I.B.E.W. LOCAL 688 HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION
AND PLAN DOCUMENT

AS AMENDED AND RESTATED
EFFECTIVE JUNE 1, 2011
(Unless Otherwise Stated Herein)

BOARD OF TRUSTEES
INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
LOCAL 688 HEALTH & WELFARE PLAN

Employer Trustees	**Union Trustees**
Steve Palmer	Carl Neutzling
Mark Bosko	Douglas Anderson
Brian Damant	Lance Biglin
William Lucas	Hubert Rice

PLAN OFFICE
Jessica Carlisle, Office Manager
I.B.E.W. Local 688 Health & Welfare Plan
67 S. Walnut St.
P. O. Box 1384
Mansfield, OH 44902
(419) 529-5889

OFFICE OF THE ADMINISTRATIVE MANAGER
I.B.E.W. Local 688 Health & Welfare Plan
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, OH 44515
Toll Free: (800) 435-2388
Fax: (330) 270-0912

PLAN COUNSEL
Timothy P. Piatt, Esq.
4150 Belden Village Street, N.W.
Suite 602
Canton, OH 44718
(330) 493-1570

SPECIAL NOTICE!

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

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To: All Participants, Dependents and Beneficiaries of the
I.B.E.W. Local 688 Health & Welfare Plan

We are pleased to distribute this revised Summary Plan Description (the "SPD"), which details the benefits available under the I.B.E.W. Local 688 Health & Welfare Plan (the "Plan"). This booklet entirely replaces and supersedes your previous booklet. This document also serves as the I.B.E.W. Local 688 Health & Welfare Plan Document and supersedes and replaces any SPD or Plan Document previously issued by the Plan.

This booklet summarizes the eligibility rules for participation in the Plan, the benefits provided to those who are eligible and the procedures which must be followed in filing a claim or appeal. In addition, contained in the booklet is important information concerning the administration of the Plan and your rights under the Plan.

Benefits offered by the I.B.E.W. Local 688 Health & Welfare Plan are ***not guaranteed*** to Eligible Participants, Eligible Retirees, Eligible Dependents and/or Surviving Spouses or Dependents covered by the Plan. The Board of Trustees reserves the right to terminate or make any changes, modifications or amendments to the benefits which the Plan provides. The Board of Trustees also has full discretion to interpret the Plan.

As a number of changes have occurred in the Plan, we urge you to READ THIS BOOKLET CAREFULLY so that you are informed of the financial protection provided for those individuals who are eligible for benefits under the Plan.

If you have any questions concerning your eligibility, the general provisions of the Plan or the Schedule of Benefits, please contact the Plan Office. Also, please note that the receipt of this booklet does not infer that you are eligible for benefits. Your eligibility will be determined by the Plan's Rules of Eligibility, which are set forth in this booklet.

Sincerely,

BOARD OF TRUSTEES
I.B.E.W. Local 688 Health & Welfare Plan

I. GENERAL INFORMATION FOR PARTICIPANTS

Your Responsibilities As A Participant

The primary purpose of this Plan is to pay benefits to all those who are entitled. However, in order for the Trustees and the Plan Office staff to acheive this objective, we need your cooperation.

There are certain responsibilties which you, as a Participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable on your behalf.

A list of your responsibilities under the Plan follows. As you read this list, you will notice that none of these responsibilities is too burdensome. In fact, just a little time and effort on your part will assist in protecting your best interests under the Plan.

Take Time To Read This Booklet

This booklet is the primary source of information about the Plan. It 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 this booklet into smaller sections dealing with specific aspects of the benefit program and have tried to simplify the language whenever possible. Use of the masculine gender (for example, he or his) is used for convenience sake only and includes the feminine gender when applicable.

REMEMBER: No one can read this booklet for you. You owe it to yourself and your family to become familiar with the details of the Plan, and this booklet provides that information. Of course, if you have any questions about your Plan which are not answered in this booklet, be sure to contact the Plan Office or the Office of the Administrative Manager for additional assistance.

If You Haven't Filed Enrollment Cards – Do It Now!

When you first became eligible for benefits under the Plan, the Plan Office should have provided enrollment cards to you for your completion and return to the Plan Office. These cards request certain basic information that is needed for your records at the Plan Office, such as your Social Security number, your address, your date of birth, and the names, ages and Social Security numbers of your Dependents and Beneficiaries. ***This information is vital!*** Without it, the Plan Office will have difficulty keeping you informed about Plan changes. ***In addition, you run the risk of not having a permanent record of your participation in the Plan. SO IF YOU HAVEN'T COMPLETED AN ENROLLMENT CARD, DO IT NOW!*** If you are not sure whether you have an enrollment card on file, contact the Plan Office. The staff will advise you as to whether your card is on file. If not, a card will be sent to you for your completion.

Notify The Plan Office Promptly Regarding Any Changes In Address, Dependents, or Beneficiaries. If you fail to do this and the Plan pays benefits on behalf of an ineligible person, the Plan may pursue legal action against you to recover the amounts wrongly paid.

When there are Plan changes or benefit improvements, the Plan will advise you by first-class mail. If you move, be sure that the Plan Office and/or the Office of the Administrative Manager has your new address so that you can receive all current information concerning your Plan.

Also, if your marital status changes or if, for some other reason, you wish to change the names of your Dependents and Beneficiaries, don't forget to send the change in writing to the Plan Office and/or the Office of the Administrative Manager. ***Unless you do so, the latest beneficiary card on file will generally determine who receives any benefits that may be payable in the event of your death.*** Failure to change your designations is often just an oversight, but such an oversight could be costly to your survivors.

Finally, if you add any Eligible Dependents to your household, the Plan Office and/or Office of the Administrative Manager should be notified regarding the name and age of each new Dependent. Since this Plan does provide certain benefits for Eligible Dependents, the Plan Office must know who your Dependents are. ***Failure to notify the Plan Office could result in the delay and/or denial of benefits on behalf of your Dependents. The same notification requirement stands for loss of eligibility status, also.***

Medical Examination

No medical examination shall be required of any covered Eligible Participant, Eligible Retired Participant, Eligible Dependent, Surviving Spouse or Dependent ("Covered Persons") to secure this coverage. However, the Trustees shall have the right through any medical review process to have a qualified physician examine the individual as often as the Trustees may reasonably require during the pendency of a claim and the right and opportunity to order an autopsy, where it is not forbidden by law, in case of death.

The Trustees Interpret The Plan

Any interpretation of the Plan's provisions rests with the Board of Trustees. No Employer or Union, nor any representative of any Employer or Union, is authorized to interpret this Plan on behalf of the Board of Trustees, nor can an Employer or Union act as an agent of the Board of Trustees.

However, the Board of Trustees has authorized the Administrative Manager and the Plan Office staff to handle routine requests from Covered Persons regarding eligibility rules, benefits and claims procedures. If there are questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination.

The Plan Can Be Changed

The Trustees have the legal right to change this Plan Document, subject to any collective bargaining agreement that applies to it. Although the Trustees hope to maintain the present level of benefits and improve upon them, if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. Therefore, benefits provided by the Plan are not guaranteed to Covered Persons. Furthermore, the benefits provided by the Plan ***are not*** vested

benefits. The Board of Trustees reserves the right to terminate or make any changes, modifications or amendments to the benefits which the Plan provides.

Any amendment to the Plan will be made by a written resolution of a majority of the Trustees and shall be effective as of the date specified in the resolution. The Administrative Manager will notify all Covered Persons of any amendment modifying substantive terms of the Plan as soon as administratively possible after its adoption. Such notification will be in the form of a Summary of Material Modifications (within the meaning of ERISA Section 102(a)(1) and Labor Regulation Section 2520.104b-3), unless incorporated in an updated SPD and Plan Document.

Your Plan Is Tax Exempt

Your Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the Employer's contributions to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not taxable as personal income.

Investment 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. In effect, it means that 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 Service rules.

About Your Plan

The Plan is maintained as a result of a collective bargaining agreement between your Employer and your Union. The I.B.E.W. Local 688 Health and Welfare Fund (the "Fund") receives contributions from participating Employers on dates and in amounts called for by the labor contract negotiated between the Mansfield Division of the Central Ohio Chapter of the National Electrical Contractors Association and your Union.

For Participants of the Office and Salaried Program, the Employer contributions are in accordance with the levels established by the Board of Trustees and are subject to change as required by the Board of Trustees.

Decisions on Plan operations and benefits are made by the Plan's Board of Trustees on which labor and management are equally represented.

Working together, the Trustees establish rules of eligibility, strive constantly to improve benefits, supervise the investment of the Fund's money and confirm 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 following:

Plan Counsel advises the Trustees about procedures and requirements to ensure that all operations of the Plan comply with federal and state laws.

The ***Plan Consultant*** 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 Plan's operations.

An ***independent auditor*** examines the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees are required to submit annual financial statements and other reports to the Internal Revenue Service. These reports are available for inspection at the Plan Office during normal business hours.

This summary provides a brief description of how your Plan was established, what its purpose is and how it operates. The following pages describe how you and your family become eligible for benefits, the benefits which are available and your responsibilities under the Plan.

In The Event Of Plan Termination

In the event the Trustees feel the Plan is inadequate to carry out the intent and purpose under the Amended Agreement and Declaration of Trust or meet the payments due or coming due to, or on behalf of, Covered Persons, the Trustees may terminated the Plan. Upon Plan termination, provided 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; and

(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.

Covered Persons 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 Trustees are able to secure by the assets then in the Fund. In the event of self-funding, Covered Persons 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.

II. GENERAL DEFINITIONS

Whenever used in this SPD and Plan Document, the following terms shall be deemed to have the meanings described below.

Ambulatory Surgical Center – The phrase "Ambulatory Surgical Center" shall refer to a place that is approved or licensed as such by an agency of the governing jurisdiction.

Amendments – Changes made to the Plan or Plan Trust by the Board of Trustees. Amendments will be effective on the date specified in the Amendment. All Amendments will be consistent with the objectives and purposes of the Trust.

Annual Maximum Limit – The phrase "Annual Maximum Limit" on an Essential Health Benefit, as defined herein and under the Patient Protection and Affordable Care Act of 2010, as amended ("PPACA"), is the maximum annual dollar amount that can be used to cap the coverage of that benefit. For the Plan Year beginning on June 1, 2011, the applicable Annual Maximum Limit for any Essential Health Benefit is $1,000,000. For the Plan Year beginning on June 1, 2012, the applicable Annual Maximum Limit is $1,250,000. For the Plan Year beginning on June 1, 2013, the applicable Annual Maximum Limit is $2,000,000. For the Plan Year beginning on June 1, 2014, no maximum annual dollar amount will be imposed on any Essential Health Benefits under the Plan. Lifetime and Annual Maximum Limits may continue to be imposed on non-Essential Health Benefits.

Beneficiary – The term "Beneficiary" shall mean a person designated by a Participant or by the terms of the Plan who is or may become entitled to a death benefit.

Birthing Center – The term "Birthing Center" means a facility licensed as such by an agency of the State in which it operates. If the State does not have any license requirements, the facility must meet all of the following tests:

(A) It is primarily engaged in providing birthing services for low risk pregnancies;

(B) It is operated under the supervision of a licensed physician;

(C) It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;

(D) It has a written agreement with a licensed ambulance service to provide immediate transportation of a Covered Person to an accredited hospital as defined herein if an emergency arises; and

(E) It has a written agreement with an accredited hospital located in the immediate geographical area of the birthing center to provide emergency admission of the Covered Person.

Calendar Year – As used herein, the term "Calendar Year" means that period commencing on

the effective date the eligible person's coverage begins and shall continue until the next following January 1st. Each subsequent "Calendar Year" shall be from January 1st through December 31st.

Cosmetic Surgery – The term "Cosmetic Surgery" means surgery which is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Custodial Care – The term "Custodial Care" means care given solely to assist a person in the routine activities of housekeeping, eating, bathing and other activities of daily living.

Date Claim Incurred – The incurred date of your claim or that of your Eligible Dependents shall be the first date on which you or your Eligible Dependents are under the care of a Physician and/or had an expense which would be payable by the Fund for services rendered.

Eligible Dependent – The term "Eligible Dependent" or "Dependent" shall mean each of the following members of the your family:

(A) Your spouse (unless legally separated).

(B) Your children:

(1) who are under twenty-six (26) years of age; or

(2) who are incapable of self-sustaining employment due to mental retardation or physical disability and who, after age 26, are principally dependent on you for support and maintenance. You must furnish due proof of such incapacity within thirty-one (31) days of any such Dependent child's attainment of age 26.

(3) For purposes of this Plan, the term "child" shall refer to the following:

(a) Your natural children;

(b) Your legally adopted children from the date the child is placed in your home by a state agency or by an order of a court of competent jurisdiction, and not from the date of birth; and

(c) Your stepchildren. If your stepchild is eligible for coverage through another plan, eligible charges shall be subject to the Coordination of Benefits provisions of this Plan.

(C) If an Eligible Dependent, age nineteen (19) or over, is confined to a Hospital on the date on which benefits with respect to that Dependent would otherwise become effective, said benefits on account of that Eligible Dependent shall not become effective until the day immediately following his or her discharge from the Hospital.

(D) A Dependent child whose coverage ended, who was denied coverage, or who was not eligible for coverage because the availability of Dependent coverage of children ended before attainment of age twenty-six (26), is now eligible to enroll or re-enroll in the Plan. Such coverage will continue until the child reaches twenty-six (26) years of age. However, such a Dependent child is ***not*** eligible for coverage if and for as long as the Dependent child is eligible for health insurance coverage offered by the his/her employer. In addition, such individual must notify the Plan Office of the eligibility of such coverage provided to him or her by his or her employer. Failure to do so, as well as attempting to enroll or re-enroll for coverage under this Plan when simultaneously being eligible for another employer's coverage, may subject the individual to civil and criminal penalties.

Eligible Participant – The term "Eligible Participant" shall mean any Employee, as defined below, who is eligible for benefits under the Plan's eligibility rules as adopted by the Trustees and as set forth in this SPD and Plan Document.

Eligible Retired Participant – The term "Eligible Retired Participant" shall mean any Eligible Participant (Active or Officer & Salaried) who (1) has retired from employment; (2) is receiving either a Normal, Early or Disability Retirement Benefit from a pension plan acceptable to the Trustees; and (3) has been continuously eligible under the Plan for at least one (1) year immediately prior to the date he or she ceases work.

Emergency Accident Care – The term "Emergency Accident Care" shall mean the hospital benefits provided by the Plan if you receive emergency outpatient treatment as a result of a non-occupational accident.

Emergency Medical Care – The term "Emergency Medical Care" shall mean the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity or severe pain that the absence of immediate medical attention could reasonably result in:

- Permanently placing the patient's health in jeopardy;
- Causing serious and permanent dysfunction of any bodily organ or part;
- Causing serious impairment to bodily functions; or
- Causing other serious medical consequences.

Employee – The term "Employee" shall mean any general foreman, foreman, journeyman, intermediate journeyman, wireman, cable puller, residential trainee, teledata technician, trainee or apprentice who (1) is employed by parties to a collective bargaining agreement with the Union (as defined herein); (2) is represented by the Union and working for an Employer (as defined herein) that is or was required to make contributions to the Fund on such person's behalf; or (3) is an officer or employee of the Union on behalf of whom the Union has agreed to make contributions at the same rate fixed for other Employers making contributions to the Fund.

