this Section of which you must be aware. The Claims Payors have contracts with Providers and Physicians which afford the Plan and you discounts and improved benefits. However, the Claims Payors may not have a contract with your particular hospital or physician. You should be aware of whether your hospitals and physicians are in the network of providers under your particular Claims Payor. If your hospital or physician is not included in your Claims Payor's Network, the Provider or Physician is not bound by a payment arrangement with your Claims Payor and you may be responsible for all or a portion of the charges. All charges applied to deductibles, co-payment and co-insurance amounts are always your responsibility. If you have any questions, please call the Fund Office or your Claims Payor.

The Plan pays for Covered Services as specified in the Schedule of Benefits beginning at page 1.

The following describes the Covered Services available when provided and billed by Providers. These Covered Services must be Medically Necessary unless otherwise specified.

Preventive Care:

A. Routine Mammogram Services - The Plan will provide coverage for one routine mammogram per Covered Participant or Eligible Dependent per Calendar Year.

B. Routine Gynecological/ Pap Exam Services - The Plan will provide coverage for one routine pap smear per Covered Participant or Eligible Dependent per Calendar Year.

C. Child Health Supervision Services (Well Baby Care) – The Plan will provide coverage for a History and Physical examination, development assessment, anticipatory guidance and laboratory services and immunizations from birth up to age twenty-six (26). Intervals are based on the current Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics ("AMP"). Immunizations

will be covered based on physician recommendation as the AMP schedule for immunizations varies based on the latest medical findings or research.

Excluded Services:

- Services which are covered to any extent under any other benefit section of the Plan.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Services not performed by a physician under his/her direct supervision during a single visit.
- Medicine, drugs, appliances, equipment or supplies.
- Dental exams.

Mental Health Care Services:

Mental health care services are provided for the diagnosis, evaluation or treatment of mental illness. Benefits are generally not payable for the treatment of a mental deficiency or mental retardation once the condition is diagnosed. For example, medical expenses for diagnosis of Downs Syndrome or Autism are covered expenses however the treatment of such condition by therapy or otherwise is not covered.

Drug Abuse and Alcoholism Services:

Detoxification and rehabilitation services are provided for the treatment of Drug Abuse or Alcoholism in addition to the appropriate services listed in the Mental Health Care Services section.

In order to be eligible for inpatient benefits the covered person must complete the program provided for alcohol and drug abuse.

Services not covered under this benefit include:

- Treatment not prescribed and performed by a physician or licensed psychologist.
- Legal services, recreational, vocational, financial, or educational counseling, except as part of a chemical dependency treatment program.
- Detoxification or drug withdrawal programs not rendered by a hospital or as part of a maintenance program.
- Personal comfort items.
- Marriage or family counseling except as part of a psychiatric treatment program.
- Charges for services provided by a Social Worker.

Physician Services:

A. Routine Adult Physical - The Plan will cover one routine physical exam per Covered Participant or Eligible Dependent per Calendar Year. However, physical

examinations or services solely required by an Insurance company to obtain insurance, by a governmental agency such as the FAA, DOT, etc. or in order to begin or to continue working are not covered if you have already exhausted your annual routine physical exam.

B. Office Visits - Medical Care and consultations to examine, diagnose, and treat an injury, ailment, condition, disease, disorder or illness are Covered Services.

C. Routine Immunizations - Coverage of all routine immunization services as allowed under the Laws of the State of Ohio. Call your Claims Payor to determine whether an immunization is covered.

D. Allergy Testing and Treatments - Allergy tests which are performed and related to a specific diagnosis are Covered Services. Desensitization treatments are also covered.

Surgery Services:

A. Sterilization procedures - Such as tubal litigations, and vasectomies, regardless of Medical Necessity. However, reversal of sterilization procedures are not covered.

B. Oral Surgery - This must be done by a Physician or Other Professional performing within the scope of his license. Oral Surgery benefits only include the following procedures:

- Mandibular staple implant, except when done to prepare the mouth for dentures.
- Maxillary or mandibular frenectomy.
- Operative and cutting procedures provided for the treatment of diseases and injuries of the mandible and maxilla.
- Surgical removal of impacted teeth, whether partially or completely covered by bone or soft tissue.
- Dental root resection (apicoectomy). Excision of tumors and cysts.
- Alveolectomy. Gingivectomy.
- Osseous surgery.

Also included is the application of anesthesia and/or injections of pain killers such as Decahedron, penicillin, or Novocain performed in association with covered procedures.

C. Cosmetic Surgery:

Cosmetic and re-constructive surgery shall be payable as other surgeries ONLY if one of the following conditions exist:

- Surgery is for the correction of conditions resulting from accidental injuries or traumatic scars from birth,

- Surgery is for the correction of congenital anomalies and treatment must be necessary to restore or correct a normal body function or to relieve pain or other symptoms;
- Surgery is for reconstruction to correct deformities resulting from Medically Necessary Surgery, due to malignancy or fibrocystic disease.

Please refer to page 108 for the Women's Health and Cancer Rights Act of 1998.

D. Multiple Surgical Procedures – For AultCare, when one or more surgical procedures are performed during one operation, the main procedure will be paid at one hundred percent (100%) of the benefit and the subsequent procedures (up to four (4) additional unless more are approved by the UM Department of AultCare) will be paid at fifty percent (50%) of the benefit.
As for Medical Mutual, when two or more surgeries are performed through the same body opening during one operation, you are covered only for the most complex procedure. However, if each surgery is mutually exclusive of the other, you will be covered for each surgery. Incidental surgery is not covered.

When two or more surgical procedures are performed through different body openings during one operation, you are covered for the most complex procedure, and the Traditional Amount for the secondary procedure will be half of the Traditional Amount for a single procedure.

If two or more foot surgeries (podiatric surgical procedures) are performed, you are covered for the most complex procedure, and the Traditional amount will be half of the Traditional Amount for the next two most complex procedures. For all other procedures, the Traditional Amount will be one-fourth of the full Traditional Amount.

E. Assistant at Surgery - A Physician's help to your surgeon in performing covered Surgery is covered when a house staff member, intern or resident is not available.

F. Anesthesia - Administration of anesthesia, done in connection with a Covered Service, by a Physician, Professional Other Provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are covered during coronary angioplasty surgery.

G. Second Surgical Opinions – A second surgical opinion and related diagnostic services to help determine the need for elective covered surgery recommended by a surgeon are covered but are not required. A second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the surgery. This benefit is not covered while you are an Inpatient of a Hospital.

If the first and second surgical opinions conflict, a third opinion is covered. The surgery is a Covered Service even if the Physicians' opinions conflict.

Diagnostic Services:

The following services can be provided to an Inpatient or an Outpatient and billed by a licensed Physician, Hospital, or independent laboratory:

- radiology, ultrasound and nuclear medicine.
- laboratory and pathology services.
- a pathologist's interpretation of a clinical examination or laboratory test.
- EKG, EEG and other electronic diagnostic medical procedures.
- magnetic resonance imaging (MRI) services, when medically necessary.

Maternity Services:

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and miscarriage. However, abortions are only Covered Services when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Covered Dependent children are not eligible for maternity benefits.

Maternity benefits will be payable only if the Eligible Participant or Dependent Spouse is eligible for benefits on the date of delivery.

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

Inpatient Services:

Benefits are payable for inpatient Hospital confinement when medically necessary for the treatment of a covered illness or injury. Eligible Inpatient Services include:

A. Bed, Board and General Nursing Services -

- a semiprivate room.
- a private room, when medically necessary. However, if you simply request a private room, the Plan will provide benefits only for the Hospital's average semiprivate room rate.
- a bed in a special care unit approved by the Plan. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.

B. Ancillary Services -

- operating, delivery, treatment rooms and equipment.

- medications and Prescription Drugs.
- blood transfusions, including administration, blood derivatives and blood typing, but excluding whole blood, blood plasma, blood components, blood storage, and the services of blood donors.
- anesthesia, anesthesia supplies and services given by an employee of a Hospital.
- Oxygen and other gases.
- medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

C. **Medical Care Visits** - The personal examination given to you by your Physician or Other Professional Provider. Consultations are not a part of this benefit.

D. **Intensive Medical Care** - Constant attendance and treatment when your condition requires it.

E. **Concurrent Care** - Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Concurrent care is also care by two or more Physicians during one Hospital stay for two or more unrelated conditions.

F. **Diagnostic Surgical Procedures** - A surgical procedure to diagnose your condition while you are in the Hospital. If you are hospitalized less than four (4) days, we only cover the diagnostic surgical procedure. If you are hospitalized four (4) days or more, we cover the diagnostic surgical procedure and Medical Care Visits except for the day the surgical procedure was performed. This means that the Plan shall not cover Physician charges on the day of surgery.

G. **Consultation** - A personal bedside examination by another Physician or Other Professional Provider, performed within the scope of his license, when requested by your Physician. The Physician or Other Professional rendering the consulting service must be board-eligible and possess the knowledge, training and skill needed to provide this service. Consultation services are not covered if the consultant subsequently takes charge of the patient. However, once the consultant has taken charge of the patient, we will consider him the treating Physician. The Plan will not provide benefits for both the treating Physician and the Physician who was initially the treating Physician for services rendered during the same time period. Staff consultations required by Hospital rules are not covered.

H. **Newborn Exam** - The first inpatient visit to examine a newborn.

I. **Excluded Services** - For Inpatient admissions, the primary purpose of which is: Diagnostic Services, Custodial Care; rest care; environmental change; or treatment by physical means when these services could have been performed on an Outpatient basis and it was not Medically Necessary that you be an Inpatient to receive them.

Special Services:

A. Pre-Admission Testing - Outpatient tests and studies required for your scheduled Hospital admission as an Inpatient which would have been covered as an Inpatient. The tests must be done within twenty-one (21) days prior to your admission.

B. Post-Discharge Testing - Outpatient tests and studies required as a follow-up to an Inpatient Hospital stay. The tests must be done within seven (7) days after your discharge.

C. Blood/ Plasma – Whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing which are medically necessary for inpatient or outpatient services are covered. Charges related to blood donation for blood that is otherwise available without a charge or for blood storage when not provided by a Hospital are not covered.

Organ Transplant Services:

This Plan will provide benefits for the Transplant of bone marrow, cornea, heart, kidney, heart and lung, liver, lung, pancreas, and pancreas/kidney for those Participants and Eligible Dependents with a condition for which they need a human organ transplant. The rules which must be followed prior to obtaining the transplant are detailed based upon your own Claims Payors rules and guidelines. However, this benefit requires that you obtain approval from your Claims Payor prior to the Transplant in order to assure that your transplant and all related treatment is covered.

If your Physician has addressed the issue of an Organ transplant with you as necessary due to your medical condition, contact your Claims Payor directly to discuss your responsibilities.

Generally, all organ transplants, just like all other services, must be Medically Necessary. Transplants which are considered Experimental, Investigational or Unproven for the specific condition are **not** Covered Services. Covered Services related to a transplant include Hospital confinement, surgical procedures, anesthesia administration, pathological studies, pre-surgical compatibility testing, preservation of the organ, and the transportation of the organ.

Predetermination of Benefits - the purpose of Pre-determination of Benefits is to assure that a proposed transplant program is covered. After your Physician has examined you, he or she must provide the Claims Payor with:

- the proposed treatment plan for the transplant program;
- the name and location of the proposed transplant center; and
- copies of your medical records, including diagnostic reports for the Plan to determine the suitability and Medical Necessity of the transplant services. Such determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ.

The Plan may also elect to have you examined by a Physician of our choice. We will then notify you and your Physician if the transplant services will be covered.

Donor Benefits – benefits necessary for obtaining an organ/tissue from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions.

Donor benefits include treatment of immediate post operative complications if medically necessary as determined by Claims Payor. Such coverage is available for only so long as the recipient's coverage is in effect.

Excluded Services, Supplies and Charges –

- Those which are not furnished through a course of treatment which has been approved by the Claims Payor;
- For other than a legally obtained human organ; or
- For travel time and travel related expenses of a donor.

Emergency Services:

A. Emergency Admission Services - Services that relate to an admission as an Inpatient in a Hospital directly from a Hospital emergency room for the sudden and acute onset of an injury, ailment, condition, disease, disorder or illness with acute symptoms that are so severe that you are considered to be unstable and unable to be transferred to another Hospital and which, in the absence of immediate and ongoing medical attention as an Inpatient, would reasonably result in:

- permanently placing the Covered Person's health in jeopardy;
- serious impairment to bodily functions;
- serious and permanent dysfunction of any body organ or part; or
- other serious medical consequences.

B. Emergency Accident Care - In order for the following services to be considered Covered Services, they must be the result of an accident which occurred while this coverage is in effect and be rendered within seventy-two (72) hours of the occurrence of the accident. We will provide coverage for:

- outpatient hospital services.
- medical, surgical and anesthesia services.
- diagnostic tests and services.
- ambulance services to and from the hospital.
- physical therapy.
- private duty nursing.
- the application of splints and casts to broken bones.
- crutches, splints, bandages, medications and dressings.

For purposes of this Benefit, the Plan defines an Accident as an unforeseen injury to the body causes by unexpected, sometimes violent means.

C. Emergency Outpatient Hospital Services -

- Medical, surgical and anesthesia services.
- Diagnostic tests and services.
- Ambulance services to and from a Hospital.
- Physical Therapy.

D. Emergency Private Duty Nursing -

- the application of splints and casts to broken bones.
- Crutches, splints, bandages, medications and dressings.

E. Emergency Medical Care - The interpretation of diagnostic tests and the treatment of a Medical Emergency are covered which include heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions which the Plan determines to be Medical Emergencies.

If you have an Emergency Medical Condition, go to the nearest hospital or dial 911 for Emergency Services. An Emergency Medical Condition is any medical condition that is severe enough to cause a prudent layperson with an average knowledge of health and medicine to believe that the absence of immediate medical attention could result in any of the following:

(1) Placing the health of an individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

Emergency Services will be Covered according to your Schedule of Benefits. If you go to a non-AultCare or non-Medical Mutual facility, payment may be limited to UCR or the Traditional Amount.