Employer or Participating Employer – As used herein, the term "Employer" shall mean:

(A) Any individual, firm, association, partnership or corporation that either is a member of the Mansfield Division of the Central Ohio Chapter of the National Electrical Contractors Association (the "Association"), or is represented in collective bargaining with the Association; and which is bound by a collective bargaining agreement between the Association and the Union and, in accordance therewith, agrees to make contributions to the Fund;

(B) Any individual, firm, association, partnership or corporation that is neither a member of nor represented in collective bargaining by the Association, but which has executed or is otherwise bound by a collective bargaining agreement between the Association and the Union and, in accordance therewith, agrees to make contributions to the Fund;

(C) The Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its employees on whose behalf it makes contributions to the Fund in accordance with a collective bargaining agreement between the Association and the Union or any other written agreement; or

(D) The Trustees of the Plan, or the trustees of any related employee benefit plan created as a result of collective bargaining between the Union and the Association, to the extent that they act in the capacity of an employer of their employees on whose behalf contributions to the Plan are made in accordance with a collective bargaining agreement between the Association and the Union or any other written agreement.

Essential Health Benefits – For Plan Years beginning on or after June 1, 2011, and as defined under the PPACA and applicable regulations, the phrase "Essential Health Benefits" refers at least to the following general categories of health benefits and devices: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services (including behavorial treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including pediatric oral and pediatric vision care.

Expense Incurred – The term "Expense Incurred" includes only those charges made for services and supplies that a prudent person would consider to be reasonably priced and reasonably necessary for the injury or sickness being treated.

Experimental or Investigative Drug, Device, Medical Treatment or Procedure – A drug, device, medical treatment or procedure is experimental or investigative:

(A) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

(B) If the drug, device, medical treatment, procedure, or the patient-informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;

(C) If Reliable Evidence, as defined below, shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(D) If Reliable Evidence, as defined below, shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

The term "Reliable Evidence" shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Home Health Agency – The term "Home Health Agency" means a public or private agency that:

(A) Is certified as a home health agency under Medicare or is licensed as a home health agency by the state in which it operates;

(B) Is primarily engaged in providing skilled nursing and other therapeutic services;

(C) Has its policies set by a professional group which governs the services provided; and

(D) Maintains records for each patient.

Hospice – The term "Hospice" means a public or private entity, or a portion thereof, which is licensed or certified as a hospice by Medicare and by the state in which it operates.

Hospital – The term "Hospital" means any institution that meets one (1) of the following requirements:

(A) Is an approved and accredited Hospital recognized by the American Hospital Association and is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis other than as a

rest home, nursing home, convalescent home, a place for the aged, unless:

(1) such confinement is for purposes other than convalescence; and

(2) the eligible person is not ambulatory during such confinement.

(B) Any institution which meets all of the following requirements:

(1) maintains permanent and full-time facilities for bed care of five (5) or more resident patients;

(2) has a licensed physician in regular attendance;

(3) continuously provides 24-hour per day nursing service by registered nurses;

(4) is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts or a place for alcoholics; and

(5) is operating lawfully in the jurisdiction where it is located.

Hospital Confined or Hospital Confinement – The term "Hospital Confined" or "Hospital Confinement" means confined in a hospital as a bed patient.

Illness – The term "Illness" is defined to mean:

(A) Bodily injury or sickness;

(B) Pregnancy, childbirth, or a condition that arises from pregnancy or childbirth; or

(C) Congenital defects or birth abnormalities, including premature birth for which more than routine nursery care is required, and transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the condition, when such ambulance transportation is certified by the attending physician as necessary to protect the health and safety of the newborn child.

Medically Necessary – The term "Medically Necessary" means that (1) the services, supplies, treatment or confinement in question must be generally recognized in the physician's practice or in the medical provider's profession as effective and essential for treatment of the injury or illness for which it is ordered; (2) the services, supplies, treatment or confinement in quesetion must be rendered at the appropriate level of care in the most appropriate setting based on generally recognized and accepted standards of medical practice in the United States; and (3) the care in questioin must be of the type that could not have been omitted without an adverse effect

on the patient's condition or the quality of medical care. On the other hand, services, supplies, treatments or confinement shall not be considered "Medically Necessary" if (1) they are experimental procedures; (2) they are investigational or primarily limited to research in their application to the injury or illness; (3) they are primarily for scholastic, educational, vocational or developmental training; or (4) they are primarily for the comfort, convenience or administrative ease of the provider, the patient, the patient's family, or the patient's caretaker.

Medicare – The term "Medicare" means the Part A and Part B plans described in Title XVIII of the United States Social Security Act, as amended. Effective January 1, 2006, Medicare shall mean the Part A, B and D (Prescription Coverage) plans decribed in Title XVIII of the United States Social Security Act.

Mental or Nervous Disorder – The term "Mental or Nervous Disorder" means mental illness or a functional nervous disorder.

Michelle's Law – If the Dependent of an Eligible Participant is a child enrolled in a postsecondary educational institution (including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965) and must take a Medically Necessary Leave of Absence, as defined below, the Plan shall not terminate coverage of such child before the date that is the earliest of:

(A) the date that is one (1) year after the first day of the Medically Necessary Leave of Absence; or

(B) the date on which such coverage would otherwise terminate under the terms of the Plan.

For the purposes of the Plan, the term "Medically Necessary Leave of Absence" means a leave of absence that:

(A) commences while such child is suffering from a serious illness or injury;

(B) is medically necessary; and

(C) causes such child to lose student status for purposes of coverage under the terms of the Plan.

The Plan must receive written certification by a treating physician of the child which states that he or she is suffering from a serious illness or injury and that the leave of absence is medically necessary.

The Plan shall include, with any notice regarding a requirement for certification of student status for coverage under the Plan, a description of the terms for continued coverage during a Medically Necessary Leave of Absence. Such description shall be in language that is understandable to the typical Participant.

The child whose benefits are continued under a Medically Necessary Leave of Absence shall be entitled to the same benefits as if, during such leave of absence, the child continued to be a covered student at the institution of higher education and was not on a Medically Necessary Leave of Absence. In addition, if the child is in a period of coverage under the Plan pursuant to a Medically Necessary Leave of Absence and

(A) the manner in which the Participant or Beneficiary is covered under the Plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(B) the coverage as so changed continues to provide coverage of Beneficiaries as Dependents,

then the Plan shall cover the child under the changed coverage for the remainder of the period of the Medically Necessary Leave of Absence of the child under the Plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

Nursing Home – The term "Nursing Home" means a licensed facility that is operating within the confines of the law to provide room and board for sick or injured persons under the supervision of a registered nurse or a doctor twenty-four (24) hours per day and meets all of the following tests:

(A) It has available at all times the services of a licensed physician who is on the staff of an accredited hospital;

(B) It maintains a daily medical record for each patient; and

(C) It is not primarily a place for rest or custodial care (i.e., assisted living), a place for the aged, a place for alcoholics or drug addicts or a hotel.

Physician or Surgeon – The term "Physician" or "Surgeon" means a person who is duly licensed to prescribe and administer all drugs and/or to perform all surgery; and shall include osteopaths, chiropractors, optometrists, podiatrists, dentists, psychologists and physical therapists when operating within the scope of their licenses, but not including the Participant, the spouse of the Participant, or persons in the immediate family of either the Participant or the Participant's spouse.

Plan Year or Fiscal Year – As used herein and for purposes of maintaining the Plan's financial records, the term "Plan Year" or "Fiscal Year" means the twelve-month period beginning on June 1 and ending on May 31.

Practitioner – The term "Practitioner" means a person, other than one defined above as a Physician or Surgeon, who:

(A) Upon referral by a physician or surgeon of medicine or doctor of osteopathy,

provides services which are covered by the Plan; and

(B) Is practicing within the scope of his or her license. Referral by a doctor of medicine or a doctor of osteopathy is not required for the services of a certified nurse midwife or a licensed midwife.

Qualified Medical Child Support Order (QMCSO) – The term "Qualified Medical Child Support Order" or "QMCSO" means a domestic relations court order that is issued as part of a child support proceeding which creates or recognizes the existence of the right of such child as an Alternate Recipient to receive benefits under a group health plan. The Plan will provide benefits in accordance with the applicable requirements of any QMCSO, as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Upon written request, a copy of the Plan's procedures regarding QMCSOs shall be provided to any Eligible Participant, Eligible Retired Participant, Surviving Spouse or Dependent.

Reconstructive Surgery – The term "Reconstructive Surgery" means surgery that is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. Reconstructive surgery also includes breast reconstruction following a masectomy which has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of a masectomy, including lymphedemas.

Surviving Spouse – The term "Surviving Spouse" means the surviving spouse of a decedent who was an Eligible Participant or Retired Eligible Participant. Such Surviving Spouse shall be eligible to participate in the Surviving Spouse Program, pursuant to this SPD and Plan Document and the applicable rules and regulations, until the Surviving Spouse is covered under another group program, excluding Medicare, or until the Surviving Spouse remarries.

Surviving Dependent – The term "Surviving Dependent" means the Dependent of a deceased Eligible Participant, Retired Eligible Participant or Surviving Spouse. Such Surviving Dependent shall become eligible to participate in the Surviving Dependent Program, pursuant to this SPD and Plan Document and the applicable rules and regulations, until the Surviving Dependent is covered under another group program, excluding Medicare.

Total Disability and Totally Disabled – The term "Total Disability" or "Totally Disabled" with respect to an Eligible Participant means the inability to perform work for pay, profit or gain at any job for which the individual is suited, by reason of education, training or experience, as a result of an Accidental Bodily Injury or Sickness. For an Eligible Dependent, Total Disability and Totally Disabled means the inability to perform the usual and customary duties or activities of an individual in good health and of the same age and sex.

Traditional Amount (TA) – The term "Traditional Amount" or "TA" means the maximum amount determined and allowed for a covered service based on the following factors:

- the actual amount billed by a provider for a given service;

- Centers for Medicare and Medicaid Services (CMS)'s Resource Based Value Scale (RBRVS);
- other fee schedules;
- input from particpating physicians and wholesale prices (where applicable); and
- other economic and statistical indicators and applicable conversation factors.

TA also means a charge or fee that is comparable and usually charged for the same or similar service rendered by other health care providers in the same geographical area and whose training, education and professional services are equivalent to those of the health care provider making such charge or fee.

Trust Fund and Trust Agreement – The term "Trust Fund" means the I.B.E.W. Local 688 Health & Welfare Fund, as established by the Trust Agreement. The term "Trust Agreement" shall mean the Amended Agreement and Declaration of Trust maintaining the I.B.E.W. Local 688 Health & Welfare Fund, as amended from time to time.

Trustees – The term "Trustees" as used in this SPD and Plan Document are the trustees of the I.B.E.W. Local 688 Health & 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 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 Persons.

Union – The term "Union" means the International Brotherhood of Electrical Workers Local Union No. 688.

Work-Related Illness or Injury – The term "Work-Related Illness" or "Work-Related Injury" means any illness or injury that arises from or is sustained in the course of work for pay, profit or gain.

III. GENERAL PROVISIONS AND LIMITATIONS

Guarantee Of Benefits

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Therefore, benefits offered by the Plan are not guaranteed to covered individuals. The Board of Trustees reserves the right to terminate or make any changes, modifications or amendments to the benefits which the Plan provides. No benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the participating Union, any Employer or the Trustees. The benefits provided for herein ***are not vested benefits***. The Trustees, the Employers and the participating Union shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the participating Union.

Exclusion For All Benefits Except For Life And Accidental Death & Dismemberment Benefits

Pre-Existing Condition Limitation – If you or your Eligible Dependent who is age nineteen (19) or over has been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under the Plan, then all expenses incurred as a result of such injury or illness will not be considered as eligible expenses until ninety (90) days after the effective date of coverage.

The Pre-Existing Condition Limitations are as follows:

The pre-existing condition limit is for ninety (90) days after the enrollment date under the Plan. This period is reduced, however, by counting certain prior coverage toward the exclusion period. Employees with six (6) months of coverage with one employer may move to a new employer with new coverage without becoming subject to the pre-existing condition exclusion of the new employer.

An employee is credited for prior coverage under a wide variety of health plans, including group health plans, individual policies, health maintenance organizations (HMOs), Medicare, and various governmental programs. Coverage is not counted toward the exclusion period of the new plan, however, if there has been an intervening break in coverage of 63 days or more, only coverage after the break may be credited.

An individual's prior plan must supply a certification of coverage at the time coverage ceases or, upon request of the individual, at any time within the next two (2) years. The certification must specify the period of creditable coverage. An employer that credits prior coverage by classes and categories of benefits must secure this information from the prior plan itself and pay a reasonable fee to the prior plan if requested.

If you do not receive a certificate by the time you should have received it or by the time you need it, your first step should be to contact the prior plan's administrator responsible for providing the certificate and request one. If any part of your creditable coverage was through an insurance company, you can also contact the insurance company for a certificate that reflects that part of your creditable coverage, as long as you make the request within twenty-four (24) months of

your coverage ceasing under the insurance policy. The Plan Office will assist you or your Eligible Dependent in obtaining a certificate of creditable coverage from any prior plan or issuer, if necessary.

In any event, if you do not receive a certificate, you may demonstrate to the Plan that you have creditable coverage (as well as the time you were in any waiting period) by producing documentation or other evidence of creditable coverage, such as pay stubs that reflect the deduction for health insurance, explanation of benefit forms (EOBs) or verification by a doctor of your former health care benefits provider that you had prior health insurance coverage.

Once you obtain a certificate of creditable coverage, you should keep it in your personal files in case you need it later. You will need the certificate if you leave your health plan and enroll in a subsequent plan that applies a pre-existing condition exclusion, or if you purchase an individual insurance policy from an insurance company.

No pre-existing condition limitation will apply to pregnancy, pregnancy-related conditions or a condition related to genetic information. Also, no pre-existing condition limitations will apply to anyone who is under nineteen (19) years of age.

Work-Related Injuries

This Plan will not pay for any charges received as a result of an injury or illness sustained or arising out of work performed for remuneration, profit or gain for which benefits are payable under the state's workers' compensation program or other similar laws, except for diagnostic-related charges that are incurred in determining if the injury or illness is work-related.

Medical Examination

The Trustees shall reserve the right, through a medical examiner, to examine a Covered Person as often as may be reasonably required during the pendency of a claim. The Trustees also reserve the right, where not forbidden by law, to order an autopsy in case of death where it is not forbidden by law.

Preferred Provider Network

The Plan has been attached to a Preferred Provider Network (PPN). The PPN is provided through Medical Mutual of Ohio and is known as Super Med Classic. The PPN's groups of hospitals and physicians have agreed to provide their services at discounted fees to the Plan's Participants and their Dependents who use the PPN providers' services. ***Your use of the PPN providers is strictly voluntary***. However, the cost savings experienced by both the Fund and you through the use of the PPN's providers will help to maintain current benefit costs and possibly provide future benefit improvements under the Plan for you and your Dependents. In many instances, your benefit for services provided by a PPN provider is paid at 80%, as compared to a 60% benefit if the services are rendered by a provider outside of the PPN.

Maintenance Drug Program

The mail order prescription drug program is provided on behalf of the Plan by SAV-RX Prescription Services. ***There may be a financial advantage (e.g., lower co-payments) for you if you use the mail order drug program.*** If you have any questions concerning this program, please contact SAV-RX Prescription Services at (866) 233-IBEW (4239), the Office of the Administrative Manager at (800) 435-2388 or the Plan Office at (419) 529-5889.

Weekly Disability Benefits

You should complete the appropriate portion of the claim form (Employee Statement), present it to your physician for completion of the attending physician's section and request that the physician forward the form to the Office of the Administrative Manager so that benefits can be processed on your behalf.

Life Insurance/Accidental Death & Dismemberment Benefits

Claim forms can be obtained from the Plan Office or the Office of the Administrative Manager.

For Retired Participants And Their Spouses Eligible For Medicare

You must furnish copies of your Explanation of Medicare Benefits (EOMB) forms to the Plan Office. If you should require assistance in filing your claims, please contact the Plan Office.

Ohio Fraud Warning Notice

Any person who knowingly (and with intent to defraud any insurance company or other person) files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Delinquent Contributions

In the event that a claim arises for an Eligible Participant or an Eligible Dependent and contributions necessary to maintain eligibility have not been received timely by the Plan Office on behalf of said individual, the claim will not be paid until such contributions are received by the Plan Office. In this instance, the Participant should notify the Plan Office of his employment and the Plan Office will make every attempt to collect the delinquency and pursue the collection of the cost of the claim from the Employer. Upon failure to obtain these items, the Participant may then appeal to the Board of Trustees for coverage of the benefit.

Termination Of Eligibility

In addition to the specific termination of eligibility provisions under the eligibility sections of this SPD and Plan Document, eligibility for benefits for a Covered Person will automatically terminate if any of the following events occurs:

(A) Termination of the Plan;

(B) Modification of the Plan to terminate coverage for the eligibility class to which such individual belongs;

(C) Plan modifications to terminate a particular type of benefit under the Plan;

(D) Such individual enters the Armed Forces on a full-time active duty basis;

(E) Such individual allows a non-covered or ineligible person to use his or her benefit card to obtain or attempt to obtain benefits from this Plan; or

(F) Such individual materially misrepresents information provided to the Plan or commits fraud or forgery.

Note: It will be your responsibility to ascertain your own eligibility status. Any notification of impending loss of eligibility will be considered a courtesy to you.

IV. RULES OF ELIGIBILITY
ACTIVE EMPLOYEES AND RESIDENTIAL/TELEDATA EMPLOYEES WORKING UNDER THE TERMS OF THE COLLECTIVE BARGAINING AGREEMENT

An Employee who is covered under the collective bargaining agreement between the Union and an Employer signatory to the Plan will be eligible for benefits subject to the following conditions:

Initial Eligibility (for Journeymen, Wiremen, Apprentices, Construction Wiremen, Construction Electrician, Teledata Technicians, Cable Pullers, Teledata Technician Apprentices)

If you have not been a previous Participant in the Plan and work your first hour of service on or after January 1, 2000, you will establish initial eligibility by working 200 hours in covered employment. The day you reach 200 hours of covered employment, you will be eligible for the remainder of the calendar quarter in which your initial eligibility has been established and also as follows:

If you reach the 200 hours in:	***You will be eligible for the remainder of that calendar quarter plus:***
January, February, & March	April, May, June & July
April, May & June	July, August, September & October
July, August & September	October, November, December & January
October, November & December	January, February, March & April

For example, if you reach the 200 hours in covered employment in January, February or March, you will be eligible until the end of March (the remainder of the calendar quarter), plus April, May, June and July.

An employee shall become covered on the date he first becomes eligible. To be eligible for subsequent quarters, you must meet the continuation of eligibility provisions set forth below. Note, however, that eligibility will continue only so long as you remain actively seeking work through the Union or the Joint Apprenticeship and Training Committee (JATC) as described in the subsection entitled "Self Contributions" below. Your benefits will cease and all reserve hours will be forfeited as of the last day of the calendar month in which you are no longer actively seeking work through the Union.

Continuation Of Eligibility

Once having met the rules of Initial Eligibility and becoming an Eligible Participant, you will remain eligible provided you are credited with minimum hours of employment per calendar quarters with one or more contributing Employers as outlined below.

You will be eligible during:	*If you work:*
May, June & July	300 hours January through March 600 hours October through March 900 hours July through March 1200 hours April through March
August, September & October	300 hours April through June 600 hours January through June 900 hours October through June 1200 hours July through June
November, December & January	300 hours July through September 600 hours April through September 900 hours January through September 1200 hours October through September
February, March & April	300 hours October through December 600 hours July through December 900 hours April through December 1200 hours January through December

This provision shall not apply if you have been ineligible for benefits for a period of twelve (12) months or longer. Once again, you are only eligible for benefits if you are actively seeking work through the Union as described in the subsection entitled "Self-Contributions" below. Your benefits will cease and all reserve hours will be forfeited as of the last day of the calendar month in which you are no longer actively seeking work through the Union.

Reinstatement Of Eligibility

If your eligibility is terminated due to failure to meet the eligibility requirements, you shall become eligible for benefits hereunder on the first day of the calendar month next following a period of three (3) consecutive months or less during which he has worked a minimum of four hundred (400) hours for which contributions have been made and received by the Fund. However, you must repay (or make the Fund whole) for any monies owed to the Fund, including but not limited to any monies owed to the Fund for misrepresentation, fraud or forgery.

Self-Contributions

If your eligibility for benefits terminates due to your failure to meet the eligibility requirements outlined above, you may arrange with the Trustees to continue eligibility, at your own expense, subject to the following conditions.

(A) You must be actively seeking work through the Union.

(1) To be "actively seeking work" you must:

(a) maintain your membership through the Union or JATC and register every thirty (30) days with the Union your continued availability for work;

(b) register every two (2) weeks with your home local union or JATC your continued availability for work if not a member of the Union; or

(c) provide evidence of your availability for work referred to you by your home local union or JATC at the time of referral which is identified as lasting at least one week.

(B) You may make self-payments representing the difference between the amount of hours paid on your behalf by a contributing Employer(s) and the minimum amount of hours required to maintain your eligibility.

(C) You may preserve your eligibility, as set forth in (1) above, if you are actively seeking work through the Union or JATC, subject to the following:

(1) if you are laid off, unemployed, on strike or have taken temporary employment with an employer outside the trade or craft or jurisdiction of the Union, you may preserve your eligibility for up to eighteen (18) months.

(2) if you are on an authorized leave of absence granted in accordance with the terms of the collective bargaining agreement, or by reason of union activities or governmental service or activity related to the construction industry, you may preserve your eligibility during the leave of absence period.

(3) if you become totally and permanently disabled so as to be prevented from performing your normal duties, you may preserve your eligibility during such disability and up to six (6) months following recovery, or until you become eligible for Medicare benefits, whichever occurs first.

(D) All self-contributions received become the property of the Fund as of the day received. Hours received relative to the work quarter for which the self-contribution was made, whether as a result of a late payment or a reciprocity agreement, may result in the self-payment being refunded.

Reciprocity

If you are working in a jurisdiction other than that of your home local union, you may be able to authorize the transfer of your hourly contributions to this Plan under the Electrical Industry Health & Welfare Reciprocal Agreement. In order to do this you must complete a Reciprocity Authorization form and all appropriate paperwork through the I.B.E.W. Electronic Reciprocity

Transfer System ("ERTS") at the time you are referred for employment. Monies are transferred at the lesser of:

(A) The other local union's rate of contribution; or

(B) This Plan's rate of contribution.

The number of hours of credit you will receive is based on this Plan's current hourly contribution rate.

Disability

For the purpose of maintaining eligibility, any employee who, due to disability as a result of accidental bodily injury or sickness, is receiving or is entitled to receive benefits under this Plan or is receiving or is entitled to receive benefits under any Workers' Compensation Law or Occupational Disease Law, shall be credited, commencing on the eighth day of disability, with twenty-five (25) hours for each week that he or she is receiving or is entitled to receive such benefits. The maximum credit shall be limited to three hundred (300) hours per disability.

Termination Of Eligibility

In addition to the general termination of eligibility provisions established elsewhere in this SPD and Plan Document, your eligibility for benefits will automatically terminate if any of the following events occurs:

(A) You are not actively seeking work through the Union or JATC;

(B) The last day of the eligibility quarter for which your participating Employer pays contributions to the Fund on your behalf; or

(C) You fail to make any required self-payment or COBRA payments.

Note: It is the responsibility of each Participant to ascertain his own eligibility status. Any notification of impending loss of eligibility will be considered a courtesy to the Participant.

Extension Of Benefits

If you (or your Eligible Dependent) were to become totally disabled as a result of an illness or accident that is not work-related, on the date coverage under the Plan for you (or your Eligible Dependent) would otherwise terminate, benefits would be paid to the same extent as if the coverage were still in effect for expenses incurred, but only for that specific illness or accident and only until the first of the following events occurs:

(A) The date on which the person ceases to be disabled;

(B) The date on which coverage with respect to such illness or accident takes effect

under any other group plan of medical benefits; or

(C) Three (3) months from the date the coverage ceases.

Family And Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) guarantees certain employees a minimum of twelve (12) weeks of coverage under the Plan based on premium payment provisions in effect immediately prior to such leave. The FMLA applies to employers who employ fifty (50) or more employees within seventy-five (75) miles of the employee's worksite for each workinq day during each twenty (20) or more calendar work weeks in the current or preceding Calendar Year.

Notwithstanding any provision in this Plan to the contrary, the following provisions shall apply to an Eligible Participant who requests, and receives, a leave of absence pursuant to the FMLA:

(A) An Eligible Participant must have been employed by the employer (i) for at least twelve (12) months; and (ii) for at least 1,250 hours of service during the twelve (12) month period immediately preceding the commencement of the leave.

(B) If the Eligible Participant is covered by the collective bargaining agreement negotiated by the Union, the Fund shall continue eligibility for the Participant and credit contributions on behalf of the Eligible Participant who is using FMLA leave as though the Eligible Participant had been continuously employed for a maximum of twelve (12) weeks as allowed by law.

(C) For the duration of the Eligible Participant's FMLA leave, coverage by the Plan, and benefits provided pursuant to the Plan, shall continue at the level coverage would have continued if the Participant had remained actively employed.

(D) An Eligible Participant using FMLA leave shall not be required to utilize his hours normally considered for purposes of "Continuation of Eligibility" (as provided for herein), or pay any greater premiums, than the Eligible Participant would have been required to pay if the Eligible Participant had been continuously employed.

(E) An Eligible Participant, upon returning from FMLA leave, shall be reinstated in the Plan to the same status as provided when the leave began, subject to benefit changes that affect all Participants in the Plan. The Eligible Participant shall not be subjected to any restrictions, waiting periods, physical examinations or other pre-existing condition exclusions that would not have been imposed upon the Eligible Participant had he or she not taken the FMLA leave.

Effective January 28, 2008, Participants with members in the Armed Forces are entitled to FMLA leave under the following circumstances:

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

(B) 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 (26) weeks of leave in a single twelve (12) month period.

Participants Serving In The Armed Forces

(A) An Active Eligible Participant who enters the Armed Forces of the United States on a full-time basis shall have the option of freezing his or her hours normally considered for purposes of the "Continuation of Eligibility" section elsewhere in this SPD and Plan Document, if any, until discharged from active full-time military duty; or utilizing his Reserve Bank, if any, to continue coverage under the Plan, as provided below.

(B) In the event an Active Eligible Participant who enters into full-time military duty of the United States has no hours accumulated towards "Continuation of Eligibility," has insufficient hours accumulated towards "Continuation of Eligibility" to maintain coverage while serving in the military service, or does not elect to utilize his or her hours accumulated towards "Continuation of Eligibility" to maintain coverage while serving in active full-time military service, contination of coverage under the Plan for the Active Eligible Participant and his or her Eligible Dependents can be continued for twenty-four (24) months, upon receipt of a timely application and required contributions established by the Board of Trustees.

(C) If an Active Eligible Participant enters the Armed Forces on a short-term basis of thirty-one (31) days or less of continuous military service, coverage under the Plan will be continued for the Active Eligible Participant and his or her Eligible Dependents at the Plan's expense. For military service that exceeds thirty-one (31) days, the Active Eligible Participant shall be responsible for contributions for those months of service subsequent to the initial service of thirty-one (31) days.

(D) An Active Eligible Participant shall notify the Plan Office or the Office of the Administrative Manager as soon as he knows or understands that he will be entering the military service of his desire to purchase continuation health care coverage for that period of time when he is in active military service, not to exceed twenty-four (24) months. This notice requirement shall be adhered to by the Active Eligible Participant unless giving such notice is precluded by military necessity or is otherwise impossible or unreasonable.

(E) Upon an Active Eligible Participant's discharge from military service, the Active

Eligible Participant's eligibility status under the Plan will be restored to the status that existed when he entered military service, with the exception of any hours accumulated towards "Continuation of Eligibility" that the Active Eligible Participant may have elected to utilize during military service. In order to restore such eligibility in the Plan, the Active Eligible Participant must notify the Plan Office, in writing, within sixty (60) days of his discharge of his intent to return to covered employment. In addition to such written notice, the Active Eligible Participant shall also supply the Plan Office or the Office of the Administrative Manager with copies of his discharge papers showing the date of his education or enlistment in military service and the date of his discharge. Failure on the part of the Active Eligible Participant to file such notice and documentation with the Plan Office may be deemed an indication that the Active Eligible Participant does not wish to restore his eligibility status under the Plan.

Effective Date Of Dependent Coverage

Your Eligible Dependents become eligible for coverage at the same time you become eligible for your coverage, or on a date when you first acquire an Eligible Dependent, whichever is later. The coverage on any Eligible Dependent will not become effective unless your coverage is also in effect on such date.

Eligible Dependents whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age twenty-six (26) are eligible to enroll or re-enroll in the Plan. Eligible Participants or Eligible Dependents may request enrollment for such children for thirty (30) days from the date of notice. Enrollment will be effective retroactively to the first day of Plan Year. For more information about enrollment for Eligible Dependents, contact the Plan Office.

Termination Of Eligibility

In addition to the general termination of eligibility provisions established elsewhere in this SPD and Plan Document, the benefits of an Eligible Dependent will terminate on whichever of the following dates occurs first:

(A) The date the Active Eligible Participant's coverage under the Plan terminates;

(B) The date of any plan modification to terminate coverage for Eligible Dependents; or

(C) The first day following the date such Eligible Dependent ceases to be an Eligible Dependent, as defined by the Plan.