If Emergency Facilities are used and it is determined by the Plan that the situation was neither an Accident or an Emergency Medical Condition, Covered Services will be paid at the level of coverage stated in the Schedule of Benefits under Non-Emergency Care.

Skilled Nursing and Extended Care Services:

The same benefits available to an Inpatient of a Hospital are available to an Inpatient of a Skilled Nursing Facility. Such services must be skilled care and authorized and provided pursuant to your Physician's Plan of Treatment. Your Physician must certify initially and every two (2) weeks that you are receiving Skilled Care and not merely Custodial Care.

No benefits are payable for the following:

- Once a patient can no longer significantly improve from treatment for the current condition as determined by the Plan,
- for Custodial Care, rest care, or care for someone's convenience.

Home Health Care Services:

Charges for home health care services and supplies are covered only for care and treatment of an injury or sickness where Hospital or Skilled Nursing Facility confinement would otherwise be required. The Home Health Care Services must be provided under a Home Health Care Plan created and monitored by your Physician.

The following are Covered Services when you receive them from a Hospital or a Home Health Care Agency:

- professional services of a registered or licensed practical nurse; treatment by physical means, occupational therapy or speech therapy; medical and surgical supplies;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients; and
- home health aide visits when you are also receiving covered nursing or Therapy Services.

Excluded Services:
The Plan does not pay home health care benefits for any services or supplies not specifically listed in this Home Health Care Services section. Examples are:

- dietitian services;
- homemaker, housekeeping services;
- food or home delivered meals; and
- Custodial Care, rest care or care for someone's convenience.

Private Duty Nursing Services:

The services of a registered, licensed vocational or licensed practical nurse when ordered by a Physician. Such services must be certified initially and every thirty (30) days by your Physician for a Medical Necessity review. Nursing services do not include care which is primarily non-medical or custodial in nature such as bathing, exercising or feeding.

Home Services - Services that require a registered, licensed vocational or licensed practical nurse's skills. We do not pay for a nurse who usually lives in your home or is a member of your Immediate Family. Nurse's notes must be sent in at the time a claim is submitted.

Hospice Services:

Hospice care consists of health care benefits provided to a terminally ill Covered Person in his home. These benefits will begin when the prognosis of life expectancy is estimated to be six months or less. A treatment plan must be developed and submitted to your Claims Payor for our approval by the Covered Person's Physician and the Provider of the hospice care benefits. All Covered Services must be provided by a licensed hospice organization or a hospice program sponsored by a Hospital or Home Health Care Agency and approved by the Claims Payor. The Covered Services which are listed in the Home Health Care Services section are also considered hospice services. In addition, your coverage Includes:

- acute Inpatient hospice care;
- respite care;
- dietary guidance;
- durable medical equipment;
- home health aide visits; and
- bereavement counseling for family members.

Approved Prescription Drugs will be limited to a two-week supply per Prescription Order or Refill. These Prescription Drugs must be required for palliative or supportive care.

Excluded Services:
In addition to the excluded services listed in the Home Health Care Services section, no hospice services will be provided for:

- Physician visits.
- volunteer services.
- spiritual counseling.
- chemotherapy or radiation therapy if other than palliative.

Ambulance Services:

These benefits must be provided by a fully-equipped Hospital or professional ambulance service. Your coverage is limited to local ground transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- from your home, scene of an accident or Medical Emergency to a Hospital.
- between Hospitals.
- between a Hospital and Skilled Nursing Facility.
- from a Hospital or Skilled Nursing Facility to your home.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If there are none, you are covered for trips to the closest such facility outside your local area.

Transportation will also by covered when provided by a professional ambulance service for other than local ground transportation but only when special treatment is required

and the transportation is to the nearest Hospital qualified to provide the special treatment.

Medical Supplies and Equipment:

A. Medical and Surgical Supplies - These supplies include syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use such as elastic bandages or thermometers.

B. Durable Medical Equipment - Durable medical equipment must be prescribed by a Physician or Other Professional acting within the scope of his license. It must serve only a medical purpose and must be able to withstand repeated use. You may rent or purchase the equipment; however, the Plan will not pay more in total rental costs than the customary purchase price, as determined by the Plan. Before renting or purchasing the durable medical equipment, you should contact your Claims Payor.

C. Prosthetic Appliances - The purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:

- replace all or part of a missing body organ and its adjoining tissues.
- replace all or part of the function of a permanently useless or malfunctioning body organ, such as hearing aids.

Excluded Services:

- dental appliances.
- replacement of cataract lenses unless needed because of a lenses prescription change,
- elastic bandages.
- garter belts or similar devices.
- orthopedic shoes which are not attached to braces.

D. Orthotic Devices - Orthotics are defined as foot devices that are more than supportive devices for foot/feet, must be medically necessary, and should meet the same requirements as durable medical equipment.

Dental Services under the Medical Plan:

Dental services are payable for certain hospital charges relating to Oral Surgery and other services which arise from accidental injury to the jaws, sound natural teeth, mouth or face that occurred on or after your Effective Date.

Oral surgery including bony impacted extractions, and root canals necessary as the result of an accident are covered under this Benefit.

Hearing Benefits

Services and Supplies for the following hearing benefits are Covered if provided by a provider or physician acting within the scope of their licenses. To be eligible for the hearing benefits, you must obtain a medical exam of the ear by a Physician-specialist. The exam must result in the determination that a hearing aid would compensate for the loss of hearing acuity. This exam would be covered under your Physician services benefit.

Covered Hearing Services include:

- **Audiometric Examination**- are covered when they are performed by a Physician-specialist or Audiologist and are performed in conjunction with the most recent medical examination of the ear.
- **Hearing Evaluation Tests** – are covered when they are performed by a Physician-specialist or Audiologist and may include the trial and testing of various makes and models of hearing aids to determine which will best compensate for the loss of hearing. This Evaluation must be indicated by the most recent Audiometric Examination.
- **Hearing Aids** – One conventional hearing aid per ear will be covered for either an in-the-ear model, behind-the-ear model (including air conduction or bone conduction types), or on-the-body model. A non-conventional hearing aid, such as a digital programmable or premium hearing aid, will be covered to the allowable reimbursement of a conventional hearing aid.
- **Conformity Evaluations**- are covered follow up visits to the prescribing Physician-specialist or Audiologist and must be an evaluation of the performance of the prescribed hearing aid to determine the conformance of the hearing aid to the prescription.

Excluded Services:

- For hearing aids ordered while the participant is Covered in the Plan, but delivered more than sixty (60) days after your coverage ends
- For eyeglass type hearing aids to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one hearing aid
- For replacement of hearing aids that are lost or broken
- For replacement parts and repairs of hearing aids
- Which are not prescribed by or performed by or upon the direction of a Physician-specialist or Audiologist
- For unusual services requested by you or your Dependent of the Physician-specialist or Audiologist

Therapy Services:

Services or Supplies used to promote recovery from an illness or injury including the following are Covered Services. However, treatment as stated below must be rendered by a licensed therapist acting within the scope of his/her license.

- **Radiation Therapy** - The treatment of disease by X-ray, radium, or radioactive isotopes.
- **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
- **Dialysis Treatments** - The treatment by dialysis methods of an acute or chronic kidney ailment, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.
- **Outpatient Cardiac Rehabilitation Services** - Payment is provided for Outpatient cardiac rehabilitation services which are Medically Necessary as the result of a cardiac event. It must be expected that the therapy will result in a significant improvement in the level of cardiac functioning. All cardiac rehabilitation services must be provided by a Hospital.
- **Physical Therapy including Chiropractic Services** - The treatment(s) given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Such services include physical treatment(s), hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, including chiropractic treatments. Your Physician must certify that treatment(s) are necessary and the Plan must make a determination that the treatment(s) are medically necessary.
- **Respiratory Therapy** -Introduction of dry or moist gases into the lungs for treatment purposes and must be provided and billed by a Hospital.
- **Hyperbaric and Pulmonary Therapy** - must be provided and billed by a Hospital in order to be considered a Covered Service.
- **Inpatient Speech and Occupational Therapy** - This must be provided and billed by a Hospital or Skilled Nursing Facility in order to be considered a Covered Service.
- **Outpatient Speech Therapy** - In order to be considered a Covered Service, this therapy must be performed by a certified/licensed therapist and be Medically Necessary due to a medical condition such as a stroke, aphasia, dysphasia, or post-laryngectomy.
- **Outpatient Occupational Therapy Services** - Payment is provided for Outpatient Occupational Therapy Services which are Medically Necessary. It must be expected that the therapy will result in a significant improvement in the level of functioning and that improvement will occur within sixty (60) days of the first treatment. All Occupational Therapy Services must be performed by a certified licensed Occupational Therapist or Physical Therapist. Occupational Therapy Services are not Covered Services when a patient suffers a temporary loss or reduction of function which is expected to improve on its own with increased normal activities.

Podiatry Services

The skills of foot care are practiced by those in the field of medicine called podiatry or chiropody. Additionally, many general Surgeons practice podiatry as part of their overall patient care.

The Plan excludes foot care only to improve the comfort or appearance, such as care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like. Corrective surgery for birth anomaly, bone spurs, bunions, or

hammertoes, are covered under the Plan. Medically necessary laboratory and x-ray charges for podiatry services are payable.

Nutritional Counseling

The Plan will provide coverage for nutritional counseling as part of the medically necessary management and treatment of cardiovascular disease, seizures, diabetes, hypertension, kidney disease, eating disorders, GI disorders, epilepsy, renal failure, metabolic disorders, heart disease, liver disease, and high cholesterol. This service is available for up to four (4) visits per Plan Year and must be performed by a qualified health professional such as a registered dietitian or licensed nutritionist. Further, such counseling is provided only following an appropriate physician's written diagnosis of the disease state (s) at issue. Payment for this benefit will be in accordance with the claims payment obligations set by the Plan.

B. EXPLANATION OF MEDICAL BENEFITS FOR MEDICARE ELIGIBLE PARTICIPANTS (SEE SUMMARY OF BENEFITS)

This section describes what is designed to supplement your Medicare Benefits. The Fund will pay part of your Medicare Eligible Expenses that are Medicare Approved Charges, but are not paid by Medicare. The Fund will pay these benefits as long as you are enrolled in both Part A and Part B of Medicare and Medicare has paid their portion.

BASIC (CORE) BENEFITS

MEDICARE PART A BENEFIT:

The following benefits are provided for Hospital Services, Medicare Part A:

(1) The Medicare Eligible Expense you incur for the Hospital Coinsurance Amount from the 61st day through the 90th day of your continuous Hospital stay.

(2) The Medicare Eligible Expense you incur for your Hospital stay for each Medicare lifetime inpatient reserve day used; and

(3) When you have used up your Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of the Part A Medicare Eligible Expenses for your Hospital stay paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a Policy Maximum Benefit of an additional 365 days.

Lifetime reserve days—In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Inpatient Hospital Care
Medicare covers:
• Up to 90 days of inpatient hospital services in each benefit period
•An additional 60 lifetime reserve days

A benefit period begins when you are admitted to the hospital and ends when you have been out of the hospital for 60 days, or have not received Medicare-covered care in a skilled nursing facility (SNF) or hospital for 60 consecutive days from your day of discharge.

Medicare provides 60 lifetime reserve days of inpatient hospital coverage following a 90-day stay in the hospital. These lifetime reserve days can only be used once — if you use them, Medicare will not renew them. Very few people remain in a hospital for 150 consecutive days. In the rare event this does occur, most Medigap policies contain a benefit for an additional 365 hospital days during your lifetime. Medigap policies are designed to pay the copayments below; certain policies also pay the deductible. Learn more.

As of 2013, Medicare requires the following out-of-pocket inpatient hospital costs:
•Deductible of $1,184 for the first day you are a hospital inpatient. This single deductible covers the next 59 days in the hospital for the same benefit period.
•Copayment of $296 per day for days 61-90 (after you have been in the hospital for 60 days)
•Copayment of $592 per day for days 91-150 (after you have been in the hospital for 90 days; these are your 60 lifetime reserve days)

MEDICARE PART B BENEFIT:

The following benefits are provided for medical services, Medicare Part B:

When you incur a medical expense that is a Part B Medicare Eligible Expense, the Fund will pay for the Medicare Approved Charge that is not paid by Medicare as follows:

> After you pay the Part B Deductible, we will pay the expense you incur for the Part B Coinsurance Amount for the Medicare Approved Charge.

BLOOD BENEFIT:

We will pay under Medicare Part A and Part B the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations.

ADDITIONAL BENEFITS

MEDICARE PART A BENEFIT:

The following additional benefits are provided for Hospital and Skilled Nursing Facility services, Medicare Part A:

1. 100% of the expense you incur for the Medicare Part A Deductible; and

2. The actual billed charges up to the Coinsurance Amounts for the 21st through the 100th day in a Benefit Period for post-hospital Skilled Nursing Facility care eligible under Part A.

MEDICARE PART B BENEFIT:

The following benefits are provided for medical services, Medicare Part B:

The expense you incur for the Medicare Part B Deductible without regard to Hospital Confinement.

MEDICAL SUPPLIES AND EQUIPMENT

A. Medical and Surgical Supplies - These supplies include syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use such as elastic bandages or thermometers.

B. Durable Medical Equipment - Durable medical equipment must be prescribed by a Physician acting within the scope of his license. It must serve only a medical purpose and must be able to withstand repeated use. You may rent or purchase the equipment; however, the Plan will not pay more in total rental costs than the customary purchase price, as determined by the Plan. In addition, any durable medical equipment, at a cost that exceeds $1,500, needs to be pre-approved by the Board of Trustees prior to payment being made.