Extension Of Dependent Coverage For A Disabled Child

If the coverage of an Eligible Dependent child would terminate solely due to attainment of the maximum age, and if:

(A) Such Eligible Dependent child became incapable of self-support due to mental retardation or physical disability which began prior to the attainment of such age,

(B) Such Eligible Dependent child is actually dependent upon the Eligible Participant for support and maintenance, and

(C) Such Eligible Participant furnishes to the Board of Trustees satisfactory proof of all of the foregoing within 31 days of such Eligible Dependent child's attainment of such maximum age,

then coverage of such Eligible Dependent child will continue past age 26. Otherwise, the Eligible Dependent child's coverage will be terminated in accordance with the termination provisions of the Plan.

The Board of Trustees may reasonably require that the Eligible Dependent child be examined by a medical examiner designated by the Board of Trustees, at the Plan's expense, prior to this extension. In addition, during the two (2) years following the Eligible Dependent child's attainment of the maximum age, the Board of Trustees may require satisfactory proof at reasonable intervals, including medical examination at the Plan's expense. However, after the two (2) year period has expired, such proof, including medical examinations, may not be required more than once per Calendar Year.

RULES OF ELIGIBILITY
OFFICE AND SALARIED PROGRAM

Eligibility shall be provided under the Office and Salaried Employee Program, provided that:

(A) You are a full-time non-bargaining unit Employee working for an Employer signatory to a contract with the Union, as reflected in the payroll records of the Employer;

(B) Your Employer has agreed to an Assent to Participate in the I.B.E.W. Local No. 688 Health & Welfare Plan's non-bargaining Unit Office & Salaried Program; and

(C) Contributions required by the Trustees are received by the Fund.

Initial Eligibility

Office and Salaried Participants will become eligible on the first day of the month following the third month in which contributions of the amount determined by the Board of Trustees are made.

Termination Of Eligibility

In addition to the general termination of eligibility provisions established elsewhere in this SPD and Plan Document, your eligibility for benefits will automatically terminate when no additional contributions have been made on your behalf.

Note: It is the responsibility of each Participant to ascertain his own eligibility status. Any notification of impending loss of eligibility will be considered a courtesy to the Participant.

Self-Contributions

If your eligibility for benefits terminates due to a reduction in the number of hours worked or termination of employment for any reason (except gross misconduct), you may arrange with the Trustees to continue your eligibility at your own expense, subject to the Plan's COBRA provisions established elsewhere in this SPD and Plan Document.

Extension Of Benefits

If you or your Eligible Dependent is totally disabled as a result of an illness or accident, which is not work-related, on the date coverage under the Plan for such person would otherwise terminate, benefits will be paid to the same extent as if the coverage were still in effect for that specific illness or accident until the earlier of:

(A) The date on which the person ceases to be disabled;

(B) The date on which coverage with respect to such illness/accident takes effect

under any other group plan of medical benefits; or

(C) Three (3) months from the date the coverage ceased.

Family And Medical Leave Act

Notwithstanding any provision in this SPD and Plan Document to the contrary, the following provisions shall apply to an Eligible Office and Salaried Participant who requests, and receives, a leave of absence pursuant to the Family and Medical Leave Act of 1993 (FMLA).

In general, the FMLA guarantees certain employees a minimum of twelve (12) weeks of coverage under their health and benefit plan based on premium payment provisions in effect immediately prior to such leave. The FMLA applies to any employer that employs fifty (50) or more employees within seventy-five (75) miles of the employee's worksite for each working day during each of twenty (20) or more calendar work weeks in the current or preceding Calendar Year.

Under the terms of this Plan, an eligible Employee must have been employed by an Employer (i) for at least twelve (12) months; and (ii) for at least 1,250 hours of service during the twelve (12) month period immediately preceding the commencement of the leave.

(A) For an Eligible Office and Salaried Participant, the Employer of such Participant shall continue to make contributions on behalf of the Eligible Participant using FMLA leave as though the Eligible Participant had been continuously employed.

(B) For the duration of the Eligible Participant's FMLA leave, coverage under the Plan and benefits provided pursuant to the Plan shall continue with the same coverage as if the Participant had remained actively employed.

(C) An Eligible Participant, upon returning from FMLA leave, shall be reinstated in the Plan to the same status as provided when the leave began, subject to benefit modifications that affect all Participants. The Participant shall not be subjected to any restrictions, waiting periods, physical examinations or other pre-existing condition exclusions that would not have been imposed upon the Eligible Participant had he or she not taken the FMLA leave.

Participants Serving In The Armed Forces

The Plan's eligibility provisions for Office and Salaried Eligible Participants serving in the Armed Forces are in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

(A) An Office and Salaried Eligible Participant who enters the Armed Forces of the United States on a full-time basis shall have the option of freezing his or her Reserve Bank, if any, until discharged from active full-time military duty to continue coverage under the Plan, as provided hereafter.

(B) Contination of coverage under the Plan for an Office and Salaried Eligible Participant and his or her Eligible Dependents can be continued for twenty-four (24) months, upon receipt of a timely application and required contributions established by the Board of Trustees,

(C) If an Office and Salaried Eligible Participant enters the Armed Forces on a short-term basis of thirty-one (31) days or less of continuous military service, coverage under the Plan will be continued for the Office and Salaried Eligible Participant and Eligible Dependents at the Plan's expense. For military service that exceeds thirty-one (31) days, the Office and Salaried Eligible Participant shall be responsible for contributions for those months of service subsequent to the initial service of thirty-one (31) days.

(D) An Office and Salaried Eligible Participant shall notify the Plan Office as soon as he or she knows or understands that he or she will be entering the military service of his or her desire to purchase continuation health care coverage for that period of time when he or she is in active military service, not to exceed twenty-four (24) months. This notice requirement shall be adhered to by the Office and Salaried Eligible Participant unless giving such notice is precluded by military necessity or is otherwise impossible or unreasonable.

(E) Upon an Office and Salaried Eligible Participant's honorable discharge from military service, the Office and Salaried Eligible Participant's eligibility status under the Plan will be restored to the status that existed when he or she entered military service. In order to restore such eligibility in the Plan, the Office and Salaried Eligible Participant must notify the Plan Office, in writing, within sixty (60) days of his or her discharge of his or her intent to return to covered employment. In addition to such written notice, the Office and Salaried Eligible Participant shall also supply the Plan Office with copies of his or her discharge papers showing the date of his or her education or enlistment in military service and the date of his or her discharge. Failure on the part of the Office and Salaried Eligible Participant to file such notice and documentation with the Plan Office may be deemed an indication that the Office and Salaried Eligible Participant does not wish to restore his or her eligibility status under the Plan.

Effective Date Of Dependent Coverage

Each Eligible Dependent of an Office and Salaried Eligible Participant will become eligible for coverage at the same time the Eligible Participant becomes eligible for coverage, or on a date when the Eligible Participant first acquires a Dependent, whichever is later. The coverage on any Eligible Dependent will not become effective unless the Eligible Participant's coverage is also in effect on such date.

Eligible Dependents whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age twenty-six (26) are eligible to enroll or re-enroll in the Plan. Eligible

Participants or Eligible Dependents may request enrollment for such children for thirty (30) days from the date of notice. Enrollment will be effective retroactively to the first day of Plan Year. For more information about enrollment for Eligible Dependents, contact the Plan Office.

Termination Of Dependent Coverage

In addition to the general termination of eligibility provisions established elsewhere in this SPD and Plan Document, the benefits of an Eligible Dependent of an Office and Salaried Eligible Participant will terminate on whichever of the following dates occurs first:

(A) The date the Office and Salaried Eligible Participant's coverage under the Plan terminates;

(B) The date of any plan modification to terminate coverage for Eligible Dependents; or

(C) The first day following the date such Eligible Dependent ceases to be an Eligible Dependent, as defined by the Plan.

Extension Of Dependent Coverage For A Disabled Child

If the coverage of an Eligible Dependent child of an Office and Salaried Eligible Participant would terminate solely due to attainment of the maximum age, and if:

(A) Such Eligible Dependent child becomes incapable of self-support due to mental retardation or physical disability prior to the attainment of such age;

(B) Such Eligible Dependent child is dependent upon the Office and Salaried Eligible Participant for support and maintenance; and

(C) Such Office and Salaried Eligible Participant furnishes to the Board of Trustees satisfactory proof of all of the foregoing within 31 days of such dependent child's attainment of such maximum age,

then coverage of such Eligible Dependent child will continue past age 26. Otherwise, the Eligible Dependent child's coverage will be terminated in accordance with the termination provisions of the Plan.

The Board of Trustees may reasonably require the Eligible Dependent child be examined by a medical examiner designated by the Board of Trustees, at the Plan's expense, prior to this extension. In addition, during the two (2) years following the Eligible Dependent child's attainment of the maximum age, the Board of Trustees may require satisfactory proof, at reasonable intervals, including medical examination at the Plan's expense. However, after the two-year period, such proof, including medical examinations, may not be required more than once per Calendar Year.

RULES OF ELIGIBILITY
RETIREE PROGRAM

If an Eligible Participant retires from employment and is receiving either a Normal, Early or Disability Retirement Benefit from a pension plan acceptable to the Trustees, the Eligible Participant will be eligible for benefits under the Retiree Program, providing the Eligible Participant must have been continuously eligible under the Plan for at least one (1) year immediately prior to the date he ceases work. Within thirty-one (31) days following his eligibility to participate in the Retiree Program, the Participant must satisfactorily complete the Retiree Program application, to be furnished by the Plan Office or the Office of the Administrative Manager, upon request, and must remit the necessary contributions, as required by the Trustees.

Payment Of Contributions

Retiree Program contributions are determined in accordance with the levels established by the Board of Trustees and are subject to change, as required by the Board of Trustees.

Termination Of Eligibility

In addition to the general termination of eligibility provisions established elsewhere in this SPD and Plan Document, the benefits of an Eligible Retired Participant and his Eligible Dependent covered under the Retiree Program will terminate on whichever of the following dates occurs first:

(A) The date the Eligible Retired Participant's coverage terminates;

(B) The date of expiration of the period for which the last contribution is made to the Fund, as required on account of the Eligible Retired Participant's coverage;

(C) The date the Eligible Retired Participant ceases to be within the classes of persons eligible for covered under the Retiree Program; or

(D) The date on which the Eligible Retired Participant's death occurs

Reemployment Of Eligible Retired Participants

If an Eligible Retired Participant returns to work for a Contributing Employer and contributions are received on his behalf, the hours worked will be credited toward the Initial Eligibility requirements under the Active Program for Eligible Participants. No credit will be given under the Retiree Program for those contributions received. Should sufficient hours be received to satisfy the Initial Eligibility requirements of the Plan under the Active Program, the Retired Participant's coverage will be transferred to the Active Program. The Retired Participant will then be entitled to the benefits available under the Active Program. The eligibility rules of the Active Program will apply to the Retired Participant until he becomes eligible once again to participate in the Retiree Program.

RULES OF ELIGIBILITY
SURVIVING SPOUSE AND SURVIVING DEPENDENT PROGRAM

Eligibility Of Surviving Spouse

If the decedent was an Eligible Participant or Eligible Retired Participant upon death, his Spouse shall be eligible to participate in the Surviving Spouse Program until the Surviving Spouse is covered under another group program, excluding Medicare, or until the Surviving Spouse remarries. The Surviving Spouse shall have the right to elect to join the Surviving Spouse Program within sixty (60) days after the date of termination of coverage as an Eligible Dependent of the deceased Eligible Participant or Eligible Retired Participant by making application and remitting timely monthly contributions established by the Trustees.

Eligibility For Benefits Of Surviving Dependent

A Dependent of a deceased Eligible Participant, Eligible Retired Participant or Eligible Surviving Spouse shall be eligible to participate in the Surviving Dependent Program as long as remaining a Dependent as that term is defined in this Plan and provided said Eligible Dependent:

(A) Elects to participate in the Surviving Dependent Program by making application within sixty (60) days following the death of the Eligible Participant, Eligible Retired Participant or Eligible Surviving Spouse; and

(B) Remits timely monthly contributions established by the Trustees.

Benefits For Surviving Spouse Or Surviving Dependent

If the Surviving Spouse or Surviving Dependent becomes eligible for benefits by meeting the eligibility requirements, as stated above, the benefits provided under either the Surviving Spouse Program or the Surviving Dependent Program, as applicable, will be the same as those previously provided to the Spouse or Dependent of the Eligible Participant or Eligible Retired Participant at the time of the Participant's death and dependent upon the age of the Surviving Spouse or Surviving Dependent.

Termination Of Eligibility

If the Surviving Spouse fails to join the Surviving Spouse Program (or the Surviving Dependent fails to join the Surviving Dependent Program) by making application within sixty (60) days following the death of the Eligible Participant or Eligible Retired Participant, or fails to make contributions required by the Trustees, eligibility for benefits shall terminate and the Surviving Spouse (or Surviving Dependent) shall not be able to be reinstated to the Surviving Spouse Program (or the Surviving Dependent Program) in the future.

In addition to the general termination of eligibility provisions established elsewhere in this SPD and Plan Document, the benefits of a Surviving Spouse under the Surviving Spouse Program, as well as the benefits of a Surviving Dependent under the Surviving Dependent Program, will

terminate on whichever of the following dates occurs first:

(A) The date the Plan is modified to terminate coverage for Surviving Spouses or Surviving Dependents; or

(B) The date on which such Surviving Spouse or Surviving Dependent fails to make any required self-payment or COBRA payments.

V. SPECIAL ENROLLMENT RIGHTS

An Active Eligible Participant, Eligible Retired Participant, or Eligible Dependent of such Participant who is eligible, but not enrolled for coverage under the Plan, may enroll for coverage under the terms of the Plan should the Participant or Eligible Dependent lose other coverage if either Scenario I or Scenario II below is met:

(A) Scenario I

(1) The Participant or Eligible Dependent was covered under a group health plan or had health insurance at the time coverage was previously offered to the Participant or Eligible Dependent;

(2) The Participant or Eligible Dependent stated in writing at such time that coverage under a group health plan or health insurance was the reason for declining enrollment and provided a copy of such written statement to the Plan Office or the Office of the Administrative Manager; **and**

(3) The Participant's or Eligible Dependent's coverage:

(a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or if not under such COBRA provision, then either the coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment), or employer contributions toward such coverage was terminated; **and**

(b) The Participant or Eligible Dependent requests such special enrollment in writing not later than sixty (60) days after the loss of coverage or termination of employer contributions.

(B) Scenario II

(1) The Participant or Eligible Dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage, or the Participant or Eligible Dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under a Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the Participant requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the Participant or Eligible Dependent is determined to be eligible for such assistance.

Even if the Participant or Eligible Dependent notifies the Plan Office within sixty (60) days after the loss of coverage or termination of employer coverage, the Participant or Eligible Dependent should refer to the Coordination of Benefits provisions established elsewhere in this SPD and Plan Document.

An Active Eligible Participant, Eligible Retired Participant, or Eligible Dependent of such Participant shall have the right to special enrollment in the Plan after the marriage, birth, adoption, or placement for adoption. The Participant or Eligible Dependent must request such enrollment not later than sixty (60) days after the event giving rise to the special enrollment rights (e.g., marriage, birth, adoption, or placement for adoption).

If you fail to notify the Plan Office within the time period of sixty (60) days stated above, you may still apply for special enrollment. However, the Eligible Dependent will not be eligible for benefits until the first of the month following the month in which you notify the Plan Office in writing. In addition, there shall be no retroactive coverage and all of the pre-existing exclusions shall apply if the Plan Office is not notified within the sixty (60) day time period stated above.

VI. SCHEDULE OF BENEFITS
ELIGIBLE PARTICIPANTS AND DEPENDENTS
(ACTIVE, INSIDE, RESIDENTIAL/TELEDATA AND OFFICE AND SALARIED PARTICIPANTS)
(Subject To The Provisions Described Herein)

Generally speaking, the Participant's or Dependent's co-payment for medical services rendered by an in-network provider (Medical Mutual of Ohio's network) shall be paid on an 80/20 basis (i.e., 20% co-payment). However, if the services are rendered by an out-of-network provider, the claims shall be paid on a 60/40 basis (i.e., 40% co-payment).[1] Both in-network and out-of-network percentage of payment shall be paid on the first $10,000 of covered charges. After you have incurred $10,000 of covered charges for any charges (both in-network and out-of-network services combined), payment will be made at 100% for both in-network and out-of-network services.

The following is a brief summary of the Schedule of Benefits provided by the Plan. Please refer to pages referenced for complete information.

Hospital Room & Board	70 day maximum per confinement. Semi-Private Room Rate payable at 100%.
Intensive Care	Not to exceed three (3) times Semi-Private Room Rate
Surgical Expense Benefit	80% of TA[2] (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Outpatient Benefits	
Pre-Admission Testing; Same-Day Surgery	80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Maternity Benefit (for Female Eligible Participant, Spouse of Male Eligible Participant, and Eligible Female Dependent)	Payable as any other illness. 80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Skilled Nursing Facility Services	80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.

[1] Except neoromusculoskeletal benefits
[2] TA = Traditional Amount (as defined elsewhere in this SPD and Plan Document)

Home Health Care Nursing Services	80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Extended Care Facility or Nursing Home (Benefits not to exceed thirty (30) days and must be for rehabilitative purposes)	80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Outpatient Diagnostic X-ray and Laboratory Procedures	80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Psychiatric and Psychological Testing (Outpatient)	80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Emergency Hospital Treatment (For Emergency Accident Care or Emergency Medical Care, as defined by the Plan)	80% of TA (60% of TA if out-of-network) on physician's services after $100.00 co-payment[3] and Calendar Year Deductible are satisfied.
Treatment of Nervous/Mental Disorders	
Inpatient	Follows Hospital Room & Board; 70 day maximum per confinement. Semi-Private Room Rate payable at 100%.
Outpatient	80% of TA (60% of TA if out-of-network) after the Calendar Year Deductible is satisfied.
Inpatient Psychiatric and Psychological Testing	Follows Hospital Room & Board; 70 day maximum per confinement. Semi-Private Room Rate payable at 100%
Treatment Of Chemical, Alcohol And Drug Abuse	
Inpatient	Follows Hospital Room & Board; 70 day maximum per confinement. Semi-Private Room Rate payable at 100%

[3] Co-payment shall be waived if you are admitted to the hospital subsequent to the emergency treatment.

Outpatient	80% of TA (60% of TA if out-of-network), after the Calendar Year Deductible is satisfied.
Pain Management or Therapy Treatment	80% of TA (60% of TA if out-of-network), after the Calendar Year Deductible is satisfied.
Physician's Visits	80% of TA (60% if out-of-network) after $25.00 co-payment per visit, and is subject to the Calendar Year Deductible.
Annual Physical Examinations (Active Hourly Participants only)	100% of TA up to $150.00 per calendar year. Charges in excess of $150.00 per Plan Year are payable based on 80% of TA (60% of TA if out-of-network), after the Calendar Year Deductible is met.
Neuromusculoskeletal Benefit (for manipulation or modality)	After 12 visits, must demonstrate proof of medical necessity. Total maximum of 36 visits per year.
Physical Therapy	80% of TA (60% of TA if out-of-network), after the Calendar Year Deductible is satisfied.
Organ and Tissue Transplant Services	80% of TA (60% of TA if out-of-network).
Hospice Care	80% of TA (60% of TA if out-of-network).
Temporomandibular Joint Dysfunction (TMJ)	100% of TA up to $400.00 Lifetime Maximum. ***No Maximum for Pediatric TMJ treatments.***
Ambulance Service or Life Flight Benefit (single trip)	80% of TA (60% of TA if out-of-network), after the Calendar Year Deductible is met.

Life Flight Benefit (single trip)	80% of TA (60% of TA if out-of-network), after the Calendar Year Deductible is met.

MAJOR MEDICAL EXPENSES
(Other Than Those Medical Expenses Already Listed Above)

In Network: Such expenses shall be paid at 80% of the first $10,000 of covered charges (both in-network and out-of-network combined) after Calendar Year Deductible ($250.00 per person) is satisfied.

Out-of-Network: Such expenses shall be paid at 60% of the first $10,000 of covered charges (both in-network and out-of-network combined) after Calendar Year Deductible ($250.00 per person) is satisfied.

All expenses in excess of $10,000 of covered charges per Calendar Year shall be paid at 100% thereafter.

PRESCRIPTION DRUGS
ELIGIBLE PARTICIPANTS, NON-MEDICARE ELIGIBLE RETIRED PARTICIPANTS AND THEIR DEPENDENTS

(A) Pharmacy

$12.00 co-payment – generic
$35.00 co-payment – brand name
$55.00 co-payment – if brand name purchased when generic is available.

(B) Mail Order

(1) 45-day supply – controlled substances

$20.00 co-payment – generic
$35.00 co-payment – brand name
$75.00 co-payment – if brand name purchased when generic is available.

(2) 90-day supply – other medically necessary prescriptions

$30.00 co-payment – generic
$90.00 co-payment – brand name
$150.00 co-payment – if brand name purchased when generic is available.

Note: All retail and mail order prescription drug charges in excess of $5,000 incurred in a calendar year by an Eligible Participant or Eligible Dependent will be payable based on a 40

percent (40%) co-payment for the remainder of the Calendar Year. Also, coverage is subject to the applicable Traditional Amount.

Prescription Safety Glasses (Active Participants Only)	100% (maximum of one pair every two years)

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT AND ACCIDENT & SICKNESS ACTIVE HOURLY AND OFFICE AND SALARIED ELIGIBLE PARTICIPANTS

Life Insurance Benefit	$10,000.00
Accidental Death & Dismemberment Benefit	$10,000.00

WEEKLY BENEFITS - ACTIVE HOURLY PARTICIPANTS ONLY

Accident & Sickness Weekly Benefits (1st day, accident; 8th day, illness)	$225.00/week; 26 week/maximum

DENTAL AND VISION CARE BENEFITS ACTIVE HOURLY AND OFFICE AND SALARIED ELIGIBLE PARTICIPANTS

Non-Pediatric Dental and Vision Care Benefits	100% of combined total up to a maximum of $800 per year for non-pediatric services. This benefit is not subject to the deductible.
Pediatric Dental and Vision Care Benefit	Subject to Annual Maximum Limit (as defined in this SPD and Plan Document), if any.

Note: Claims are payable through the Plan Office. Payments will be made directly to the Participants. Proof of payment to the provider is required. The Plan has up to thirty days from the date when the Participant presents the expense claim(s) to pay the applicable benefit. For payment to be received for claims paid in a Calendar Year, the claim and proof must be submitted to the Plan Office not later than January 31st of the following Calendar Year.

SCHEDULE OF BENEFITS
RETIREE PROGRAM

For Eligible Retired Participants, Surviving Spouses And Their Eligible Dependents Not Yet Eligible For Medicare

Hospital, Medical and Surgical Benefits:	The benefits shall be the same as the benefits provided under the Active Program (except for the exclusion of Accident & Sickness Weekly Benefits and Accidental Death & Dismemberment Benefits).

For Eligible Retired Participants, Surviving Spouses And Their Eligible Dependents Eligible For Medicare (Parts A And B)

The following Schedule of Benefits is provided to Eligible Retired Participants, Surviving Spouses and their Eligible Dependents who are eligible for Medicare, Parts A and B:

Inpatient Hospital Charges	Part A Deductible Amounts
Skilled Nursing Facility Expenses (Medicare-approved)	Part A Deductible – 21st through 100th day
Blood (when furnished by hospital or skilled nursing facility during a covered confinement)	First three pints
Medical Expenses	20% of Medicare-approved amount after $110 Calendar Year Deductible is satisfied.
Durable Medical Equipment	Twenty percent (20%) of Medicare-approved amount / Calendar Year
Outpatient Hospital Treatment	Twenty percent (20%) of Medicare-approved amount after $110 Calendar Year Deductible
Ambulatory Surgical Services	Twenty percent (20%) of Medicare-approved amount after $110 Calendar Year Deductible

Preventive: Annual Mammograms, Pelvic Examinations (annual – high risk, every 3rd year – average risk), Prostatic Specific Antigen (PSA), Colonoscopy (starting at age 50, every 10 years)	Twenty percent (20%) Medicare-approved amount (Annual Deductible waived)

Retiree Prescription Program (for Medicare Eligible Participants and Spouses): Retirees are eligible for prescription benefits through SAV-RX Prescription Services Economy Plan. This program provides economical prescription benefits for certain formulary drugs at a $10.00 co-payment (generic) or a $20.00 co-payment (brand name). The formulary list of prescription drugs for which you will be able to utilize the $10.00 (generic) or $20.00 (brand name) co-payments shall be determined by SAV-RX Prescription Services' Economy Plan design and the Trustees of the Plan have no control over such list. If a needed drug is not part of the Economy Plan formulary, your cost will be 100% of the SAV-RX discounted rate.

Exclusions: If you are eligible for, but not enrolled in, Medicare Part A and B, the Plan will make its payment in consideration of the benefits which would have been payable on your behalf under the Medicare program. ***Benefits will not be payable by this Plan for any expenses that Medicare does not consider to be eligible benefits under Medicare.***

VII. SUMMARY OF MAXIMUM LIFETIME BENEFITS FOR NON-ESSENTIAL HEALTH BENEFITS

(Applies To All Participants, Dependents, Surviving Spouses And Surviving Dependents)

Gastric Bypass Surgery (when medically necessary) – $10,000.00

Hospice Care – $50,000.00

Non-Pediatric Temporomandibular Joint Dysfunction (TMJ) – $400.00

VIII. SUMMARY OF CONTINUATION OF COVERAGE (COBRA)

A federal law has been adopted requiring most employers that sponsor group health care plans to offer Covered Employees and their Dependents the opportunity to continue their health care coverage in certain instances where the coverage under the Plan would otherwise end.

Your Rights

If you are an Employee covered by the Plan, you have the right to choose continuation coverage if you lose your eligibility for coverage under the Plan due to a reduction in the number of hours worked or termination of employment for any reason, unless termination is due to gross misconduct on your part.

If you qualify for continuation coverage due to a reduction of hours or termination of employment but do not elect such coverage for your entire family, your Spouse or Dependent Children are still entitled to elect continuation coverage.

If you are the Spouse of a Participant covered under the Plan, you have the right to choose continuation coverage for yourself if you lose your group health care coverage under the Plan for any of the following reasons:

(A) Termination of your Spouse's employment (for reasons other than gross misconduct), or a reduction in the hours worked by your Spouse;

(B) Death of your Spouse;

(C) Divorce or legal separation from your Spouse: or

(D) Your Spouse becomes enrolled in Medicare following the date of the Qualifying Event.

If you are a Dependent Child of a Participant covered under the Plan, you have the right to continuation coverage if you lose your eligibility for coverage under the Plan for any of the following reasons:

(A) Termination of employment (for reasons other than gross misconduct) or a reduction in the number of hours worked by your parent, who is the Covered Participant under the Plan;

(B) Death of your parent, who is the Covered Participant under the Plan;

(C) Parents' divorce or legal separation;

(D) Your parent who is the covered Participant under the Plan becomes enrolled in Medicare following the date of the Qualifying Event; or

(E) You cease to satisfy the Plan's definition of a "Dependent Child".

Newborn And Adopted Children

A child who is born to or placed for adoption with an individual under COBRA during a period of COBRA coverage will also be eligible to become a Qualified Beneficiary. Qualified Beneficiaries can be added to COBRA coverage upon proper notification to the Plan Office within 31 days of the birth or adoption. In addition, COBRA coverage may be elected on behalf of a newborn or adopted child if the parent is no longer entitled to COBRA.

Your Obligations

Under the law, you or a family member have a responsibility to notify the Plan Office about a divorce, legal separation or a child losing Dependent status under the Plan. Such notification should take place immediately after any of these three events occurs. If such an event is not reported to the Plan Office within sixty (60) days after it occurs, continuation coverage will not be provided.

It is the responsibility of the individuals to notify the Plan Office regarding any of the following events:

(A) Death

(B) Divorce/legal separation

(C) Termination of employment

(D) Reduction in hours

(E) Medicare enrollment

(F) Disability, as determined by the Social Security Administration

(G) Qualification for services under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) due to military service

It would be advisable, however, for the Spouse of a deceased Participant to contact the Plan Office as soon as possible after the Participant's death so that continuation of coverage can be made available to the Surviving Spouse and any Dependent Children at the earliest possible date.

It is also extremely important that the covered Participant, Spouse or Dependent notify the Plan Office immediately about any changes in address so that if anyone qualifies for continuation coverage, the election notice will be mailed to the correct address. This is critical because the election of continuation coverage must be made within a sixty (60) day time limit. If the notice is sent to the wrong address, the time limit may be exceeded, in which case no continuation coverage would be extended.

Procedures For Obtaining Continuation Coverage – Other Requirements

Once the Plan Office knows that an event has occurred which qualifies you or other family members for continuation coverage, the Plan Office will notify you about your right to elect continuation coverage. Upon qualification for continuation coverage, once you receive this election notice, you will have sixty (60) days after the later of the date your coverage will terminate or the date of the election notice within which to notify the Plan Office whether or not you want the continuation coverage. If you do not elect the coverage within the sixty (60) day time period, your group health coverage will end.

In addition, in order to continue coverage, the first payment must be made to the Plan Office within forty-five (45) days of the election. Thereafter, monthly payments must be made to the Plan Office no later than thirty (30) days from the due date of the payment.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay for all or part of the amount required for continuation coverage. If a charge is made, it will be shown on the election notice. If you elect continuation coverage, the Plan is required to give coverage which, as of the time such coverage is provided, is identical to the coverage provided other similarly situated beneficiaries and for which you were eligible prior to the Qualifying Event.

The law requires that you be given an opportunity to maintain continuation coverage for a maximum of thirty-six (36) months unless you lost your coverage due to a termination of employment or due to a reduction in hours worked, in which case the required continuation period is eighteen (18) months. If you are determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of continuation of coverage and provide notice to the Administrative Manager of the disability determination within sixty (60) days after the date the determination is issued and before the end of the initial coverage period, the maximum coverage for you and other members of your family who have elected COBRA coverage may be extended for an additional eleven (11) months (for a total of twenty-nine (29) months).

In addition, the American Recovery and Reinvestment Act of 2009 (ARRA) and the Department of Defense Appropriation Act of 2010 reduce the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008, and ending with February 28, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the Plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage.

Particularly, the law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009, and can last up to fifteen (15) months.