C. Prosthetic Appliances - The purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:

- replace all or part of a missing body organ and its adjoining tissues.
- replace all or part of the function of a permanently useless or malfunctioning body organ, such as hearing aids.

Excluded are dental appliances, replacement of cataract lenses unless needed because of a lenses prescription change, elastic bandages, garter belts or similar devises, or orthopedic shoes which are not attached to braces.

D. Effect of Changes in Medicare:

The benefits described above are intended to supplement, not to duplicate, the benefits of Medicare. If you are required to pay a greater or lesser amount because of a change in Medicare, the benefits will be adjusted. A benefit adjustment due to a change in Medicare will occur on the date such change takes effect.

VII. EXPLANATION OF DENTAL BENEFITS

Retirees are required to elect dental coverage and pay the required premium upon entering the Retiree Program.

The Fund will reimburse you for the cost of any Dental Benefits based upon the amounts and percentages specified in the Schedule of Benefits. Benefits are provided per family per calendar year for dental services provided by a licensed dentist or dental technician.

Many dentists will send a Determination of Benefits request to the Fund Office before beginning any extensive work. These requests are not required by the Plan and will not be resumed.

Orthodontic Treatments and Braces

Specifically included in the definition of dental services are services for performing orthodontia procedures. Orthodontia procedures are procedures for the straightening of the teeth, such as braces. Normally, the costs of these procedures is agreed upon prior to the first treatment. Treatment involves multiple visits to the dentist and many adjustments over a period of many months, possibly even years, depending upon the severity of treatment.

Most dentists require a contract stating the cost of these services and any payment terms, such as amount and length of payment. A copy of that contract must be submitted to the Fund Office. The contract will assist us in determining how payments will be made and in what amounts. Installment payments will be subject to the per family calendar year limitations, however, not to exceed thirty six (36) monthly payments.

Root Canals
The Plan will pay 85% of billed charges with a limit of one (1) root canal per individual per year.

Coordination of Benefits.
Benefits payable under this Plan will be reduced by the amount of benefits payable for vision services or materials provided under any other group insurance policy, any other hospital, surgical or medical benefit or service plan, union welfare or employee benefit plan for which any Employer directly or indirectly makes contributions or payroll deductions.

VIII. EXPLANATION OF VISION BENEFITS

Retirees are required to elect vision coverage and pay the required premium upon entering the Retiree Program.

The Plan will pay for the Vision Services incurred in the manner designated on the claim form according to the following schedule:

VISUAL ANALYSIS:	
	Base Payment
Vision Survey	$30.00
Vision Analysis without tonometry	$30.00
Vision Analysis with tonometry	$30.00

LENSES (Once every calendar year per person):	

(glass or plastic, including professional services).

When it is determined that eyeglasses are required for vision correction, the following allowances shall be paid (in addition to the allowance for Visual Analysis).

Single Vision Lenses	$35.00
Bifocal Lenses	$50.00
Trifocal Lenses	$65.00
Lenticular Lenses	$100.00

FRAMES (once every two calendar years per person):	
Frames	$80.00

CONTACT LENSES:	
Standard	$125.00
Disposable	$125.00

SERVICE FEES:	
Lenses	$25.00
Frames	$15.00

NOTE: The amounts listed herein are the base payments payable at 100% under the Vision Care Program. Any excess of charges, including sales tax, will be paid at 80% of billed charges, except for all excess charges relating to disposable contact lenses and frames.

Excluded Services:

No payment shall be made under the Vision Care Program for expenses incurred for:

(1) Professional services or material for:

(a) Visual field charting
(b) Orthopedics or vision training
(c) Subnormal vision aids
(d) Aniseiknoic lenses
(e) Two (2) pairs of glasses in lieu of bifocals
(f) Non-prescription lenses (standard safety glasses)
(g) Charges for tints, scratch resistant coating, anti-reflective coating, ultraviolet resistant coating and excess materials fees such as polycarbonate and oversize fees are excluded

(2) Charges for services which are not listed as included items.

(3) Medical or surgical treatment.

(4) Services or material provided as a result of any Workers' Compensation Law, or similar legislation, or obtained through or required by any government agency, or program, whether federal, or state or any subdivision thereof.

(5) Any eye examination required by an Employer as a condition of employment.

(6) The cost of providing one (1) pair of safety glasses once every calendar year will be paid in full for the Eligible Employee and for any office and salary employee where it is certified by the office and salary employee's employer that safety glasses are an occupational necessity.

(7) ALL COVERED PERSONS WILL BE ENTITLED TO RECEIVE LENSES AND EXAMINATIONS ONCE EVERY CALENDAR YEAR AND FRAMES ONCE EVERY TWO CALENDAR YEARS.

Coordination of Benefits.
Benefits payable under this Plan will be reduced by the amount of benefits payable for vision services or materials provided under any other group insurance policy, any other hospital, surgical or medical benefit or service plan, union welfare or employee benefit plan for which any Employer directly or indirectly makes contributions or payroll deductions.

IX. EXPLANATION OF PRESCRIPTION DRUG BENEFITS

The Prescription Drug Card Benefit covers charges for drugs prescribed by a physician, dispensed by a pharmacist and not available over the counter without a prescription.

A. Covered Expenses Include:

- **FDA Approved Drugs** – Except for exclusions in Paragraph C.
- **Federal Legend Drugs** - Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription."
- **State Restricted Drugs** -Any medicinal substance which may be dispensed by prescription only according to state law.
- **Compounded Medication** - Any medicinal substance which has at least one ingredient that is a Federal Legend or State Restricted Drug in a therapeutic amount.
- **Insulin** - Available by prescription only (includes insulin syringes).
- **Celebrex** - Available only upon pre-approval from physicians separate and apart from prescription.

B. Prescription Drug Administrator

A Prescription Drug Administrator has contracted with the Canton Electrical Welfare Fund to provide an efficient and cost effective program that will be easy for you and your Dependents to use when you purchase your prescriptions at a Network Pharmacy. Please check your pharmacy directory for locations nearest you. The Prescription Drug Card Program requires you to present your Identification Card at the pharmacy and pay the co-insurance amount in order to fill your prescription.

If you purchase your prescription drugs at a pharmacy that does not participate in the Prescription Drug Administrator's Network, then you will be required to pay the cost in full at the pharmacy. You must then submit a claim form for reimbursement to the Prescription Drug Administrator directly which is subject to annual deductibles and maximums.

If you choose the generic you will pay 10% of the cost of the prescription or a $5.00 minimum subject to the annual deductible.

If you obtain the brand name prescription you will pay 20% of the cost of the prescription or a $10.00 minimum subject to the annual deductible.

If you obtain a brand that has a generic equivalent you will be responsible to pay the difference of the cost between the brand name and the generic plus the brand name co-payment.

If you do not use your Identification Card, you will have to pay for your prescription in full and file a claim for payment directly to the Prescription Drug Administrator. The address for the Prescription Drug Administrator, telephone number and the time services are available are identified on page 115. You can also contact the Fund Office for the Claim Form.

This prescription drug benefit is subject to the Plan's overall Annual Maximum benefit limit.

If using a prescription benefit manager participant network, Participants will pay a 75% co-payment for Mail Order and Retail drugs for the following conditions:

- Nail Fungus
- Influenza
- Non-Sedating Antihistamines
- Acne

If using a prescription benefit manager participant network, Participants will pay a 100% co-payment* for Mail Order and Retail for medicines used for drugs for the following conditions:

- Smoking Cessation
- Erectile Dysfunction
- Contraceptives
- Obesity
- Anabolic Steroids
- Fertility
- Hair Growth
- Hair Removal
- Cosmetic Dermatology

C. Excluded Services, supplies, and charges

- Contraceptive Drugs and Devices;
- Anti-Obesity Drugs;
- Vitamins (except pre-natal vitamins or vitamins prescribed by a physician);
- Cosmetic Drugs;
- Fertility Drugs
- Retin-A is limited to Covered Persons under age 23;
- Anabolic Steroids and Growth Hormones;
- Therapeutic Devices;
- Artificial appliances;
- Fees for administering or injecting Prescription Drugs;
- Charges for more than a 90-day supply of Prescription Drugs;
- Any refill or a Prescription Drug, dispensed after one year from the date of the original Prescription Order;
- Drugs you can purchase without a Prescription, commonly called over-the-counter products;
- Prescription Drugs consumed or administered at the location where the Prescription Order is issued;
- Experimental or Investigational Drugs.
- Viagra
- Resulin

- Singulair - Coverage for the prescription drug Singulair now requires a letter of medical necessity, at least annually, for prior authorization to be submitted to the Fund Office.

D. Mail Order Pharmacy Services

Under the mail order pharmacy option, your Plan allows you to receive a ninety (90) day supply on a valid prescription order with copayments of 20% for Brand Name drugs and 10% for Generic drugs. With Brand Name drugs subject to a $10.00 minimum and generic drugs subject to a $5.00 minimum.

The Mail Order Pharmacy is an ideal option for Participants using maintenance medications used to treat chronic conditions, such as arthritis, diabetes, high blood pressure, etc. The Mail Order prescriptions will be delivered directly to your home by the U.S. Postal Service. Priority delivery is available for a postage charge.

Mail Order Procedure:

(1) You must complete a mail order patient profile form prior to your first order which lists information on you and your Dependents. This Form is available from Prescription Drug Administrator or the Fund Office, if needed.

(2) For your first prescription filled by the Mail Order, you need your Physician to write two prescriptions. One should be submitted to the Network Pharmacy in order to obtain your initial fill and the other should be sent to Sav-Rx by mail. The mail order prescription should be written for up to a ninety (90) day supply plus any additional refills. You will need to allow up to two (2) weeks for processing and delivery.

X. EXPLANATION OF LIFE INSURANCE BENEFITS

In the event of your death at any time or place while you are covered under this Plan, the Fund will pay to the beneficiary designated by you the sum as set forth in the Schedule of Benefits as a Life Insurance Benefit. In all cases, upon receipt of due proof that an Eligible Employee, Eligible Retiree or Office and Salary Participant died while covered under this Plan, the Trustees will authorize the payment of the amount of Life Insurance Benefits specified in the Schedule of Benefits to your Beneficiary.

For purposes of this Section the following definitions apply:

Beneficiary - Benefits for loss of life shall be paid to the beneficiary designated by the Eligible Participant, or if there is no beneficiary designated or surviving, to the estate of the decedent or in accordance with the Policy with the Plan. The Eligible Participant may designate a beneficiary or may change a previously designated beneficiary by filing with the Trustees a properly completed written request on a form satisfactory to the Trustees. Such designation or change shall take effect only upon receipt by the Fund Office. If no named beneficiary survives the Insured, the amount of insurance will be paid as follows:

1. to the Insured's spouse, if living; if not,

2. in equal shares to the then living children of the Insured, if any; if none,
3. in equal shares to the father and mother of the Insured, if living; if not,
4. in equal shares to the sister(s) and/or brother(s) of the Insured, if any; if none,
5. to the estate of the Insured.

If the beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, payment will not be made until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent the Fund from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

Assignment - The benefits provided under the Plan are not assignable.

Coverage - Life insurance benefits are provided for Eligible Participants only. In order to be an Eligible Participant, you must be an employee as defined in this SPD, and otherwise qualifies for coverage under this Plan. Life Insurance benefits are provided for Eligible Office and Salary Participants, Eligible Retirees over age 65 and Eligible Retirees under age 65 but are not available for Eligible Dependents.

Due Proof - A Certified copy of the Death Certificate. In the case of an accident, you must also submit any newspaper clippings and/or official reports which give details of the accident. In any event, proof of death must be received within two (2) years of the date of death.

XI. EXPLANATION OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Should an Eligible Employee or Office and Salary Participant be injured on or off the job while covered and sustain any of the following losses, independent of sickness and all other causes, within three hundred and sixty five (365) days from the date of the accident causing such loss, the Trustees will pay the Principal Sum as specified in the Schedule of Benefits for loss of life, both hands, both feet, sight of both eyes, one hand and one foot, one hand and the sight of one eye, or one foot and the sight of one eye.

The Trustees will pay one half (50%) of the Principal Sum for loss of one hand, one foot, or the sight of one eye.

The loss of hand or hands, or foot or feet, means cut or broken apart at or above the wrist joint or ankle joint, respectively. The loss of sight means at least sight in one eye is completely gone and cannot be recovered.

The total amount of benefits payable for all losses to any one (1) person resulting from any one (1) accident will not be greater than the principal sum allowed in the Summary of Benefits.

In the event the Trustees are unable to determine the cause of death, they shall reserve the right to consult such expert outside assistance as may be necessary to accurately determine the cause of death.

Benefits shall not be payable for any loss caused by or connected with:

(a) suicide or attempted suicide; or
(b) intentionally self-inflicted injury; or
(c) disease or mental infirmity or from the medical or surgical treatment or diagnosis for such disease or infirmity; or
(d) ptomaines; or
(e) bacterial infection except pyogenic infection which occurs through or with an accidental cut or wound; or
(f) war or any act of war, whether declared or undeclared; or
(g) travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
(h) the Eligible Participant being under the influence of any drug, except those prescribed by a physician, including alcohol, narcotics, hallucinogens and gas or fumes, which are taken or inhaled voluntarily; or
(i) by voluntary poisoning.

XII. EXPLANATION OF WEEKLY SICKNESS BENEFITS

Only Eligible Employees and Eligible Office and Salary Participants are Entitled to this Benefit.

When you are unable to work at the trade of an electrician or an occupation for which eligibility under this Plan is based due to a non-occupational accident or sickness and you are under the care of a legally qualified physician, the maximum weekly benefit amount as specified in the schedule of benefits will be paid to you. However, you must be actually employed or on the Union referral list at the time the accident or sickness occurs to be eligible for weekly benefits.

This weekly benefit will begin on the first day for an accident after a one (1) day waiting period and for an illness after a seven (7) day waiting period. The benefits will continue until the maximum duration payable during any and all disabilities as specified in the schedule of benefits.

During partial weeks of disability, you will be paid at the daily rate of one seventh (1/7th) of the Maximum Weekly Benefit Amount. Two (2) or more periods of disability are considered as one unless between periods of disability you have been released by your

physician to return to active full-time employment for four (4) continuous weeks (or you are on the Union referral list for four (4) continuous weeks; or unless the disabilities are due to causes entirely unrelated and begin after you have returned to full-time active work.

Upon receipt of your Physician's release, your Weekly Benefits for that illness will terminate.

Except for Office and Salary Participants, during the period of the receipt of Weekly Benefits, you will receive credit of thirty five (35) hours per week toward eligibility, not to exceed twenty six (26) weeks of credit in a calendar year.

If you are receiving a Weekly Benefit, you may be able to maintain your eligibility, refer to page 16.

XIII. BENEFIT EXCLUSIONS

We do not provide benefits for services, supplies or charges:

(1) For Retirees over age 65 or Retirees that are otherwise Medicare Eligible, the Plan does not pay any Covered Services that are not allowed under Medicare's Rules.

(2) Which are not prescribed by or performed by or under the direction of a Physician or Other Professional.

(3) Which are not performed within the scope of the Provider's or Physician's license.

(4) For Claims which are not submitted to your Claims Payor or Fund Office within twelve (12) months of date the claim was incurred.

(5) For charges for care, treatment, services and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care, including care, treatment, services and supplies which are experimental in nature.

(6) Charges Incurred in connection with any Hospital confinement or any surgical, medical, or other treatment services or supplies which are not recommended and approved by a Physician who is attending the covered individual.

(7) Which are for illness or injury occurring in the course of employment if benefits are available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party.

(8) Which are not Medically Necessary, duplicative or above UCR or the Traditional Amount as determined by the Plan.

(9) To the extent governmental units or their agencies provide benefits, except health departments as determined by AultCare or Medical Mutual.

(10) For an injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war, whether declared or undeclared.

(11) For an injury, ailment, condition, disease, disorder or illness that occurs as a result of an atomic explosion or other release of nuclear energy (except only when being used for medical treatment of a disease or injury of a Covered Person), whether in peace time or in war time and whether intentional or accidental.

(12) For which you have no legal obligation to pay in the absence of this or like coverage.

(13) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

(14) Received from a member of your Immediate Family.

(15) Incurred prior to or after you stop being a Covered Person except as specified under the Benefits After Termination of Coverage section.

(16) For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.

(17) Which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness.

(18) Primarily for outpatient, educational, vocational or training purposes.

(19) For the services of blood donors.

(20) For topical anesthetics or stand-by anesthesia, except as specified.

(21) Care and treatment of obesity, weight loss or dietary control whether or not, in any case, a part of the treatment plan for other sickness, except that nutritional counseling in the management and treatment of cardiovascular disease, seizures, diabetes, hypertension, kidney disease, eating disorders, GI disorders, epilepsy, renal failure, metabolic disorders, heart disease, liver disease, and high cholesterol is a covered benefit for up to four (4) visits per Plan Year and is provided only following an appropriate physician's written diagnosis of the disease state(s) at issue.

However, Gastric Restrictive Surgery (surgical treatment of morbid obesity) will be covered when medically necessary. For this, medical necessity is defined as follows:

(a) Documented five (5) year history of Morbid Obesity (body mass index (BMI) over 40 kg/m^2). Individual consideration may be given to patients who are unable to consistently keep weight below 40 kg/m^2; and

(b) Documented failure of non-surgical methods of weight reduction (documentations of a duration of at least one (1) year); and

(c) Absence of significant psychopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations; and

(d) Documentation of Participant's or Dependent's willingness to comply with pre-operative and post-operative treatment plans; and

(e) Participant or Dependent is at least eighteen (18) years of age; and

(f) Documentation that the Participant or Dependent has received counseling post-operatively regarding cosmetic difficulties.

Any Gastric Restrictive Surgery must be pre-certified and coordinated with Medical Mutual's or AultCare's Care Management Department. Gastric Banding is not covered under this Plan as an eligible expense. This benefit is subject to the Plan's overall annual maximum benefit limit.

(22) For marital, family or other counseling services, except as specified.

(23) For the treatment of sexual problems not caused by organic disease, except as specified.

(24) For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.

(25) For artificial insemination or in-vitro fertilization or any charges relating to male infertility.

(26) For or related to the treatment of temporal mandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporal mandibular joint dysfunction not caused by documented organic disease or physical trauma.

(27) For services and/or supplies for personal comfort convenience or hygiene items such as television, telephone, admission kits, lotion, powder, hair appointments, arid magazines, etc.

(28) For hypnosis, acupuncture, massotherapy or massage therapy.

(29) For telephone consultations, missed appointments, completion of a claim form, or copies of medical records.

(30) For fraudulent or misrepresented claims.

(31) Which are not specified as Covered Services or which are specifically excluded in the text of this document.

(32) For travel time and travel-related expenses of a Provider, Physician or Other Professional.

(33) For expenses 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.

(34) For travel, even though prescribed by physicians, convalescent, custodial or sanitarium care, rest homes.

(35) For services and/or supplies furnished during periods when the patient is temporarily absent from the hospital.

(36) To the extent that payment under this Plan is prohibited by law to which you or your family member is subject at the time expenses are incurred.

(37) To the extent that charges are otherwise payable as fully described under Coordination of Benefits.

(38) For, or in connection with, custodial care or housekeeping.

(39) For expenses incurred after termination of the Plan.

(40) For air conditioners, purifiers, humidifiers, dehumidifiers, whirlpools, heating pads, hot water bottles, hypo-allergenic pillows or mattresses or waterbeds and orthotics, unless other provided.

(41) For exercise equipment and nutritional supplements except vitamins as prescribed.

(42) For services rendered or billed for, by a school or halfway house or for a member of its staff.

(43) Milieu therapy, any confinement in an institution primarily to change or control one's environment.

(44) Claims for services and/or supplies for treatment of an accident/illness which occurred while committing a felony which results in a conviction.

(45) For radial keratotomy or keratoplasty.

(46) For chelation therapy.

(47) For oral chemotherapy which is not administered in a hospital.

(48) Care and treatment of an injury or sickness that results from engaging in a hazardous hobby for award, reward or profit. A hobby is hazardous if it is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Care and treatment of an injury or sickness that results from engaging in motorcycle use for transportation, water and snow skiing will be considered eligible expenses.

(49) For expenses incurred for protective items used by the Provider, Physician or Other Professional.

(50) For all taxes and surcharges, except for sales tax covered under the Vision Care Benefits.

(51) Charges for, or related to, pregnancy of a surrogate mother.

(52) Charges incurred for court ordered treatment and/or testing.

(53) Charges for, or related to, biofeedback.

XIV. FILING FOR PAYMENT OF YOUR BENEFITS

For Hospital and Medical Claims involving Aultcare Enrollees and Their Dependents and Other Types of Claims:

When you receive health care services:

- Show your identification card to the provider of service
- Ask the provider to file a claim for you

In the case that you and your dependents use Providers who participate in the Aultcare Network, the provider will submit a claim for you directly to Aultcare for payment.

However, if you use a Non-Participating or Out of Network provider or physician, it is your responsibility to submit the claim form to Aultcare for payment. Generally, you may have to file a claim under the following circumstances:

(1) When services are provided in hospitals or other health care institutions, which do not contract with Aultcare.

(2) When outpatient services are provided by hospitals outside of the geographic area served by your local Aultcare Program.

(3) When a provider has charged you for a service that you believe should be submitted to Aultcare.

(4) When you believe that the provider's claim submitted to Aultcare was inaccurate.

If you must submit a claim for hospital services received, you should:

- Obtain an itemized bill from the hospital, doctor or other service provider
- Obtain a claim form from Aultcare or the Fund Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

All claims for payment must include the following information:

- Name of the Participant
- Name and address of the provider of service (doctor, hospital, etc.)
- Patient's Name and relationship to the Participant
- Date of Service
- Diagnosis Codes
- Type of Service
- Amount Charged for each Service

Submit original itemized bills and make copies of these bills for your own records. Once submitted, itemized bills cannot be returned. When submitting an itemized bill, all information must be on the provider's pre-printed letterhead or stationery.

Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

Payment for these Non-Participating or Out of Network Providers will be made to you directly once you have met your deductibles, copayment and coinsurance obligations. It is your responsibility to provide this payment to your provider.

A claim is not filed until it is received by Aultcare. They will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, Aultcare may request additional information from you or the provider. You and/or your provider will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Fund, you will be notified by the Aultcare that the claim is denied with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or SPD provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

How to file a claim for Medicare Benefits

If you are covered by Medicare while a Participant under this Fund, be sure to show your provider your Medicare and Fund Identification cards. The necessary information to file with your secondary insurance is the Fund's Identification Card. Be sure to ask the provider if they will file your secondary Insurance or if you will be responsible to file yourself. Never assume that the provider will submit your claim to the Fund on your behalf. It is not the responsibility of the provider to submit for you although many of them do so as a courtesy and to insure that they receive their payments.

All claims must be submitted to Medicare first. When Medicare has processed the claim, you and your doctor will receive a Medicare Explanation of Benefits (EOB).
If the provider will be submitting your claim to the Fund for the 20% not covered by Medicare, they must send three (3) things to the address on the Fund's Identification card:

(1) A copy of the itemized bill.
(2) Something indicating that they have your signature on file to assign payment directly to the provider.
(3) A copy of the Medicare Explanation of Benefits.

If the provider submits all of the above, the payment from the Fund will be made directly to them. THE FUND WILL NOT PROCESS ANY CLAIM THAT IS NOT ACCOMPANIED BY A MEDICARE EOB.

If the provider will not submit to your secondary insurance, you have the option of submitting the claims yourself or sending the Medicare EOB's to the Fund Office. When submitting the claim yourself, you need to contact the Fund Office for a claim form and send it along with the Medicare EOB to the Fund. The Fund will send any payment to you. YOU IN TURN WILL BE RESPONSIBLE FOR PAYING THE PROVIDER.

You must submit originals of all itemized bills and the Medicare EOB. You should make copies of the itemized bills and Medicare EOB for your own records. Once your claim is received, the itemized bills and Medicare EOB cannot be returned.

To avoid delay in handling your claim, be sure your answers to any questions are complete and correct. This claim form must be accompanied by itemized bills showing:

(1) Person or organization providing the service or supply,
(2) Type of service or supply,
(3) Date of service or supply,
(4) Amount charged, and
(5) Name of patient.

A claim is not filed until it is received by the Fund Office. The Fund Office will process your post service claim, which will typically be the type of claim filed under the filing procedure outlined above, within thirty (30) days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your provider will have at least 45 days to submit the additional information.

When certain expenses are not eligible for payment under the Fund, you will be notified by the Fund Office that the claim is denied in whole or part with an exception of the reasons for the denial. This notification which is called a Notice of the Adverse Benefit Determination shall be in writing and will contain the following:

(1) The specific reason for the adverse benefit determination;

(2) The specific reference to the Plan and/or Summary Plan Description provision on which the averse benefit determination was based;

(3) A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

(4) The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;

(5) A notice of your right to a written explanation of any exclusion which affects your claim; and

(6) A description of the Fund's Appeals Procedure.

How to file a claim for Dental Benefits

If you receive services from any dental provider, you may be required to file the claim yourself. Some dentists will file the claim on your behalf once you supply them with the information from your identification card.

In order to complete the claim you need to do the following:

- Obtain an itemized bill from the dentist
- Obtain a claim form from the Fund Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

Itemized bills must contain the following information:

- Name of the Participant
- Name and address of the provider of service (doctor, hospital, etc.)
- Patient's full name and relationship to Participant
- Date(s) of service
- Description of the services performed on each date or description of the item
- Amount charged for each service/item

Please note: If you have already made payment for the services you received, you must also submit proof of payment with your claim form.

Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

You must submit originals of all itemized bills. You should make copies of the itemized bills for your own records. Once your claim is received, itemized bills cannot be returned.

If you have already made payment for the services you received, you must also submit proof of payment with your claim. In the event you do not provide proof of your payment to the provider, the payment from the Fund will be made to the provider directly on your behalf.

A claim is not filed until it is received by the Fund Office. They will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund Office may request additional information from you or dentist. You and/or your dentist will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Fund, you will be notified by the Fund Office that the claim is denied with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or SPD provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or

information is necessary;

- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

How to file a claim for Vision Benefits

If you receive services from any vision provider, you may be required to file the claim yourself. Some providers will file the claim on your behalf once you supply them with the information from your identification card.

Itemized bills must contain the following information:

- Name of the Participant
- Name and address of the provider of service
- Patient's full name and relationship to Participant
- Date(s) of service
- Description of the services performed on each date or description of the item
- Amount charged for each service/item

Please note: If you have already made payment for the services you received, you must also submit proof of payment with your claim form.

Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

You must submit originals of all itemized bills. You should make copies of the itemized bills for your own records. Once your claim is received, itemized bills cannot be returned.

If you have already made payment for the services you received, you must also submit proof of payment with your claim. In the event you do not provide proof of your payment to the provider, the payment from the Fund will be made to the provider directly on your behalf.

A claim is not filed until it is received by the Fund Office. They will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund Office may request additional information from you or the provider. You and/or your provider will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Fund, you will be notified by the Fund Office that the claim is denied with an explanation of the reasons for the denial. You will

receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or SPD provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

How to file a claim for Prescription benefits under the Sav-Rx Program

You will receive a personalized Sav-Rx Prescription Benefits Identification Card with eligible family status listed on the card. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating Sav-Rx pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will complete a claim form and ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase is not a claim for benefits. If you do not receive your prescription at the retail pharmacy due to a denial of coverage, you need to contact the Fund Office to make a claim for benefit coverage.