To be considered an "Assistance Eligible Individual" and get reduced premiums, you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008, through February 28, 2010, and elect the coverage;

- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008, through February 28, 2010;

- MUST NOT be eligible for Medicare; AND

- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.[4]

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008, through February 28, 2010, and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

IMPORTANT

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare, you MUST notify the Plan Office in writing. If you do not, you may be subject to a tax penalty.

- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return), all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For specific information related to your plan's administration of the Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact the Office of the Administrative Manager, I.B.E.W. Local 688 Health & Welfare Plan, 67 S. Walnut Street, Mansfield, Ohio 44902, (419) 529-5889.

If you are denied treatment as an "Assistance Eligible Individual," you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the Premium Reduction, go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

[4] Generally, this does not include coverage for only dental, visions, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

Termination Of COBRA Coverage

The law also provides that continuation coverage may be canceled for any of the following reasons:

(A) Your Employer no longer provides group health care coverage;

(B) The premium for your continuation coverage is not paid on a timely basis or is not paid in full;

(C) You become covered under another group health plan following the date of your Qualifying Event (provided that the other group health plan does not contain exclusions or limitations with respect to any pre-existing conditions);

(D) You become enrolled in Medicare after the date of your election of COBRA coverage; or

(E) You have extended coverage for up to twenty-nine (29) months due to your disability and there has been a final determination that you are no longer disabled.

Continuation coverage under COBRA is provided subject to your eligibility for coverage. The Plan reserves the right to terminate your COBRA coverage if you are determined to be ineligible.

It is recommended that you contact the Plan Office if you should have any questions concerning COBRA.

A copy of a general COBRA Notice to be supplied to Participants and Dependents upon eligibility for COBRA benefits is provided in the next section of this SPD and Plan Document.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this Notice because you have recently become covered under a group health plan (the Plan). 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 this SPD or contact the Plan Office, I.B.E.W. Local 688 Health & Welfare Plan, 67 S. Walnut Street, Mansfield, Ohio

44902 (419-529-5889) or Office of the Administrative Manager, I.B.E.W. Local 688 Health & Welfare Plan, c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio, 44515 (Toll Free: (800) 435-2388; Fax: (330) 270-0912).

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:

(A) Your hours of employment are reduced; or

(B) 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:

(A) Your spouse dies;

(B) Your spouse's hours of employment are reduced;

(C) Your spouse's employment ends for any reason other than his or her gross misconduct;

(D) Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or

(E) 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:

(A) The parent-employee dies;

(B) The parent-employee's hours of employment are reduced;

(C) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(D) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);

(E) The parents are divorced or legally separated; or

(F) 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 Plan Office or 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 Plan Office or the Office of the Administrative Manager.

How Is COBRA Coverage Provided?

Once the Plan Office or 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 spouses, 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 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. Also, there are two ways in which the 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.

You must notify the Plan of the disability within sixty (60) days of the determination of disability by the Social Security Administration and before the end of the eighteen (18) month continuation period. If the Social Security Administration later determines that you are no longer disabled, you must notify the Plan of that determination within thirty (30) days of the determination. You must send written notice to:

Plan Office
I.B.E.W. Local 688 Health & Welfare Plan
67 S. Walnut Street
Mansfield, Ohio 44902

You should use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Plan Office of a disability determination.

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.

You must notify the Plan within sixty (60) days after the second qualifying event occurs. You must sent this notice to:

Plan Office
I.B.E.W. Local 688 Health & Welfare Plan
67 S. Walnut Street
Mansfield, Ohio 44902

You may use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notfy the Plan Office of these events.

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 NOTICE FORM
FOR COVERED EMPLOYEES AND QUALIFIED BENEFICIARIES

From:_____ (Enter your name)

Address:_____ (Enter your address)

To: I.B.E.W. Local 688 Health & Welfare Plan
67 S. Walnut Street
Mansfield, Ohio 44902

Date: _____

Re: COBRA Notice to I.B.E.W. Local 688 Health and Welfare Plan

Dear Plan Office Manager:

This letter is to inform you of the following event(s) **[Check the event(s) that apply and include and/or attach the requested information]**:

☐ My spouse and I have/will become divorced or legally separated.

Date of divorce or legal separation: _____

Names of covered employees (participant) and all qualified beneficiaries (spouse and other dependents):

_____

_____

Attach a copy of the decree of divorce or legal separation.

☐ My child will/has ceased to be covered under the Plan as a dependent child of a participant.

Date child has/will no longer be considered a dependent _____

Name of child:_____

Reason why child is no longer a dependent:

_____

☐ I myself and/or my dependents, who are currently receiving COBRA, have a second qualifying event due to an employee's death, entitlement to Medicare, divorce or legal

separation or child losing dependent status.

State the qualifying event that applies:_____

Date of the Second Qualifying Event:_____

Attach a certified copy of the death certificate or a copy of the decree of divorce or legal separation.

☐ I myself and/or my dependent have been determined to be disabled by the Social Security Administration.

Name of the Disabled person: _____

Date of the Social Security determination:_____

Attach a copy of the determination letter from the Social Security Administration.

☐ I myself and/or my dependent have been determined to be no longer disabled by the Social Security Administration.

Name of the Disabled person: _____

Date of the Social Security determination: _____

Attach a copy of the determination letter from the Social Security Administration.

If you have any questions about this Notice Form, please contact me or [my representative _____ (enter the name of your representative, if you have named one to act on your behalf)] at the following telephone number _____.

My current address, and that of my dependents, is:

_____.

_____.

_____.

Sincerely,

_____

(Signature of Covered Employee or Qualified Beneficiary who is completing this Notice)

_____

(Print Name of Covered Employee or Qualified Beneficiary who is completing this Notice)

COBRA CONTINUATION COVERAGE ELECTION NOTICE
(To Be Provided To All Eligible Participants Upon A Qualifying Event)

Date: _____

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 I.B.E.W. Local 688 Health & Welfare Plan. 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 I.B.E.W. Local 688 Health & Welfare Plan, 67 S. Walnut Street, Mansfield, Ohio 44902; (419) 529-5889.

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 _____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 _____ and can last until _____.

COBRA continuation coverage will cost $_____ 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:

Plan Office
I.B.E.W. Local 688 Health & Welfare Plan
67 S. Walnut Street
Mansfield, Ohio 44902
Phone: (419) 529-5889

You may mail it to the address shown on the Election Form or hand deliver it to the Plan 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 furnish a completed Election Form 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 I.B.E.W. Local 688 Health & Welfare Plan (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, the 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:

- any required premium is not paid in full;
- 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;
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage; or
- 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 Plan Office or 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 directions 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, for 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. First, you can lose the right to avoid having pre-existing condition 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 will 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 percent (or in the case of an extension on continuation coverage due to a disability, 150 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 tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees for are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the 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 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. More information about the Trade Act is available at www.doleta.gov/tradeact/2002act_index.cfm.

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:

Plan Office
I.B.E.W. Local 688 Health and Welfare Plan
67 S. Walnut Street
P.O. Box 1384
Mansfield, Ohio 44902
Phone: (419) 529-5889

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:

Plan Office
I.B.E.W. Local 688 Health and Welfare Plan
67 S. Walnut Street
P.O. Box 1384
Mansfield, Ohio 44902
Phone: (419) 529-5889

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.

Can You Elect Other Health Coverage Besides Continuation Coverage?

No.

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 SPD 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 SPD, you should contact the I.B.E.W. Local 688 Health & Welfare Plan, 67 S. Walnut Street, Mansfield, Ohio 44902; Phone: (419) 529-5889.

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.)

Keep Your Plan Informed Of Address Changes

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

IX. LIFE INSURANCE BENEFITS

Life Insurance Benefits

If you are an Active Hourly Participants or Office and Salaried Participant, you shall be eligible for life insurance benefits upon your initial eligibility date under the Plan. However, if you are not available for active, full-time work on that date, you will not be eligible for the life insurance benefits provided by the Plan until you return to or become available for active, full-time work.

In the event of your death while covered under this Plan, the Plan, through the insurance carrier, will provide a death benefit payment of $10,000.00 to your designated Beneficiary(ies). A death benefit of $5,000.00 is provided under the Plan to the designated Beneficiary(ies) of Retired Participants.

Any conversion privileges for such benefits would be limited to any such privileges which ***may*** be available through any insurance company contracted by the Plan to provide such benefits, if the Plan does not self-insure such benefits.

X. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR ACTIVE HOURLY AND OFFICE AND SALARIED PARTICIPANTS ONLY

The insurance company engaged by the Plan shall provide a benefit of $10,000.00 on your behalf resulting from injuries sustained in an accident, provided that:

(A) The losses occur within 90 days following the date of the accident; and

(B) Are a direct and exclusive result of the injuries, independent of all other causes.

Schedule of Losses

Life	$10,000.00
Both Hands or Both Feet	$10,000.00
Sight of Both Eyes	$10,000.00
One Hand and One Foot	$10,000.00
One Hand or Foot and Sight of One Eye	$10,000.00
One Hand or One Foot	$5,000.00
Sight of One Eye	$5,000.00

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Loss of hand or foot means severance of entire hand or foot at or above the wrist or ankle joint respectively. Loss of sight means the total and irrecoverable loss of sight.

Exclusions/Limitations

Benefits will not be payable for a loss which is caused directly or indirectly, wholly or partly, by any of the following:

(A) Bodily or mental illness, or disease or any kind;

(B) Ptomaines or bacterial infections (except infections caused by pyogenic organisms that occur with and through an accidental cut or wound);

(C) Suicide or attemped suicide, while sane or insane;

(D) Intentional self-inflicted injury;

(E) Participation in, or the result of participation in, the commission of a felony, riot, or civil commotion;

(F) War or act of war, declared or undeclared, or any act related to war or insurrection;

(G) Service in the armed forces of any country while such country is engaged in war; or

(H) Police duty as a member of any military, naval or air organization.

Designation Of Beneficiary (Life And Accidental Death And Dismemberment Benefits)

Your Beneficiary shall be the person who you have designated on a form satisfactory to the insurance company engaged by the Plan. If you designate more than one Beneficiary but fail to indicate the amount each Beneficiary should receive, the total amount will be shared equally by all surviving Beneficiaries.

You may change your Beneficiary at any time by filing a written notice satisfactory to the insurance company. The new designation shall take effect on the date you sign the notice of change. When a new designation takes effect, the interest of any previous Beneficiary shall cease.

In the event you have not designated a Beneficiary or the Beneficiary is not alive at your death, payment will be made in the following order of preference:

(A) Surviving spouse;

(B) Surviving children, in equal shares:

(C) Surviving parents, in equal shares;

(D) Surviving brothers and sisters, in equal shares; or

(E) Executor or administrator of your estate.

Any conversion privileges for such benefits would be limited to any such privileges which ***may*** be available through any insurance company contracted by the Plan to provide such benefits, if the Plan does not self-insure such benefits.

XI. ACCIDENT AND SICKNESS WEEKLY BENEFITS ACTIVE HOURLY ELIGIBLE PARTICIPANTS ONLY

When you are disabled due to an accident or sickness, and under the care of a legally qualified physician, the Weekly Benefit will be paid to you beginning on the day shown in the Schedule of Benefits, up to the maximum number of weeks payable during any disability, as specified in the Schedule of Benefits.

During partial weeks of disability, you will be paid at the daily rate of one-seventh of the Weekly Benefit.

Maximum Benefit

A maximum benefit of twenty-six (26) weeks shall be applied for each Period of Disability.

Period Of Disability

Successive periods of disability due to unrelated causes which are separated by your return to full-time employment for at least eighty (80) hours within two (2) consecutive weeks shall be considered separate periods of disability for purposes of determining maximum benefits. Successive periods of disability related to the same cause shall be considered as one period of disability unless the subsequent disability is separated from the prior disability by eighty (80) hours within two (2) consecutive weeks of active full-time work or normal employment.

Exceptions And Limitations

Payment under this Plan shall not be made for the following:

(A) Disabilities resulting from your occupation or employment and which are considered eligible for payment under any workers' compensation or occupational disease law (or similar law);

(B) Disabilities for which you are not under the care of a legally qualified physician and for which there is no acceptable certification of the illness or accident provided to the Office of the Administrative Manager by the physician.

(C) Disabilities for which you have or had a right to payment under the temporary disability laws of any state.

XII. HOSPITAL, MEDICAL AND SURGICAL BENEFITS FOR ELIGIBLE PARTICIPANTS, ELIGIBLE RETIRED PARTICIPANTS, ELIGIBLE DEPENDENTS, SURVIVING SPOUSES AND DEPENDENTS

If a Covered Person incurs expenses as a result of non-occupational sickness or injury, the Plan will provide the benefits described below, subject to the applicable maximums and deductibles as set forth in the Plan.

Plan Deductible And Co-Payment Amounts

Payment of Eligible Expenses is provided by the Plan if the Covered Person incurs Covered Charges as a result of accidental bodily injury or illness. The Plan will pay the Covered Charges unless indicated to the contrary herein. Each Covered Person shall be subject to the Calendar Year Deductible of $250.00. Furthermore, each Covered Person shall be required to pay 20% of all Major Medical Expenses (in-network) and 40% of all Major Medical Expenses (out-of-network) out of the first $10,000 of covered charges.

Inpatient Hospital Expense Benefits

(A) Hospital Room and Board – Benefits will be payable up to the Semi-Private Room Rate for a maximum of 70 days during any one period of confinement. Benefits will also be payable for the Traditional Amount Room Rate for Intensive Care, Burn Unit, Cardiac Care and Isolation or Contagion Care, but not to exceed three (3) times the Hospital's Semi-Private Room Rate. These items include operating, recovery, delivery rooms and other treatment rooms; diagnostic tests such as x-rays, scans, laboratory tests, electrocardiograms and electroencephalograms, medical and surgical dressing, supplies, casts and splints, blood processing and administration, oxygen, anesthetics and drugs, radiation therapy, and physical therapy. Hospital Miscellaneous benefits will also be provided for a newborn baby's nursery charges during the time the mother is confined.

(1) Continuous Confinement – Successive periods of Hospital confinement of the Eligible Participant or Eligible Dependent due to the same or related causes, not separated by a return to the Participant's regular occupation for a period of eighty (80) hours within two (2) consecutive weeks of active full-time work or normal employment, will be considered one period of Hospital confinement. In the case of an Eligible Dependent or a Retired Participant not eligible for Medicare, successive periods of Hospital confinement, due to the same or related causes, not separated by ninety (90) consecutive days will be considered one period of Hospital confinement.

(B) Hospital Miscellaneous Charges – Benefits will be payable for a maximum of seventy (70) days during any one period of confinement for the Traditional Amount of miscellaneous items needed for inpatient treatment or evaluation when

ordered by a Physician and necessary for diagnosis or treatment.

(C) In-Hospital Medical Benefits – Medical care expense benefits, while confined, will provide payment of the Traditional Amount charged per physician's visit up to the maximum of seventy (70) visits per confinement. In-Hospital Medical Benefits will not be payable for more than one treatment in any one day, or for any treatment which is not rendered by a Physician or Surgeon in the physical presence of the patient. In-Hospital Medical Benefits will not be provided for dentistry, eye refractions or the fitting of glasses. Benefits are provided for consultations if required by the patient's medical condition and the provider in charge of the case requests the consultation. You are limited to one (1) consultation per consultant during any one inpatient stay.