If you elect to have your prescription filled by a pharmacy other than a participating Sav-Rx pharmacy, do not use your Sav-Rx Prescription Benefits Identification Card. Follow the Claim Reimbursement Procedure described herein to obtain reimbursement of prescription expenses.

You can obtain a Sav-Rx Direct Reimbursement form from the Fund Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to the address on the form. Reimbursement will be made directly to you by Sav-Rx on the same basis as benefits would have been paid to a participating Sav-Rx pharmacy.

If you are not eligible for benefits at the time you contact the Sav-Rx pharmacy or in the event that the prescription is not a covered drug under the Fund, you must contact the Fund Office for additional information and to make a claim for coverage of the

prescription benefits. The Fund Office will review the claim and provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or SPD provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Fund's Appeals Procedure set forth below.

How to file claim for Death Benefits and Accidental Death and Dismemberment Benefits

Claims should be submitted to the Fund Office as soon as possible; do not delay in filing any claims.

Claims for Death benefits will be provided through the Fund Office. Your beneficiary must contact the Fund Office in order to obtain a claim form. Your beneficiary must submit the completed claim form with all required documentation to the Fund Office which includes a certified copy of the death certificate.

Generally, the Fund will notify your beneficiary of the decision on the claim for benefits within ninety (90) days. In the event that the Fund needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial ninety (90) day period.
When the claim for life insurance benefits falls within the Fund exclusions, your beneficiary will be notified by the Fund Office that the claim is denied with an explanation of the reasons for the denial. He/ she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The sections of the Plan and/or SPD upon which the adverse benefit determination was based;
- A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

How to file a claim for Weekly Disability Benefits

Claims should be submitted to the Fund Office as soon as possible; do not delay in filing any claims.

Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund Office notifies you of the delay.

If the Fund Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund Office receives the information from you, you will be notified of the decision on the claims within 30 days.

The Fund Office will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or SPD provision on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of this Fund's Appeals Procedure set forth below.

Proof of Claims

The Fund is not liable unless we receive written proof that Covered Services have been provided to you and your Eligible Dependents. We may require provider's notes or other documentation before proof of loss is considered sufficient to determine benefits.

Time limitations for submitting claims

Your claims or claims incurred by your Eligible Dependents, which are not filed within twelve (12) months after the initial date in which the claim was incurred will not be payable unless the failure to file was beyond the control of the Participant.

Our right to review claims

When a claim is submitted, either your Claims Payer or the Fund Office will review the claim to ensure that the service was Medically Necessary and that all other conditions for coverage are satisfied. The Fund will determine medical necessity. The fact that a Provider may recommend or prescribe the treatment does not mean that the service is automatically a Covered Service.

Settlement claims

All benefits provided by the Fund, other than for benefits for loss of time on account of disability, will be payable as soon as possible after the initial decision to pay the benefit is made as outlined above. Any payment made by the Trustees in good faith pursuant to this provision shall fully discharge the Trustees to the extent of such payment. If the Fund erroneously pays for services and the error is discovered later, then the Fund has the right to recover the overpayment and you are responsible to repay such amounts when requested.

Payment Directly to Providers

Benefits will be paid directly to the Provider on whose charge claim is based, without evidence of payment made by a member; except medical payment to providers who do not participate in the AultCare Network which will be paid to the member.

If any person to whom benefits are payable is a minor or, in the opinion of the Fund, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. However, if no request for payment has been made by his legal guardian, the Fund may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, the Fund may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters, or to the executors or administrators of your estate.

Physical Examination

The Fund at its own expense shall have the right and opportunity to examine the person of any Member whose Injury or Sickness is the basis of any claim, as often as it may reasonably require during the pendency of a claim.

XV. APPEALS PROCEDURE

First Level Review For Medical Claims Provided Through Aultcare

You or your authorized representative may appeal the decision by the Aultcare to deny any claim for medical benefits in whole or 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.

You may file a written notice of appeal to Aultcare at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. 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 Aultcare, giving the date of the Notice. The Appeal should be addressed as follows:

Aultcare
Attention Grievance and Appeals Coordinator
P.O. Box 6910
Canton, Ohio 44706

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.

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

AultCare will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", within thirty (30) days from receipt of your request. You will be notified of the decision of Aultcare as soon as possible after the decision is made.

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

- The specific reason for the denial;
- The sections of the Plan and/or SPD upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a Second Level Appeal to the Benefits Committee of the Board of Trustees.

Second Level Appeal

You or your authorized representative may appeal the decision on the First Level Appeal by AultCare to deny in whole or in part any claim for benefits. 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.

You may file a written notice of appeal to the Benefits Committee of the Board of Trustees at any time within sixty (60) days after the mailing of the Notice of Denial of the First Level Appeal. The written notice only needs to state your name, address,

social security number and the fact that you are appealing from the First Level Appeal decision of the Fund Administrative Manager, giving the date of the Notice. The Appeal should be addressed as follows:

Benefits Committee.
Canton Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

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.

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.

The Benefits Committee will consider your Second Level Appeal within thirty (30) days from receipt of your request. You will be notified of the decision of the Benefits Committee as soon as possible after the decision is made.

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

- The specific reason for the denial;
- The sections of the Plan and/or SPD upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;
- A notice of your right to file a voluntary appeal to the Board of Trustees as outlined below; and
- A notice of your right to file a lawsuit in federal court under ERISA Section 502(a).

Filing an Appeal Regarding Medical Claims Provided Through Medical Mutual

Expedited Review Process

A request for an expedited review must be certified by your Provider that your Condition could, without immediate medical attention, result in any of the following:

1. seriously jeopardize your life or health or your ability to regain maximum function or with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; or

2. in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The appeal does not need to be submitted in writing. You or your Physician should call the Care Management telephone number on your identification card as soon as possible.

Expedited reviews will be resolved within 72 hours after you have submitted the request, with a possibility of extending to five calendar days with good cause.

The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

Filing an Appeal

If you are not satisfied with a benefit or Medical Necessity determination decision, you may file an appeal. No more than two appeals on one claim will be considered in accordance with the procedures explained below.

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card. You may also write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

Medical Mutual
Member Appeals Unit
MZ: 01-4B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
FAX: (216) 687-7990

The request for review must come directly from the patient unless he/she is a minor or is an authorized representative.

You can choose another person to represent you during the appeal process, as long as Medical Mutual has a signed and dated statement from you authorizing the person to act on your behalf.

You may appeal if your claim is denied because Medical Mutual determined (1) the Services received or requested were not Covered Services or (2) the Services received or requested to be received were not Medically Necessary.

First Level Mandatory Appeal for Medical Necessity Denial

The Plan offers all Card Holders a first level mandatory appeal. You must complete this first level of appeal before any additional action is taken.

First level mandatory appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above.
Under the appeal process, there will be a full and fair review of the claim. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

You may submit written comments, documents, records and other information relating to the claim being appealed. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that you are appealing.

The appeal procedures are as follows:

Urgent Care Appeal

• You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child, or could affect the ability of the patient to regain maximum functions. The appeal must be decided within 72 hours of the request.

Pre-Service Claim Appeal

• You, your authorized representative or your Provider may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The

pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post Service Claim Appeal

• You, your authorized representative or your Provider may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

All notices of a denial of benefit will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based.
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, then that
- information will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request;
- upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- your right to bring civil action under federal law following the denial of a claim upon review, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

If your claim is denied for Medical Necessity at the first level mandatory appeal, you will be eligible for the Second Level Voluntary Internal Review Process.

Second Level Voluntary Internal Appeal to Medical Mutual

Unless your Group requires you to use an alternative dispute resolution procedure, if your first level mandatory appeal is denied, you have the option of a voluntary second level appeal by Medical Mutual. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the first level of appeal.

The voluntary second level of appeal may be requested at the conclusion of the first level mandatory appeal. The request for the voluntary second level of appeal must be received by Medical Mutual within 60 days from the receipt of the first appeal decision.

Medical Mutual will complete its review of the voluntary second level appeal within 30 days from receipt of the request.

The voluntary second level of appeal provides a full and fair review of the claim. There will be a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the first level mandatory appeal. All determinations of Medical Necessity, that are based in whole or in part on medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment.

The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination of your appeal.

Review Procedure for Medicare, Dental, Vision, Prescription, Death and Weekly Disability Benefits

You or your authorized representative may appeal the decision by the Fund Office to deny any claim for dental, vision, death, accidental death, accidental dismemberment or loss of time weekly benefits in whole or part. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure. 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.

You may file a written notice of appeal to the Benefits Committee of the Canton Electrical Welfare Fund at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. 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
Canton Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

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.

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.

The Benefits Committee will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", at its next regularly scheduled quarterly meeting. In the event that your appeal is received less than thirty (30) days prior to the scheduled meeting date, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You will be notified of the decision of the Board of Trustees as soon as possible after the meeting, but in no case later than five (5) days after the decision is made.

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

- The specific reason for the denial;
- The sections of the Plan and/or SPD upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;
- A notice of your to file a voluntary appeal to the Board of Trustees as outlined below; and
- A notice of your right to file suit under ERISA Section 502(a).

The decision of the Board of Trustees is final and binding.

Voluntary Appeal to the Board of Trustees

Once you have filed your appeal through Medical Mutual, Aultcare or 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. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice of Final Decision by the Benefits Committee.

The Appeal should be addressed as follows:

Board of Trustees
Canton Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

The Board of Trustees will review the appeal at their next scheduled quarterly meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

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

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

(2) 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;

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

(4) 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:

- A statement that using this procedure will have no effect on your right to receive other benefits under this Fund
- A statement that you have the right to have a personal representative with regard to your claim;
- 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.

XVI. COORDINATION OF BENEFITS

Coordination of Benefits is the procedure used to pay health care expenses when a Covered Person is covered by more than one health care plan. The objective is to make sure the combined payments of all health care plans are no more than your actual bills.

When a Covered Person is covered by another plan in addition to this one, we will follow the coordination of benefit rules defined in this section to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

This plan pays for benefits only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

The term "plan" as used in this section shall be considered separately for each plan and also between that part of any plan which applies to anti-duplication provision and that part which does not.

Plans That Do Not Coordinate Benefits
This Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

Individual (not group) policies or contracts;
Medicaid;
Group hospital indemnity coverage's which pay less than $100 per day;
School accident coverage;
All supplemental sickness and accident policies; and
Medical payment provisions of individual automobile policies.

When this Plan is Primary
When this Plan is primary, we will pay the full benefit provided by your contract as if you had no other coverage.

This Plan will maintain primary responsibility for coverage when there is another plan in the following order:

(1) If you have coverage under another plan that does not coordinate benefits, that group plan will always be primary;

(2) The plan which covers you as an active employee due to present employment with an employer who is not a participating employer, will always be primary;

(3) The plan which covers you as an active participant has primary responsibility before the plan covering you as an dependent;

(4) The plan which covers you under its provisions while you are laid-off or retired or if you are a dependent of a laid-off or retired participant will not be primary to a plan that covers you on some other basis.

Coordination Rules for Dependent Children
When a dependent child is covered by the plans of both parents, the "Birthday Rule" will apply:

(1) The plan of the parent whose birthday falls earlier in the year will pay before the plan of the parent whose birthday falls later in that year (this is known as the birthday rule); however

(2) If both parents have the same birthday, the plan which has covered the parent longer will pay the benefits before the plan which covered the other parent for a shorter period of time.

When parents of a dependent which are divorced or separated:

(1) If a court decree specifies that a certain parent is responsible for the child's health care expenses, his/her plan pays as primary;

(2) If no court decree specified that a certain parent is responsible for the health care expense, then:

(a) the plan of the parent with custody pays first,
(b) the plan of the spouse of the parent with custody (i.e. the stepparent) pays second; and
(c) the plan of the parent without custody pays last.

For all other situations involving the Eligible Participant and Dependent(s) which are not described above, the order of benefits will be determined in accordance with following:

(1) If the Spouse fails to comply with the requirements of the other plan or fails to utilize a Health Maintenance Organization (HMO) which has been selected by he or she as a participant under the other plan which would have been the primary provider, this Plan will not pay any portion of the allowable expenses incurred by the spouse.

Medical Mutual will pay the difference between the other insurance allowed and paid. If the primary carrier allowed zero, regardless of the reason, Medical Mutual's payment would be based on this Plan's benefit plan.

When this Plan Pays As Secondary

When this Plan is secondary, our payments will be based on the balance left after the primary plan has paid, or after compliance with the primary plan's rules and regulations. This Plan will not pay more than the balance due. In no event will we pay more than we would have paid had this Plan been primary.

This Plan will pay only for health care services that are covered as stated in this SPD.

This Plan will pay only if you have followed all of our procedural requirements.

This Plan will pay no more than the allowable expense for the charges involved. If our allowable expense is lower than the primary plan's, we will use the primary plan's allowable expense, which may be less than the actual bill.

Coordination Disputes

If you believe that this Plan did not pay a claim properly, you should first attempt to resolve the problem by contacting your Claims Payor or Fund Office.

Provision Enforcement

This Plan will coordinate benefits to the extent that we are informed by you or some other person or organization of your coverage under any other plan. We are not required to determine if and to what extent you are covered under any other plan.

In order to apply and enforce this provision or any provision of similar purpose of any other plan, it is agreed that:

(1) any person claiming benefits described in this document will furnish us with any information we need; and

(2) we may, without the consent of or notice to any person, release to or obtain from any source any necessary information.

Coordination With Governmental Programs and Programs Required by Statue
Benefits payable under this Plan for allowable expenses incurred during a claims determination period shall be paid from this Plan subject to the following limitations:

(A) **Medicare**
This Plan will pay its benefits before Medicare for the following individuals:

(1) an actively employed Eligible Member who is age 65 or older and/or an actively employed Eligible Member's Spouse who is age 65 or older.

(2) a disabled Eligible Member who is under age 65 and who has a relationship with a participating Employer indicative of an Employee status, or an Active Employee's disabled Spouse or Dependent who is under 65 and who is eligible for benefits under Medicare.

This Plan will be considered the primary plan of benefits for an Eligible Person under the age 65 who is disabled due to end-stage renal disease from the first three (3) months after the first date of dialysis. After this period there is a thirty (30) month coordination period during which this Plan is primary. If the Eligible Person successfully completes a self-dialysis training program during the three (3) month waiting period, entitlement to Medicare begins with the first month of the course of dialysis. The patient self-dialyzes thereafter.

Transplant – Medicare is primary payer for a period of thirty-six (36) months after a successful transplant. If the transplant occurs during the three (3) month waiting period, entitlement to Medicare begins with the month the individual is admitted as an inpatient to a hospital for procedures in preparation for (or anticipation of) a kidney transplant, provided the transplant surgery takes place within the following two months. If the transplant is delayed more than two months after the preparatory hospitalization, entitlement begins with the second month prior to the month of the transplant.

If the transplant occurs after three (3) month waiting period, but still within the 30-month coordination period, Medicare remains secondary through the remaining coordination period months. The coordination period and the 36-month Medicare primary period run concurrently.

If the transplant fails within 36 months of the transplant, the patient remains entitled to Medicare. However, if Medicare coverage lapses, then the transplanted kidney fails, the waiting period is waived, but a new 30-month coordination period begins.

For all other Eligible Participants eligible for Medicare, whether or not enrolled in or applied for, benefits are to be paid first by Medicare, after which this Plan will make its coordinated benefit payment. The amount of benefits payable under this Plan will be coordinated so that the aggregate amount of benefits paid will not exceed the Usual, Customary and Reasonable expenses as determined by charges generally incurred in the geographical area covered under this Plan. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if no other plan was involved.

(B) **Other Governmental Programs**
For all Eligible Participants eligible for benefits under a governmental program or eligible for benefits as a result of any state or federal statue or regulation (other than Medicare), this Plan will pay its pro-rata share up to one-half of the allowable expenses as determined by benefits provided under the Plan. If after the other plan has paid its allowable share, its share is less than the share paid by this Plan and it would leave a balance for the individual, then this Plan will pay the remaining allowable expenses, if any.

Facility of Payment
If payment is made under any other plan which this Plan should have made under this provision, then this Plan has the right to pay whoever paid under the other plan. The Board of Trustees will determine the necessary amount under this provision. Amounts so paid are benefits under this Plan and the other plan is discharged from liability to the extent of such amounts paid for covered services.

XVII. TERMINATION OF COVERAGE

Termination Of Individual Benefits
The benefits of any Participant covered hereunder shall terminate on whichever of the following dates occurs first:

(1) The date the coverage terminates;

(2) The date of expiration of the period for which the last contribution or self-payment is made to the Trustees on the account of the Participant's coverage;

(3) The date on which the Participant enters full-time service in the armed forces;

(4) The date on which the Participant ceases to be within the classes of persons eligible for coverage under the Plan, has used his reserve hours and is no longer eligible for coverage as stated in this SPD; or

(5) The date the Plan terminates.

Termination Of Coverage For Employee Who Becomes A Member of Armed Forces

Eligibility for benefits cease on the date you enter full time service in the Armed Forces. The Fund will reinstate your benefits without a waiting period or initial eligibility periods or other exclusions upon your reemployment with any Employer under this Fund when you meet the following requirements:

- If you are called up for active duty in the armed services, you are entitled to the protection of the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA). The Fund will provide coverage to you and your dependent(s) if the service related absence will be for less than thirty-one (31) days provided you would have lost eligibility for coverage in the Plan during that period. If your leave is for thirty-one (31) days or longer, you need to contact the Fund Office to discuss your options to continue coverage for you and your dependents. Questions regarding your entitlement to this leave and to the continuation of benefits should be referred to the Fund Office.

- If you are in qualified military service for more than thirty-one (31) days, the cost of providing continuation of coverage will be your responsibility. If you advise the Fund that you wish to utilize your bank hours to provide coverage for you and/or your eligible dependent(s) during the period of time that you are in the military service, the Fund will reduce your bank hours before billing you a monthly continuation coverage premium. You will then be entitled to make the self-payments for a maximum period of twenty four (24) months. Otherwise, your bank hours will be frozen.

- Your coverage will be reinstated upon your reemployment with any Contributing Employer under this Fund if you apply for reemployment within fourteen (14) days after your honorable discharge, if you serve between thirty-one (31) and one hundred eighty-one (181) days in qualified military service. If your service exceeds one hundred eighty-one (181) days, you must apply for reemployment within ninety (90) days after your honorable discharge. Additionally, you must be re-employed with a Contributing Employer in this Fund.

You must give the Fund Office notice of your qualified military service as soon as you know that you are leaving Covered Employment to join the Armed Services and must provide the Fund Office with notice that you were previously an Eligible Participant with

the Fund within sixty (60) days after you return to work with a Contributing Employer under this Fund.

Termination Of Dependent Benefits
The benefits of any Eligible Dependents shall terminate on whichever of the following dates occurring first:

(1) The first date following the date such Dependent ceases to be an Eligible Dependent;

(2) The date the Participant's coverage terminates;

(3) The end of the month of the date the Dependent child attains his or her twenty-sixth (26^{th}) birthday. However, benefits may continue thereafter providing such child continues to meet the definition of "Eligible Dependent";

(4) The date the Plan is discontinued.

Termination Of Coverage For Dependents Of Deceased Employee
In the event of the death of an Eligible Member, the Member's legal spouse or dependent, as defined in the Plan, shall be eligible to participate in the Surviving Spouse/Dependent Program, in accordance with the Eligibility Rules on pages 27-28.

XVIII. COBRA CONTINUATION COVERAGE OPTION

Under certain circumstances, coverage for you and your Eligible Dependents can be temporarily continued, at your expense, after it would normally end. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides you with the right to this continuation coverage.

COBRA provides you and your Eligible Dependents with the opportunity to continue the same or similar coverage in the Plan even if you have suffered an event which would usually terminate your coverage under this Plan. You pay the full cost of the continued coverage plus a small administrative charge. You may not continue Life Insurance, Accidental Death and Dismemberment Insurance, and Accident and Sickness Benefits.

Eligibility for COBRA Continuation Coverage
All Eligible Participants and their Eligible Dependents may be entitled to continue their coverage under the Plan if they suffer a "qualifying event." COBRA continuation coverage applies to each individual under the Plan. Additionally, if you, the Eligible Employee, have a newborn child, adopt a child, or have a child placed with you for adoption (for whom you have the financial responsibility) while COBRA continuation coverage is in effect, you may add such child to your coverage. You must notify the Fund Office, in writing, of the birth or placement in order to have this child added to your coverage.

Children born, adopted, or placed for adoption, as described above, have the same COBRA rights as your spouse and dependent(s) who where covered by the Plan before the event that triggered COBRA continuation coverage, and their continued coverage depends upon the timely and uninterrupted payment of the premiums on their behalf.

Definition of "Qualifying Event"

If coverage ends for one of the following "qualifying events," the COBRA continuation coverage will be available to any covered person whose coverage would otherwise stop due to one of the following events:

(1) your termination from work or reduction of work hours, including retirement, but not including termination due to gross misconduct;
(2) your death;
(3) your divorce or legal separation;
(4) your dependent child no longer qualifies for dependent coverage under the terms of the Plan; or
(5) you become entitled to Medicare after the date of your election to maintain COBRA continuation coverage.

Your Obligations

Under the law, you and your Dependents have the responsibility to notify the Fund Office about a divorce, legal separation, or a child losing Dependent status under the Plan. Such notification MUST take place immediately after any of these three qualifying events. If you and/or your Dependents do not report the event to the Fund Office within sixty (60) days of the date the qualifying event occurred, COBRA continuation coverage will not be provided.

It is the responsibility of you and your employer to notify the Fund Office regarding a death, termination of employment, reduction in hours, or Medicare entitlement.

It is advisable, however, for the Spouse of a deceased Participant to contact the Fund Office as soon as possible after the Participant's death so that COBRA continuation coverage will be offered to the Surviving Spouse and Dependents at the earliest possible date.

It is also extremely important that you and your Dependents notify the Fund Office immediately about any changes in your address, so that if COBRA continuation coverage becomes available to you or your Dependents, the Fund Office will be able to forward the Notice to the correct address.

Once the Fund Office has notice of a qualifying event, the Fund Office will notify you and each of your Dependents individually of the right to elect COBRA continuation coverage and provide you with the amount of the premium required to elect this coverage. You and each of your Dependents individually will have the right to make this election within sixty (60) days after the date of the qualifying event. If you and your Dependents do not notify the Fund Office that you wish to elect the COBRA

continuation coverage within this sixty (60) day period, and then remit the application premium within forty-five (45) days of the expiration of the 60-day period, your coverage under the Plan will be terminated and you will no longer have the ability to elect COBRA continuation coverage.

18 month COBRA Continuation Coverage

If you are no longer an Eligible Employee because of a reduction in work hours, termination or retirement, you will be eligible to maintain COBRA Continuation Coverage for up to eighteen (18) months.

29 Month COBRA Continuation Coverage

If your coverage ends due to one of the above "qualifying events" and, at the time of the event, or within the first sixty (60) days of COBRA Continuation Coverage, you or your Eligible Dependent is determined to be totally and permanently disabled by the Social Security Administration (SSA), COBRA Continuation Coverage for the disabled person will be offered for an additional eleven (11) month period, or a total of twenty-nine (29) months. This option seeks to offer the disabled person coverage until Medicare coverage becomes effective. Coverage for the additional eleven (11) months may be at a higher cost, as set by the Trustees.

Please notify the Fund Office of the SSA determination of disability within sixty (60) days of the determination and before the end of the first eighteen (18) months of coverage. Otherwise, you will **not** be eligible for the additional eleven (11) months of coverage.

36-Month COBRA Continuation Coverage

Your Eligible Dependents may elect to purchase COBRA Continuation Coverage for up to thirty-six (36) months. Your dependents are entitled to elect COBRA Continuation Coverage which may last for up to thirty-six (36) months for any of the following "qualifying events:"

(1) your death;
(2) your spouse and you are divorced or legally separated;
(3) your dependent child no longer qualifies as a dependent under the terms of the Plan.

Your COBRA Continuation Coverage Terminates

COBRA Continuation Coverage may end for any of the following reasons:

(1) you or your dependent(s) become covered under another group health plan which is substantially the same as this Plan as an employee, dependent or spouse. However, coverage will continue if you or an Eligible Dependent has an existing health problem for which coverage is excluded under the other group health plan;
(2) the required premium is not paid at the time specified by the Trustees;
(3) the Fund terminates as a health coverage provider;

(4) you or your dependent(s) reach the maximum COBRA Continuation Coverage period allowed as provided above;
(5) you or your dependent(s) become eligible for Medicare after the date of your election to maintain COBRA Continuation Coverage.

When your coverage ends under this Plan, you will be provided with a certification of your length of coverage as required by the existing federal laws. This certificate may help to reduce or eliminate any pre-existing limitations under your new group medical plan.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budge Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Office of the Administrative Manager.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such COBRA continuation coverage.

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

(1) Yours hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

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

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
(5) You become divorced or legally separated from your spouse.

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

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
(5) The parents divorced or legally separated from your spouse; or
(6) The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy filed with respect to one or more of the contractors who are signatories to the collective bargaining agreement with the Union and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?
The Plan will offer COBRA coverage to qualified beneficiaries only after the Administrative Manager has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Office of the Administrative Manager of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Administrative Manager within sixty (60) days after the qualifying event occurs. You must provide this notice to the Fund's Office of the Administrative Manager.

How is COBRA coverage provided?

Once the Office of the Administrative Manager receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, is a covered employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

If you or anyone in your family covered under this Plan is determined by the Social Security Administration to be disabled and you notify the Office of the Administrative Manager in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage.

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly

given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

COBRA CONTINUATION COVERAGE ELECTION NOTICE
To be provided to all eligible Participants upon a Qualifying Event

Dear: {Enter Name of Participant, Spouse, Dependent Children, as appropriate}

This Notice contains important information about your right to continue your health care coverage in the Canton Electrical Welfare Fund. Please read the information contained in this notice very carefully.

This Notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this Notice or your rights to COBRA coverage, you should contact the Office of the Administrative Manager, Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515; (800) 435-2388.

If you do not elect to continue your health care coverage by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on___date_ due to:

- ☐ End of Employment
- ☐ Death of Employee
- ☐ Enrollment in Medicare
- ☐ Reduction in Hours of Employment
- ☐ Divorce or Legal Separation
- ☐ Loss of Dependent Child Status

Each person "qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to _____ months (enter 18 or 36, as appropriate) and check appropriate box or boxes below:

- ☐ Employee or Former Employee
- ☐ Spouse or Former Spouse

☐ Dependent Child(ren) covered under the Plan on the day before the event that caused the loss of coverage

☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on _____date_____ and can last until _____date_____

COBRA continuation coverage will cost $_____amount stated_____ per month. You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

COBRA CONTINUATION COVERAGE ELECTION FORM

IMPORTANT – To elect continuation coverage, you MUST complete the enclosed "Election Form" and return it to us. Under federal law, you must have sixty (60) days after the date of this Notice to decide whether you want to elect COBRA continuation coverage under the Plan. Send the completed form to:

Office of the Administrative Manager
Canton Electrical Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

You may mail it to the address shown on the Election Form or hand deliver it to the Fund office. The completed Election Form must be post-marked by _____date_____ or received by_____date_____, if submitted by other means. If you do not submit a completed Election Form by this date, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form to the Office of the Administrative Manager before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights in included in the pages after the Election Form.