(D) Surgical Benefits – Benefits will be payable to a maximum of 80% (60% out-of-network) of the Traditional Amount for surgery performed by a legally qualified Physician or Surgeon. Two (2) or more surgical procedures performed through the same incision will be considered as one (1) operation.

(E) Voluntary sterilization procedures will be payable in accordance with the Plan's established surgical rates. Expenses relating to a reverse sterilization procedure will not be considered eligible for payment under the Plan.

(F) Voluntary abortions for Covered Persons will be considered as an eligible expense under the Plan only in the event it is medically necessary as a life-sustaining measure on behalf of the mother, or if it is a result of a criminal act, as verified by not less than two (2) physicians.

(G) The Plan will not cover any charges relating to cosmetic surgery, except for the repair of accidental non-occupational injuries sustained while covered under this Plan, or for those procedures covered in accordance with the Women's Health and Cancer Rights Act of 1998, as set forth below. (Also refer to Plan Limitations And Exclusions Section of the booklet.)

Women's Health and Cancer Rights Act of 1998 – The Plan's Schedule of Benefits shall include benefits for: 1) reconstruction of the breast on which a mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and treatment for physical complications of all stages of mastectomies, including lymphedemas.

Outpatient Benefits

Pre-Admission Testing/Same-Day Surgery – If the Physician orders pre-admission testing in a Hospital or Same-Day Surgery performed in an operating room and such services are in lieu of being provided on an inpatient basis, the Plan will provide for payment of these services at 80% (60% out-of-network) of the Traditional Amount subject to the Calendar Year Deductible.

Maternity Benefits

Mothers' and Newborns' Health Protection Act – Maternity benefits for female Eligible Participants, spouses of male Eligible Participants and Eligible Dependents for any hospital confinement in connection with childbirth for the mother or newborn child will not be restricted to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Caesarean section. It is permissible for a mother and her newborn to be voluntarily discharged before the forty-eight (48) hour or ninety-six (96) hour minimum has elapsed with the Physician's consent.

Maternity-related expenses will be payable as any other illness for female Eligible Participants, legal spouses of male Eligible Participants and Eligible Dependents.

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). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Not Payable – No benefits will be provided for surrogate pregnancies. (Refer to Plan Limitations And Exclusions, Item MM.)

Skilled Nursing Facility Services – If you require skilled nursing care, you may use any unused portion of the inpatient hospital maximum stay for care in a Skilled Nursing Facility. Two days of care in a Skilled Nursing Facility count as one inpatient hospital day. Coverage will be provided for semiprivate accommodations and all other services provided by the Facility which are necessary for the treatment of illness or injury for which you are confined.

No skilled nursing facility benefits are provided for:

(A) After you have reached the maximum level of recovery possible, and you require only supportive care, or when skilled nursing services are not required to be provided by licensed professionals on a continuing daily basis; or

(B) When confinement is intended solely for convenience or for custodial care.

Home Health Nursing Care Benefits – Home Health Care benefits are limited to one hundred (100) visits per person per Calendar Year. When you are essentially homebound and required home care services, benefits will be available for the following when provided by a hospital program for Home Health Care of Home Health Care Agency:

(A) Skilled nursing services of an RN or LPN, excluding private duty nursing services;

(B) Physical, occupational or speech therapy;

(C) Medical and surgical supplies;

(D) Oxygen and its administration;

(E) Medical social services; and

(F) Home health aide services when you are also receiving covered nursing or therapy services.

No benefits are provided for:

(A) Dietitian services;

(B) Homemaker services;

(C) Maintenance therapy;

(D) Dialysis treatment or equipment;

(E) Meals; or

(F) Drugs and medications.

Extended Care Facility or Nursing Home – Benefit for such services must be for rehabilitative purposes. Payment for such treatment shall be made at 80% (60% if out-of-network) of the Traditional Amount, after the Calendar Year Deductible is satisfied.

Outpatient Diagnostic X-ray and Laboratory Benefits – These benefits will pay for diagnostic X-ray, consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine, diagnostic pathology, consisting of laboratory and pathology tests, diagnostic medical procedures, consisting of electrocardiogram, electroencephalogram, other electronic diagnostic medical procedures, and physiological medical testing at 80% (60% if out-of-network) of the Traditional Amount for such service. Benefits will also be provided for routine mammograms and pap smears and prostatic specific antigen (PSA) tests. Benefits will also be provided for one colonoscopy every 10 years beginning at age 50.

Not Payable – No benefits will be payable under this provision for expenses relating to hearing and speech tests, eye refractions or pre-marital examinations. (Refer to Plan Limitations and Exclusions.)

Psychiatric and Psychological Testing – Payment for such treatment shall be made at 80% (60% if out-of-network) of the Traditional Amount, after the Calendar Year Deductible has been satisfied.

Emergency Hospital Treatment – The Plan will provide benefits for outpatient Emergency Accident Care of Emergency Medical Care as a result of accidental bodily injury. Payment for such treatment shall be made at 80% (60% if out-of-network) of the Traditional Amount after the Calendar Year Deductible is met, and will also be subject to a $100.00 co-payment.

Nervous And Mental Disorders – Inpatient shall be 70 day maximum per confinement, Semi-Private Room Rate payable at 100%. Outpatient treatment for nervous and mental disorders will be payable at 80% (60% out-of-network) of Traditional Amount, after the Calendar Year Deductible has been satisfied.

The services rendered must be provided under the clinical supervision of a licensed physician or a licensed psychologist, whether performed in an office, hospital or a community mental health facility approved by the Commission on Accreditation of Hospitals or certified by the Department of Mental Health and Mental Retardation.

Psychiatric or Psychological Testing will be payable at 80% (60% out-of-network) of Traditional Amount charged, after the Calendar Year Deductible is satisfied.

Chemical, Alcohol And Drug Abuse – Inpatient shall be 70 day maximum per confinement, Semi-Private Room Rate payable at 100%. Outpatient treatment will be payable at 80% (60% out-of-network) of the Traditional Amount, after the Calendar Year Deductible has been satisfied. Eligibility for inpatient benefits requires completion of a rehabilitation program for treatment in its entirety in order for the expenses incurred to be considered for payment by the Plan.

Pain Management Treatment or Therapy Treatment – Pain Management or Therapy Treatment by a licensed physician or provider will be payable at 80% (60% out-of-network) of Traditional Amount charged, after the Calendar Year Deductible is satisfied.

Physician's Visits – Benefits are for services provided by a medical or osteopathic physician and are payable at 80% (60% if out-of-network) of the Traditional Amount, after the Calendar Year deductible is met. You will also be required to pay a $25.00 co-payment per visit.

Annual Physical Examinations (for Active Hourly Participants only) – Benefits are payable at 100% of the Traditional Amount subject to a maximum provider charge of $150.00 per calendar year. Any charges in excess of the $150.00 maximum are payable based upon 80% (60% if out-of-network) of the Traditional Amount, subject to the Calendar Year deductible.

Treatment For Neuromusculoskeletal Conditions (Chiropractic) – The benefits provided under the Plan relating to treatment of neuromusculoskeletal conditions shall be subject to the following conditions and limitations:

(A) The Plan will consider eligible charges incurred only for active therapeutic treatment for an acute or chronic condition which is directed toward the correction of the condition within an anticipated reasonable and predictable period of time.

(B) Diagnostic tests and therapeutic treatments must be considered to be scientifically valid and clinically accepted in accordance with established medical review mechanisms and standards.

(C) Treatments using manipulation or adjustment that are performed only by hand shall be considered as an eligible expense under the Plan.

(D) X-ray expenses will be considered for payment under the Plan, provided that they are considered to be medically necessary. ***Full spine x-rays will not be considered for payment under the Plan.***

(E) Manipulation, mobilization, adjustment, massage and/or physical therapy charges that are incurred by an Eligible Dependent who is under the age of ten (10) will not be considered for payment by the Plan unless prescriptions from a Board-certified pediatrician and a Board-certified pediatric orthopedist have been furnished.

(F) ***Treatment will be limited to a maximum number of thirty-six (36) visits per Calendar Year.***

No coverage will be provided under this provision for the following:

(A) Experimental drugs and medicines that are not commercially available and approved for general use by the United States Food and Drug Administration as effective for the treatment or diagnosis of the injury or illness.

(B) Services or procedures that are not considered effective for the treatment or diagnosis of the injury or illness at the time they are performed or provided.

Physical Therapy – Services of a licensed physical therapist are covered by the Plan, provided that the services are prescribed by an attending physician. If a maximum of twenty-four (24) treatments should be exceeded, the provider will be required to submit to the Trustees, prior to the completion of the twenty-four (24) treatments, documentation that will serve to justify the medical necessity for the additional treatments. The individual may be required to have an independent medical examination by a provider selected by the Trustees. ***Treatment will be limited to a maximum number of forty (40) visits per Calendar Year.***

Organ Tissue and Transplant Services – Services performed by a provider for a Covered Person, including the services for the removal of an organ from a donor when the donor is not a Covered Person and is not covered under another health care plan. ***Prior approval must be obtained for benefits to be provided for Human Organ and Tissue Transplant Services, except for a cornea or kidney transplant.*** To obtain approval, contact the Administrative Manager as soon as your physician suggests that your condition may require any of these transplants. ***This benefit excludes any and all costs of meals and/or lodging.***

Tissue Transplants: Benefits are payable for Tissue Transplants and all related charges that are described as Covered Services.

Benefits are payable for the following Tissue Transplants:

* Cornea transplants;
* Allogeneic and autologous bone marrow transplants for certain diagnoses.

In order for a tissue transplant to be considered eligible, it must not be considered experimental and/or investigative.

Stem Cell Harvests without a planned transplant are payable only when they are in relation to the diagnosis of:

* Acute Myelogenous Leukemia
* Acute Lymphoplastic Leukemia
* Pediatric Tumors

Human Organ Transplants: Benefits are payable for Human Organ Transplants and all related charges that are described as covered services, including the acquisition, preparation, transportation and storage of the human organ.

Benefits are payable as set forth above and as shown in the Schedule of Benefits for the following transplants:

* heart transplants;
* heart/lung transplants;
* liver transplants;
* lung transplants;
* pancreas transplants; and
* kidney transplants.

Transplant of kidney and end-stage renal disease will be covered under the organ transplant provisions. If you require an organ transplant that is not specified above, contact the Administrative Manager for prior approval.

Hospice Care – Benefits are payable at 80% (60% if out-of-network) of the Traditional Amount, after the Calendar Year deductible is met.for treatment of a terminally ill Participant or Eligible Dependent at a licensed or certified hospice facility.

Temporomandibular Joint Dysfunction (TMJ) – The benefits provided under the Plan relating to the treatment of TMJ shall be limited to a lifetime maximum of $400.00 for services provided by a legally qualified Physician or Surgeon. There shall be no lifetime maximum for pediatric TMJ services.

Podiatric Expense Benefits – No benefits are provided by the Plan for foot care due to the

treatment of weak, strained or flat feet, the instability or imbalance of the foot; or the treatment of corns, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness. (Refer to Plan Limitations and Exclusions, Item CCC.)

Ambulance Services – Ambulance services by a licensed professional ambulance service are limited to the first trip for any one injury, sickness, pregnancy, childbirth or other related medical condition, so long as the following factors are met:

(A) The transportaion is by a vehicle designed, equipped and used only to transport the sick and injured;

(B) The transporation is from the scene of an accident or medical emergency to a hospital or between hospitals; and

(C) The trip is to the closest facility that can give the appropriate services for the condition.

Life Flight Services – Life flight services by a licensed professional ambulance service are limited to the first trip for any one injury, sickness, pregnancy, childbirth, or other related medical condition, so long as the following factors are met:

(A) The transportation is by a vehicle designed, equipped and used only to transport the sick and injured;

(B) The transportation is from the scene of an accident or medical emergency to a hospital or between hospitals;

(C) The trip is to the closest facility that can give the appropriate services for the condition; and

(D) Certification by an attending physician must be received indicating that transportation using ground facilities would not have been appropriate due to the life threatening and emergency nature of the accident or illness.

Major Medical Benefits – Major Medical Benefits under the Plan are payable at 80% (60% if out-of-network) of the Traditional Amount after the Calendar Year Deductible has been satisfied, including the following, unless indicated otherwise elsewhere in this SPD and Plan Document:

(A) Hospital Services in excess of the seventy (70) day limitation.

(B) Anesthesia administration and other medical care except when otherwise limited.

(C) Physicians' office visits (subject to a $25.00 co-payment).

(D) Insulin and syringes without a Physician's written prescription provided the Plan

Office is advised in advance by the Physician of the prescribed dosage (unless processed by a third-party prescription provider).

(E) Private-duty nursing by a registered nurse or a licensed practical nurse (not a relative) at home or in a Hospital when medically necessary. The care must not be custodial in nature.

(F) Blood and blood plasma, in excess of two (2) pints during each Calendar Year to the extent it is not donated or replaced.

(G) Well-baby care including physicians' office visits and immunizations for Eligible Dependent Children under six (6) years of age.

(H) Radium, radioactive isotopes and x-ray therapy.

(I) Chemotherapy benefits (in network or out-of-network) are provided for the administration of chemotherapy in connection with covered services when rendered by a provider.

(J) Medical supplies.

(K) Rental not to exceed the purchase price of durable medical equipment, including hospital-type equipment, hospital beds, wheel chairs, oxygen equipment, inhalation respiratory therapy devices or similar durable therapeutic equipment which a Physician prescribes for use in your home. Rental of equipment for kidney dialysis will not be an Eligible Expense under the Plan on or after the day such person is entitled to benefits for these charges under Medicare. At their discretion, the Trustees may authorize the purchase of such equipment for you.

To be considered durable medical equipment, the equipment must be able to be used over again by other patients, must primarily serve a medical purpose, must not be useful to persons who are not sick or injured and must be appropriate for use in your home. The durable medical equipment supplier must have your Physician's prescription before delivering any of the items. Durable medical equipment will not include modes of transportation, such as customized vans with wheel chair lifts, etc.

(L) Orthopaedic braces (replacement and repair, if medically necessary).

(M) Colostomy and illeostomy bags.

(N) Initial replacement of natural limbs and eyes when loss occurs while eligible for benefits under this Plan.

(O) Initial permanent lens immediately following cataract surgery (replacements will not be covered).

(P) Dental services rendered by a Physician or a Dentist for the treatment of an injury to the jaw or to natural teeth, including the initial replacement of these teeth and any necessary dental x-rays resulting from an accident.

(Q) Oral surgery services for the removal of fully boney-impacted wisdom teeth.

(R) Routine mammograms and pap smears, prostatic specific antigen (PSA) tests, including corresponding office visit expenses.

(S) Allergy testing (to diagnose) when performed, ordered or billed by a provider. The allergy extract (the injection of the serum and the serum itself) and the office visit in connection with the allergy testing are also processed as Major Medical benefits.