I (We) elect to continue our coverage in the Canton Electrical Welfare Fund (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a._____

Type of Coverage Elected*: _____

b. _____

Type of Coverage Elected*: _____

c. _____

Type of Coverage Elected*: _____

d. _____

Type of Coverage Elected*: _____

_____

Signature Date

_____

Print Name Relationship to Individual(s) listed above

_____

Print Address Telephone Number

*Type of coverage elected:

(1) Participant Only
(2) Participant and Spouse
(3) Family

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, covered employee's Spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other Participants or Beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights, under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to eighteen (18) months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medical entitlement. This Notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

(1) any required premium is not paid in full

(2) a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
(3) a covered employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage, or
(4) the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of the Administrative Manager of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify

the Office of the Administrative Manager of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have cause the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Office of the Administrative Manager within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the direction on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. For example, if pre-existing conditions limitations or exclusions apply, you can lose the right to avoid having these limitations or exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of continuation coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the rights to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may

not exceed 102 (or in the case of an extension on continuation coverage due to a disability, 150 percent) percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for continuation coverage for each option is described in this Notice.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

When and how must payment for COBRA continuation coverage be made?

First payment for COBRA continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your payment is correct. You may contact the Office of the Administrative Manager to confirm the correct amount of your first payment. Your first payment for COBRA continuation coverage should be sent to:

Office of The Administrative Manager
Canton Electrical Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Periodic payments for COBRA continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. The amount due for each coverage period for each qualified beneficiary is shown in this Notice. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for COBRA continuation coverage should be sent to:

Office of the Administrative Manager
Canton Electrical Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of its grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan.

For more information
This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your Summary Plan Description or from the Office of the Administrative Manager. If you have any questions concerning the information in this Notice, your rights to coverage, or if you want a copy of your Summary Plan Description, you should contact the Office of the Administrative Manager; Canton Electrical Welfare Fund, c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515, (800) 435-2388.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

XIX. FAMILY MEDICAL LEAVE ACT OF 1993

THE FAMILY AND MEDICAL LEAVE ACT (FMLA) was enacted on February 5, 1993. FMLA is generally effective on February 5, 1994. FMLA requires your Employer to provide you with up to 12 weeks of unpaid leave during any 12-month period for specified family and medical reasons, if you are eligible. During this period, your Employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing Employer for at least 12 months and for at least 1,250 hours during the 12-month period before the leave begins. Generally, your Employer is obligated to provide Family and Medical leave only if your employer employs 50 or more employees each working day during each of 20 or more work weeks during the current or preceding calendar year.

During the FMLA leave, your Employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility.

A covered Employer must grant an eligible Participant up to a total of 12 work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

(1) For the birth of a child or placement of a child for adoption or foster care;

(2) To care for an immediate family member (spouse, child or parent) with a serious health condition; and

(3) To take medical leave when the Eligible Employee is unable to work because of a serious health condition.

Further, Participants with members in the Armed Services are entitled to FMLA leave under the following circumstances:

(1) When leave is needed so that the Participant can care for an injured or ill family member in the Armed Services; and

(2) When such leave is required due to "any qualifying exigency" related to a family member's service or call to duty.

The Participant must be a spouse, parent, child, or nearest blood relative of the member in the Armed Services. A Participant who is eligible for FMLA leave under this provision will be granted up to twenty-six weeks of leave in a single twelve (12) month period.

Arrangements will need to be made for the Eligible Employee to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, the Eligible Employee must be restored to his or her original job or to an equivalent job. In addition, the Eligible Employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave.

Please contact the Fund Office if you have any questions regarding your options under the FMLA.

Repayment of Contributions to Employer
If you take a leave under the FMLA and you fail to return to your Employer for any reason after such absence, under the Act your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your Employer, you should return to work at the end of your leave of absence under the FMLA.

XX. NOTICE OF PRIVACY PRACTICES

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.

SECTION 1: PURPOSE OF THIS NOTICE

This Notice is required by law. The Canton Electrical Welfare Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI).
- Your rights to privacy with respect to your PHI.
- The Fund's duties with respect to your PHI.
- Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and
- The person or office you should contact for further information about the Fund's privacy practices.

SECTION 2: YOUR PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Fund May Disclose Your PHI

The Fund Sponsor has amended its Fund Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

- *At your request.* If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.

- *As required by an agency of the government.* The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

- *For treatment, payment or health care operations.* The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out: treatment, payment, or health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. *For example:* The Fund may disclose to a treating physical therapist the name of your treating physician so that the physical therapist may ask for your x-rays from the treating physician.
Payment is paying claims for health care and related activities.	Payment includes, but is not limited to, making coverage determination Payment. These actions include billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. *For example:* The Fund tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.
Health Care Operations keep the The Fund operating soundly	Health care operations, include but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business funding and development, business management and general administrative activities. *For example:* The Fund uses information about your medical claims to project future benefit costs or to audit the accuracy of claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Fund must generally obtain your written authorization before it will use or disclose psychotherapy notes about you from your psychotherapist. However the Fund may use and disclose such notes when needed to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1. When required by law.

2. Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. Domestic violence or abuse situations. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4. Health oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensures or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

6. Law enforcement health purposes. When required for law enforcement purposes (for example, to report certain types of wounds).

7. Law enforcement emergency purposes. For law enforcement purposes including:

a. Identifying or locating a suspect, fugitive, material witness or missing person, and

b. Disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. ***Determining cause of death or organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person to determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claim or for other reasons regarding the administration of the Fund. The "Plan Sponsor" of this Fund is the Canton Electrical Welfare Fund Board of Trustees.

SECTION 3: YOUR INDIVIDUAL PRIVACY RIGHTS

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

Privacy Official, c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

In addition, the Fund will accommodate an individual's reasonable request to receive communication of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

The Fund must provide the requested information within thirty (30) days if the information is maintained on site or within sixty (60) days if the information is maintained offsite. A single thirty (30) day extension is allowed if the Fund in unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has sixty (60) days after receiving your request to act on it. The Fund is allowed a single thirty (30) day extension if the Fund is unable to comply with the sixty (60) day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI.

Designated Record Set: includes your medical records and billing records that are maintained in paper form or electronically by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health Fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analysis and not used to make decisions about you is not included.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI. This accounting period starts as of April 14, 2003 and allows you to request an accounting for up to six (6) years of disclosures after that date. The maximum period of time you can request is six (6) year. Please contact the Fund Office for a complete listing of the contents of an accounting. You should request a copy of the Fund's Accounting for Disclosure Policy.

If you disagree with the record of your PHI, you may amend it.

If the Fund denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

Forms are available for these purposes.

The Fund has sixty (60) days to provide the accounting. The Fund is allowed an additional thirty (30) days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a twelve (12) month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider spouse's covered under the Fund as the personal representative for each other. Additionally, the Fund will consider a covered parent, guardian, or other person acting *in loco parentis* as the personal representative of any dependent covered by the Fund unless applicable law requires otherwise. A parent may act on an individual's behalf, including requesting access to their PHI. Covered dependents, including your spouse may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice. Additionally, the Fund will automatically consider any person designated under a Power of Attorney which is on file with the Fund as a personal representative.

You or your spouse may elect not to have one another as your personal representative. You or your spouse must fill out an Opt-Out of Personal Representation Form and submit the form to the Privacy Official. Your covered dependent children also have the right to submit an Opt-Out Form if they do not wish to have one or both of their parents as their deemed personal representative. All requests are reviewed by the Privacy Official who may deny the requests, especially those based upon State law restrictions.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

SECTION 4: THE FUND'S DUTIES

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the covered participant and dependents.

You may designate a personal representative by completing a form that is available from the Fund Office.

Any revised version of this notice will be distributed within sixty (60) days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

> The Fund must limit its uses and disclosures of PHI or requests for PHI to the minimum necessary amount to accomplish its purpose.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

> You have the right to file a complaint if you feel your privacy rights have been violated.
>
> The Fund may not retaliate against you for filing a complaint.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

This notice is written to inform you of the Fund's obligation to maintain the privacy of your PHI.

SECTION 5: YOUR RIGHT TO FILE A COMPLAINT WITH THE FUND OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Fund Privacy Official at the address provided in Section 3.

You may also file a complaint with:

Secretary of the U.S. Department of Health and
Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

SECTION 6: IF YOU NEED MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address provided in Section 3.

SECTION 7: CONCLUSION

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

XXI. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of a participant or beneficiary who is receiving benefits under the

plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to a Plan's annual deductibles and coinsurance provisions.

XXII. STATEMENT OF YOUR RIGHTS UNDER ERISA

ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the Canton Electrical Welfare Plan. 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 SPD.

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.

(A) ERISA provides that all Plan Participants and Beneficiaries shall be entitled to:

(1) 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 Pension and Welfare Benefit Administration.

(2) Obtain, upon written request to the Administrative Manager 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 Administrative Manager may make a reasonable charge for the copies.

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

(4) Obtain a complete list of employers sponsoring the Plan upon written request to the Administrative Manager which list is available for examination by Participants and Beneficiaries.

(5) 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.

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.

(B) In addition to creating right for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

(C) 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.

(D) If you have a claim for a welfare benefit is 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. The Plan's Claims Procedures are furnished automatically without charge as a separate document. If you have a claim for benefits which is denied, in whole or in part, you may file suit in a state or federal court after you exhaust your appeal rights.

(E) 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 thirty (30) days, you may file suit in Federal court. In such a case, the court may require the Plan Administrative

Manager 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 Administrative Manager. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state of 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.

(F) If you have any questions about your Plan, you should contact the Plan Administrative Manager 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:

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street, Suite 556
Washington, DC 20006
Tel: (202) 254-7013

Or

U.S. Department of Labor
Employee Benefits Security Administration
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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the pension and welfare benefits administration.

XXIII. ADDITIONAL INFORMATION REQUIRED BY ERISA

Name Of Plan
Canton Electrical Welfare Fund

Plan Established And Maintained By
Board of Trustees
Canton Electrical Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Employer Identification Number: 34-6573626

Plan Number: 501

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.

Plan Year/Fiscal Year
The Plan Year is the same as the Fiscal Year which for the Fund begins on November 1 of each year.

Type Of Administration Of The Plan Although this Plan technically is administered and maintained by the joint Board of Trustees of the Canton Electrical Welfare Fund, the Trustees have delegated certain administrative functions to a professional third party administrator, Compensation Programs of Ohio, Inc.

Address all communications with the Board of Trustees to: Board of Trustees Canton Electrical Welfare Fund, c/o Compensation Programs of Ohio, Inc. 33 Fitch Boulevard, Austintown, Ohio 44515, Phone: (800) 435-2388.

Agent For Service Of Legal Process
The following person has been designated as the agent for service of legal process:

Ronald G. Macala
Timothy R. Piatt
Macala & Piatt, LLC
601 South Main Street

North Canton, Ohio 44720

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

Name, Title And Address Principal Place of Business Of Each Trustee

Management Trustees

Brent Fatzinger
Abbott Electric Inc.
1935 Allen Avenue, S.E.
Canton, Ohio 44707

Ted Foster
Hilscher-Clarke Electric
519 – 4th Street, N.W.
Canton, Ohio 44703

Jennifer Neuhaus
NECA
6657 Frank Avenue, N.W.
Suite 110
Canton, Ohio 44720

Mark Gold
WW Schaub Electric
501 Applegrove Street, N.W.
North Canton, Ohio 44720

Union Trustees

Matthew Leslie
2333 Nave Street, S.E.
Massillon, Ohio 44646

Tim Kieffer
2333 Nave Street, S.E.
Massillon, Ohio 44646

Philip Williams
2333 Nave Street SE
Massillon, Ohio 44646

Collective Bargaining Agreement: This Plan is maintained pursuant to a Collective Bargaining Agreement between the International Brotherhood of Electrical

Workers Local Union No. 540 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.

Funding Medium For The Accumulation Of Plan Assets: Assets are accumulated and medical benefits are provided by the Trust Fund. Some Plan assets are invested. These investments are made only upon the direction of the Board of Trustees.

Type Of Plan
This Plan is maintained for the purpose of providing death, dismemberment, disability, hospitalization, surgical, medical, dental, vision, prescription drug and other related benefits.

Information relevant to the provision of these benefits is as follows:

- Life Insurance and Accidental Death and Dismemberment Benefits are insured and administered by Amalgamated Life Insurance Co., 333 Westchester Avenue, White Plains, NY 10604.

- Accident and Sickness Weekly Benefits are self insured and administered by the Canton Electrical Welfare Fund, c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515.

- For Eligible Employees, Office and Salary Participants and their Eligible Dependents enrolled in the SuperMed Plus Plan, the hospital, medical and surgical benefits are administered through the provider network operated by Medical Mutual of Ohio, 2060 East Ninth Street, Cleveland, Ohio 44115. SuperMed Plus benefits are self insured by the Canton Electrical Welfare Fund.

- For Eligible Employees, Office and Salary Participants and their Eligible Dependents enrolled in the Aultcare Plan, the hospital, medical and surgical benefits are administered through the provider network operated by Aultcare, 2600 Sixth Street S.W., P.O. Box 6910, Canton, Ohio 44706-0910. The Aultcare Plan benefits are self insured by the Canton Electrical Welfare Fund.

- For Eligible Retired Participants and their Eligible Dependents over and under Age 65 who are Medicare Eligible, Medicare Supplemental Insurance Benefits are self-insured and administered by the Canton Electrical Welfare Fund, c/o c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515. Additionally, non-Medicare Eligible Retired Participants and their Eligible Dependents under Age 65 may participate in the Aultcare Plan or the SuperMed Plus Plan listed above.

- The vision benefits are self-insured and administered by the Canton Electrical Welfare Fund c/o c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515.

- The dental benefits are self-insured and administered by the Canton Electrical Welfare Fund c/o c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515.

The prescription drug benefits are self-insured by the Canton Electrical Welfare Fund and administered by Sav-Rx Prescription Services, 224 North Park Avenue, Fremont, NE 68025, Tel. No. (866) 233-IBEW (4239). Its Hours of Service are:

Monday through Friday	7:00 AM to 9:00 PM
Saturday	9:00 AM to 2:00 PM
Sunday	Closed

Call Sav-Rx Member Services Help Desk for more information.

XXIV. PLAN DEFINITIONS

Wherever used in this SPD, the following terms shall be deemed to have the meanings described below:

Alcoholism - a condition classified as a mental disorder and described in the International Classification of Diseases of the United States Department of Health and Human Services (ICD-9-CM), as alcohol dependence, abuse or alcoholic psychosis.

Allowable Expenses - any necessary, reasonable and customary item of expense for hospital or medical treatment which is covered under at least one of the Plans covering the person for whom a claim is made,

Amendments - the provisions of the Trust Agreement and the Plan Document may be amended from time to time by the Trustees and such amendments shall be effective when voted upon by the majority of such Trustees provided that such amendment shall be made consistent with the objectives and purposes of the Trust.

Another Plan or Other Plan - includes any plan providing benefits or services for or by reason of hospital, medical or dental treatment which benefits or services are provided by:

(a) group blanket or franchise insurance coverage
(b) any coverage under labor-management trustees plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group
(c) any other plan which has a coordination of benefits provision within

that plan any other plan which provides coverage arising out of any claim or cause of action which might accrue because of the alleged negligent conduct of a third party.

(d) any governmental plan or program created by federal or state statute or regulations for the purpose of providing some or all of the benefits as set forth in this Plan, including but not limited to Medicare, whether enrolled in or applied for.

Benefit Period - the period of time that starts on the first full day you enter the hospital. It ends after you have been out of the hospital or nursing facility for sixty (60) days in a row. Please refer to the definition of "In-Hospital Benefit" in Attachment A for Medical Mutual.

Calendar Year - the twelve month period that starts January 1 and ends December 31 each year.

Claim Incurred Date - The incurred date of a claim shall be the first date on which a Covered Person is under the care of a Physician and/or has had expenses which would be payable by the Plan.

Claims Payor - depending upon the selection made by the Eligible Participant, the Claims Payor is either Medical Mutual of Ohio or Aultcare for Eligible Employees, Eligible Office & Salary Participants and non-Medicare Eligible Retirees under age 65. Compensation Programs of Ohio, Inc. is the Claims Payor for Medicare eligible retirees.

Covered Person - the Eligible Participant and, if family coverage is in force, the Eligible Participant's Eligible Dependents.

Covered Service - a Provider's or Physician's service or supply for which the Fund will pay as listed in this SPD.

Custodial Care - care which does not require the constant supervision of skilled medical personnel to assist the patient in meeting his activities of daily living; such care can be taught to and administered by a lay person. Custodial Care includes, but is not limited to, administration of medication which can be self-administered or administered by a lay person with training; or help in walking, bathing, dressing, feeding or the preparation of special diets. Custodial Care does **not** include care provided for its therapeutic value in the treatment of an injury, ailment, condition, disease, disorder or illness.

Diagnostic Service - a test or procedure performed when a Covered Person has specific symptoms to detect or monitor an injury, ailment, condition, disease, disorder or illness. It must be ordered by a Physician or Other Professional performing within the scope of his license. These services are limited to the Diagnostic Services listed in this SPD.

Drug Abuse - a condition classified as a mental disorder and described in the International Classification of Diseases of the United States Department of Health and Human Services (ICD-9CM), as drug abuse, dependence or drug psychosis.

Effective Date - 12:01 a.m. on the date when coverage begins, as determined by the Plan.

Eligible Dependent(s) - Your covered dependents are your legal spouse and your dependent child (children) from date of birth until age twenty-six (26), unless and for so long as the child (children) are not eligible for health insurance coverage from that child(s)' employer. The term dependent shall not apply to an individual who is in full-time military service.

If you have a mentally retarded or permanently physically handicapped child age 26 or over, this child is eligible if he or she meets all of the following conditions:

(a) Incapable of independent self-support; and
(b) Unmarried, and
(c) Covered by the Plan as your dependent before becoming 26 years of age, and
(d) Was mentally retarded or permanently physically handicapped prior to age twenty-six (26) if the child was still an Eligible Dependent at the onset of the mental retardation or permanent handicap.

When filing a claim for a mentally retarded or permanently physically handicapped child over 26, you must include a physician's statement (on letterhead stationery) which details the severity of your child's mental retardation or permanent physical handicap. Additional information may be requested.

The term "child" (or children) means the following:

(a) Your natural born child.
(b) Legally adopted child, including a child being placed for adoption, whether or not the adoption has become final.
(c) Stepchild and provided a divorce decree does not obligate the other natural parent to provide health care or health insurance coverage.
(d) A child for whom you have been granted legal custody of the child by a court of record according to the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as defined in ERISA Section 609(a).
(e) A child of a participant who is recognized under a medical child support order as having the right to enrollment for the group health plan.

Proof that the child is an Eligible Dependent may be established by one or more of the following documents: Child's Birth Certificate, Child's Baptismal Certificate, or Court order or record or other legally recognized proof of dependent status.

Eligible Employee - an employee of a Participating Employer who is working under the terms of the collective bargaining agreement or other agreement with the Board of Trustees except for Office and Salary Participants, who is eligible for benefits as set forth in the eligibility rules adopted by the Trustees.

Eligible Office & Salary Participant - an employee of a Participating Employer who is working for that Employer which has signed an Assent of Participation in order to allow for the employees coverage in this Plan, who is eligible for benefits as set forth in the eligibility rules adopted by the Trustees.

Eligible Participant - any Eligible Employee, Eligible Office & Salary Participant, Eligible Retiree Under 65, Eligible Retiree Over 65 who is eligible for benefits as set forth in the eligibility rules adopted by the Trustees.

Emergency - means the sudden and unexpected onset of a Sickness or Injury.

Excess Expense - the difference between the actual Medicare Part B charge as billed and the Medicare Approved Charge. The billed charge may not exceed any charge limitations established by Medicare or state law.

Experimental/Investigative - any treatment, procedure, faculty, equipment, drug, device or supply which the Plan does not recognize as accepted medical practice or which did not have required governmental approval when a Covered Person received it. Determination will be made by the Plan in its sole discretion and will be conclusive.

Home Health Care Agency - an institution which meets the specifications of Chapter 3923 of the Ohio Revised Code, except for the requirement that such institution be operated within the state of Ohio and which provides skilled nursing and other services on a visiting basis in the Covered Person's home; and is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospice Facility - an institution which provides palliative care for terminally ill patients.

Hospital - an institution that is: (1) licensed as a hospital and operated pursuant to law; and (2) approved for payment and defined as a Hospital by Medicare.

Identification Card - the health care card provided by the Claims Payor to an Eligible Participant. It shows his/her identification number and the Group Plan Number.

Immediate Family - your parents, spouse, children or siblings or any other person living with you.

Incurred - a charge is considered incurred on the date the Covered Person receives the service or supply for which the charge is made.

Inhospital Benefit Period - a period of time beginning when a Covered Person enters a Hospital and ending when the Covered Person has been out of the Hospital for 14 consecutive days.

In-Network Provider or Physician - the status of a Hospital, Provider or Physician which is:

(a) located inside the state of Ohio which has an agreement with the Claims Payor regarding payment for Covered Services;
(b) designated by the Claims Payor as Contracting; or
(c) located outside the state of Ohio and which has an agreement with an affiliated Claims Payor's plan or network regarding payment for Covered Services.

Injury - bodily injury which: (1) is accidental; (2) is sustained as a direct result of an accident; (3) is independent of disease or bodily infirmity or any other cause.

Inpatient - a Covered Person who receives care as a registered bed patient in a Hospital or Facility Other Provider for whom a room and board charge is made.

Maximum Benefit - the total amount of benefits we will pay.

Medicaid - Title XIX of the Social Security Act.

Medical Care - professional services given by a Physician or Other Professional to treat an injury, ailment, condition, disease, disorder or illness.

Medically Necessary - medically necessary care as defined by Medicare.

Medicare - Title XVII of the Social Security Act, the "Health Insurance for the Aged Act", as added by the Social Security Amendments of 1965, as then constituted or later amended. This term may be used to refer to the insurance program provided by the Act as well as the Act itself.

Medicare Administrator - the entity appointed by the Health Care Finance Administration (HFCA) to administer the Medicare program.

Medicare Approved - the status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

Medicare Approved Charge - that portion of a Part B Medicare Eligible Expense that is determined by Medicare to be reasonable and reimbursable to the provider of medical care. The payment may be from you or Medicare or a portion from both.

Medicare Coinsurance Amount - that portion of Medicare Approved Charges that you must pay. It does not include (1) Medicare Part A Deductible; (2) Medicare Part B Deductible; or (3) any other Medicare-defined Deductible.

Medicare Deductible - the amount of Medicare Approved Charges you must incur before Medicare starts to pay for covered losses.

Medicare Eligible Expense - expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Mental Illness - a condition classified as a mental disorder in the international Classification of Diseases of the United States Department of Health and Human Services (ICD-9-CM), excluding Drug Abuse and Alcoholism.

Other Professional - only the following persons or entities which are licensed as required:

(a) Dentist.
(b) Doctor of chiropractic medicine.
(c) Laboratory (must be Medicare Approved).
(d) Licensed practical nurse (L.P.N.).
(e) Licensed vocational nurse (L.V.N.).
(f) Mechanotherapist (licensed or certified before November 3, 1975).
(g) Nurse-midwife.
(h) Physical therapist.
(i) Podiatrist.
(j) Psychologist.
(k) Registered nurse (R.N.).
(l) Occupational therapist.
(m) Durable medical equipment or prosthetic appliance vendor.

Out-of-Network Provider or Physician - a Provider or Physician generally that does not have a contract with your Claims Payor regarding the payment for services rendered.

Outpatient - a Covered Person who receives services or supplies while not an Inpatient.

Part A Deductible - the Benefit Period Inpatient Hospital Deductible under Part A of Medicare.

Part B Deductible - the Calendar Year Medical Deductible under Part B of Medicare.

Participating Employer - Any Employer who employs persons under the terms of the collective bargaining agreement, or other agreement with the Board of Trustees, and in accordance therewith agrees to participate and contribute to the Fund.

Physician - a person legally licensed to treat Sickness or Injury. That person may not be you or a member of your immediate family.

Pharmacy - a Provider which is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable sate laws.

Plan - The plan of benefits of the Canton Electrical Welfare Fund.

Prescription Drug (Federal Legend Drug) - any medication which by federal or state law may not be dispensed without a Prescription Order.

Prescription Order- the request for medication by a Physician duly licensed to make such a request in the ordinary course of professional practice.

Provider - the following entities which are licensed, where required, and which for compensation from their patients render covered services. The following institutions are included in this definition, however, other institutions may be considered Providers by your Claims Payor:

(a) Hospital.
(b) Alcoholism Treatment Facility.
(c) Ambulatory Surgical Facility.
(d) Day/Night Psychiatric Facility.
(e) Dialysis Facility.
(f) Drug Abuse Treatment Facility.
(g) Home Health Care Agency.
(h) Hospice Facility.
(i) Psychiatric Facility.
(j) Psychiatric Hospital.
(k) Skilled Nursing.

Psychologist - an Other Professional who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no license law, the Psychologist must be certified by the appropriate professional body.

Refill - a second or subsequent filling of a Prescription Drug.

Sickness - an illness or disease of a participant.

Skilled Care - care which requires the skill, knowledge and training of a Physician, or a registered nurse, or a licensed practical nurse, or a physical therapist performing under the supervision of a Physician. In the absence of such care, the Covered Person's health would be seriously impaired. Skilled Care is care which cannot be taught to or administered by a lay person.

Skilled Nursing Facility - an institution or portion thereof that: (1) is licensed under and operated pursuant to state law; (2) defined and certified by Medicare as a skilled nursing facility; and (3) is approved for payment by Medicare or is qualified to receive such approval if so requested.

Surgery - any of the following:

(a) The performance of generally accepted operative and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Usual and related preoperative and postoperative care;
(d) Other procedures as reasonably approved by the Claims Payor and Board of Trustees.

Trust Agreement - the Agreement and Declaration of Trust establishing the Canton Electrical Welfare Fund and as is from time to time amended.

Trust Fund or Fund - the Canton Electrical Welfare Fund as established by the Trust Agreement.

Trustees - the Trustees of the Canton Electrical Welfare Fund as appointed in accordance with the Trust Agreement. The Trustees shall hold all property, income and assets in trust for the purposes of the Trust Fund for the benefit of the Participants. The Trustees shall have the sole authority to administer and manage the Fund and any decisions made by them shall be final and binding on all covered Participants and Eligible Dependents.
Union - International Brotherhood of Electrical Workers Local Union No. 540 (IBEW), Canton, Ohio.

United States - all the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam and the Northern Mariana Islands.

Usual, Customary and Reasonable Charges: the charges that the Claims Payor determines is reasonable for Covered Services provided to Covered Persons by a Provider or Physician. For an In-Network Provider or Physician, the amount payable is a negotiated rate established between the Claims Payor and the Provider or Physician. For an Out-of-Network Provider or Physician, the UCR or Traditional Amount is the maximum amount allowed for a Covered Service based on the following criteria:

(a) the UCR will never exceed the actual amount billed by the Provider or Physician for a given service; or
(b) the UCR may be limited to the customary charge based on the distribution of charges billed by all Providers or Physicians for a given service within a given specialty and geographic area; or
(c) the UCR must also be reasonable to the Trustees with respect to customary charges for services of comparable complexity and difficulty.

For In-Network Providers and Physicians, charges above the UCR will not be covered by the Fund. However, you are not responsible for charges over the UCR limit due to the contract the Provider or Physician has with your Claims Payor.

For Out-of-Network Providers and Physicians, charges above UCR will normally not be covered by the Plan. You will be responsible for the charges exceeding UCR, including co-payments, if applicable due to the fact that the Claims Payor does not have a contract with the Out-of-Network Provider or Physician.