(T) Diabetic Education – When the attending physician certifies that the patient requires diabetes education as an Outpatient, benefits will be provided for the following services when rendered by an approved Outpatient Diabetes Education Program:

- Up to ***a maximum of six (6) outpatient visit***s during a Calendar Year for initial assessment and education. These initial six (6) visits will be provded only once during the lifetime of the patient.

- Benefits for post-assessment of the patient's competency after completion of the initial visits and review of areas in which competency was not achieved will be limited to two outpatient visits within the Calendar Year in which the initial visits were completed.

- Subsequent outpatient visits will be limited to two per Calendar Year for follow-up education and to refresh existing knowledge as well as present techniques that are appropriate for management of the diabetes condition.

(U) Cardiac Rehabilitation – Benefits are provided for services performed by a provider for cardiac rehabilitation that are regulated exercise programs deemed effective in the physiological and psychological rehabilitation of many patients with cardiac conditions. Payment may be made for certain services performed in conjunction with these programs if the patient is referred by an attending physician and has had:

- Previous coronary bypass surgery;
- A diagnosis of stable angina pectoris; or
- A myocardial infarction within the preceding twelve (12) months.

(V) Diagnostic Testing for Sleep Apnea, not to exceed two (2) tests per year. Such testing shall be pre-certified and coordinated with the Office of the Administrative

Manager.

(W) Morbid Obesity Expense Benefits – Benefits will be provided for eligible surgical expenses relating to morbid obesity that are medically necessary in the absence of any other effective alternative courses of treatment. (Morbid obesity is defined to mean a condition in which the individual's body mass index is 40 or greater, i.e., approximately 100 pounds over ideal body weight, as defined by the Comprehensive Weight Management Program of the Ohio State University Hospital.) Benefits will be provided for Gastric Restrictive Surgery (surgical treatment of morbid obesity), when medically necessary. Such medical necessity is defined as follows:

(1) 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;

(2) Documented failure of non-surgical methods of weight reduction (documentation of a duration of at least one (1) year);

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

(4) Documentation of the patient's willingness to comply with pre-operative and post-operative treatment plans;

(5) The patient is at least eighteen (18) years of age;

(6) Documentation that the patient has received counseling post-operatively regarding cosmetic difficulties.

Any Gastric Restrictive Surgery must be pre-certified and coordinated with the Plan Office or the Office of the Administrative Manager. Furthermore, gastric banding is not covered under this Plan as an eligible expense. The maximum lifetime benefit for such procedure(s) and any and all related expenses and diagnostics (including services rendered after surgery) shall not exceed Ten Thousand Dollars ($10,000.00).

(X) Dental/Vision Care Benefits – The Plan will pay 100% of the total incurred for dental and vision care combined up to a maximum of $800 per year per Participant/Participant's family of the combined total amount (excluding pediatric oral and vision care, which has no lifetime maximum limits). This benefit also is not subject to the Calendar Year deductible. Payment of the benefit is made by reimbursement directly to the Participant upon the Participant's presentation to the Plan of proof of payment to the provider. The Plan has up to thirty (30) days from the date when the Participant presents the expense claim(s) to pay the

applicable benefit amount. For payment to be received for claims in a Calendar Year, the claim and proof must be submitted to the Plan Office not later than January 31st of the following Calendar Year.

(Y) Gardasil Vaccination – The Plan will provide coverage for the three-dose Gardasil vaccination regimen. Gardasil is a vaccine, through injection, that helps protect against diseases caused by the Human Papillomavirus (HPV) Types. This benefit is payable as other major medical benefits – 80% in network and 60% out-of-network of the Traditional Amount (TA) after the Calendar Year deductible has been satisfied.

THERE ARE NO EXTENDED MAJOR MEDICAL BENEFITS AFTER TERMINATION OF COVERAGE.

XIII. PRESCRIPTION SAFETY GLASSES FOR ACTIVE PARTICIPANTS ONLY

The Plan will provide a maximum benefit of one (1) pair every two (2) Calendar Years.

XIV. PRESCRIPTION DRUG PROGRAM – COVERED DRUGS AND EXCLUSIONS – ELIGIBLE PARTICIPANTS, ELIGIBLE RETIRED PARTICIPANTS (NON-MEDICARE ELIGIBLE), ELIGIBLE DEPENDENTS OF ELIGIBLE PARTICIPANTS OR ELIGIBLE RETIRED PARTICIPANTS (NON-MEDICAL ELIGIBLE), SURVIVING SPOUSES OR SURVIVING DEPENDENTS

Drugs Covered

(A) Legend drugs. For exceptions, see the List of Exclusions below;

(B) Insulin;

(C) Disposable insulin needles/syringes;

(D) Disposable insulin needles/syringes when prescribed at the same time as insulin will be included under the same co-payment. ***Disposable insulin needles/syringes must be dispensed in days supply corresponding to the amount of insulin to be dispensed and must be submitted at the same time to be included under the same co-payment as the insulin***;

(E) Disposable blood/urine glucose/acetone agents (e.g., Chemstrips, Clinitest tablets, Diastic Strips and Tes-Tape);

(F) Alcohol swabs;

(G) Glucose Elevating Agents;

(H) Lancets and Lancet devices;

(I) Legend Prenatal and Single Entity Vitamins;

(J) Compounded mediation of which at least one ingredient is a legend drug;

(K) Any other drug which the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

(L) Legend oral contraceptives;

(M) Viagra and Levitra (maximum of twelve (12) pills per month);

(N) Mental health prescriptions, except as excluded below;

(O) Self-injectable drugs; and

(P) AIDS-related medications.

Step Therapy Program

The Plan's prescription drug program will also include a Step Therapy Program for the use of Proton Pump Inhibitors such as Prilosec, Nexium, Prevacid and Protonix. This program, will limit the duration of such drugs.

Exclusions

(A) A.D.D. medications, unless approved by the Trustees (upon submission of medical documentation which substantiates that the use of such prescriptions is medically necessary);

(B) Anorectics (any drug used for the purpose of weight loss);

(C) Anti-wrinkle agents (e.g., Renova);

(D) Dermatologicals, hair growth stimulants;

(E) Fluoride supplements;

(F) Growth hormones;

(G) Hematinics;

(H) Immunization agents, blood of blood plasma;

(I) Levonorgestrel (Norplant);

(J) Mineral and nutrient supplements;

(K) Non-legend drugs other than those listed above;

(L) Tretinoin topical (e.g., Retin-A);

(M) Vitamins, except those listed above;

(N) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed above;

(O) Injectable drugs, other than insulin, as described above;

(P) Charges for the administration or injection of any drug;

(Q) Drugs labeled "Caution – limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;

(R) Medicine that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

(S) Legend smoking deterrent medications containing nicotine or any other smoking cessation aids;

(T) Contraceptives, non-oral dosage or topical form;

(U) Ortho Evra I Nuvaring;

(V) Contraceptive implants;

(X) Fertility drugs;

(Y) Cosmetic drugs; and

(Z) Non-sedating antihistamines, unless a letter of medical necessity is provided by a treating physician.

XV. RETIREE PRESCRIPTION DRUG PROGRAM – COVERED DRUGS AND EXCLUSIONS ELIGIBLE RETIRED PARTICIPANTS (MEDICARE ELIGIBLE) AND THEIR ELIGIBLE DEPENDENTS

Drugs Covered

(A) Legend drugs that are provided by the Sav-Rx Economy Plan. For exceptions, see the List of Exclusions below;

(B) Insulin;

(C) Any other drug that the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber;

(D) Legend oral contraceptives; and

(E) AIDS-related medications.

The formulary list of prescription drugs for which you will be able to utilize the $10.00 (generic) or $20.00 (brand name) co-payments shall be determined by Sav-Rx Prescription Services' Economy Plan design and the Trustees of the Plan have no control over such list. Please be reminded that the list of drugs covered by the Economy Plan is limited.

Exclusions

(A) A.D.D. medications, unless approved by the Trustees (upon submission of medical documentation which substantiates that the use of such prescriptions is medically necessary);

(B) Anorectics (any drug used for the purpose of weight loss);

(C) Anti-wrinkle agents (e.g., Renova);

(D) Dermatologicals, hair growth stimulants;

(E) Fluoride supplements;

(F) Growth hormones;

(G) Hematinics;

(H) Immunization agents, blood of blood plasma;

(I) Levonorgestrel (Norplant);

(J) Mineral and nutrient supplements;

(K) Non-legend drugs other than those listed above;

(L) Tretinoin topical (e.g., Retin-A);

(M) Vitamins, except those listed above;

(N) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed above;

(O) Injectable drugs, other than insulin, as described above;

(P) Charges for the administration or injection of any drug;

(Q) Drugs labeled "Caution – limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;

(R) Medicine that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

(S) Legend smoking deterrent medications containing nicotine or any other smoking cessation aids;

(T) Contraceptives, non-oral dosage or topical form;

(U) Contraceptive implants;

(V) Syringes;

(W) Insulin syringes;

(X) Diabetic supplies;

(Y) Fertility drugs;

(Z) Cosmetic drugs;

(AA) Injectable drugs;

(BB) Self-injectable drugs;

(CC) Viagra, Levitra or other impotency medications; and

(DD) Mental health prescriptions.

Please be reminded that the list of drugs covered by the Economy Plan is limited. The formulary list of prescription drugs for which you will be able to utilize the $10.00 (generic) or $20.00 (brand name) co-payments shall be determined by Sav-Rx Prescription Services' Economy Plan design. The Trustees of the Plan have no control over such list.

XVI. PLAN BENEFIT LIMITATIONS AND EXCLUSIONS HOSPITAL, MEDICAL AND SURGICAL BENEFITS

In addition to limitations and exclusions noted elsewhere in this SPD and Plan Document, no benefits will be provided under the Plan for the following expenses:

(A) Hospitalization, medical or surgical treatment and/or supplies provided by the United States Government or any instrumentality therefore, except as required by law.

(B) Any loss caused by war or an act of war, whether or not declared.

(C) Any loss incurred while engaged in military service, except as provided otherwise herein.

(D) Any services for which any benefits are available under federal, state or other laws (except where payment under the Plan is mandated).

(E) Any services for which workers' compensation or occupational disease benefits are available.

(F) Any loss incurred while attempting or during the commission of a felony.

(G) Any loss incurred in connection with intentionally self-inflicted injury or sickness, unless such injury or sickness is the result of a medical condition (including both physical and mental conditions) or involves a Dependent who is eight (8) years old or younger.

(H) Experimental services, procedures or substances that have not been recognized by established medical review mechanisms as accepted standards of medical practice (i.e., Federal Drug Administration or American Medical Association).

(I) Charges that are in excess of the Traditional Amount.

(J) Charges which the Participant or Dependent has no legal obligation or is not required to pay.

(K) Charges for which a Dependent is entitled to benefits as a Participant or a former Participant of another plan.

(L) Services rendered prior to the effective date of coverage or subsequent to the termination of coverage.

(M) Charges that are unrelated to treatment resulting from an accident, injury or illness.

(N) Care that is not medically necessary for the treatment of an illness or injury, except as specified in this SPD and Plan Document.

(O) Any expenses incurred for any service or treatment that is not recommended by a Physician.

(P) Charges incurred during confinement in a Hospital owned or operated by a state, province or political subdivision, unless there is an unconditional requirement to pay these charges.

(Q) Riding, driving or testing a vehicle used in a race or speed contest, or participation in the sport of parachute jumping or bungee jumping.

(R) Participation in a riot or insurrection, unless related to lawful union activities.

(S) Travel or flight in or descent from any type of aircraft, if you are a student pilot or member of the crew, or if you are a passenger on:

(1) Any civilian aircraft not having a current and valid worthiness certificate, or piloted by a person who does not then hold a valid and current certificate of competency or a rating authorizing him to pilot such aircraft; or

(2) Any type of aircraft operated by any military authority of the United States, or by any duly constituted governmental authority of any other country recognized by the United States government while in the course of any training maneuvers of any Armed Forces.

(T) Any charges that exceed the annual and lifetime maximum benefit provisions established under this Plan for non-essential health benefits, as defined by federal law.

(U) Any services in a nursing or convalescent home or extended care facility, unless for rehabilitative purposes.

(V) Any personal services and supplies (including telephone rentals, hygiene, convenience items, etc.).

(W) Any charges incurred as a result of a pre-existing condition, as defined by this SPD and Plan Document and to the extent such limitation complies with federal, state and other applicable laws.

(X) Any expenses for custodial care or domiciliary care.

(Y) Any services rendered for or billed by a school or halfway house or a member of its staff.

(Z) Any over-the-counter drugs, prescriptions and medicines, including vitamins, nutritional supplements and other non-prescription items, unless otherwise covered under the terms of this SPD and Plan Document.

(AA) Any travel expenses, whether or not recommended by a physician, except for local ambulance service.

(BB) Any services not recommended or prescribed by a physician, dentist or optometrist while acting within the scope of his or her license as being necessary for the treatment of an illness or injury.

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

(DD) Marital or family counseling or training services.

(EE) Homemaking services, such as housekeeping, meal preparation or serving as a companion or sitter.

(FF) Any services performed by a person who ordinarily resides in the Eligible Person's home or is a relative (as defined under the Plan to mean the spouse of the Eligible Person, or the parent, child, brother or sister of the Eligible Person or the Eligible Person's spouse).

(GG) Speech therapy, except for purposes of rehabilitative treatment, as prescribed by a physician.

(HH) Charges relating to gastric restrictive surgery (except for such surgical procedures relating to morbid obesity), gastric binding, weight loss treatment, and other treatment of obesity, including stomach stapling and nutritional counseling.

(II) Cosmetic surgery, including breast augmentation and face lifting, except for the repair of accidental injuries or for the reconstruction of the breast on which a mastectomy has been performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses required due to such mastectomy, including lymphedemas.

(JJ) Charges incurred for donation of any body organ or tissue by a Covered Person to another individual.

(KK) Charges relating to infertility studies or charges relating to the restoration or enhancement of fertility or the ability to conceive by artificial means, including but not limited to in-vitro fertilization or embryo transfer and for services performed for and the treatment of infertility, including but not limited to drug therapy, IUI (intrauterine insemination), ART (Assisted Reproductive Technologies), and all related services.

(LL) Transsexual surgery and any related treatment thereto.

(MM) Surrogate pregnancies.

(NN) Abortions, unless 1) medically necessary as a life-sustaining measure for the mother; or 2) as a result of a criminal act, where the mother is an Eligible Participant, spouse of an Eligible Participant or Eligible Dependent.

(OO) Charges relating to sexual dysfunctions, including but not limited to impotency and implantation of a penile prosthesis.

(PP) Birth control devices.

(QQ) Reversal of sterilization procedures.

(RR) Charges for air conditioners, purifiers, humidifiers, dehumidifiers, heating pads, ice packs and hot water bottles.

(SS) Services and supplies furnished during a period when the Covered Person is temporarily absent from a hospital.

(TT) Charges relating to eye refractions, eye glasses/contact lenses (except when required following a cataract operation), for correction of myopia or hyperopia by means of corneal microsurgery, such as keratomilerusis, keratophakia, radial keratotomy and all related services and lasik procedure.

(UU) Hearing aids (including fittings and examinations) and tinnitus maskers.

(VV) Orthotics, corrective shoes, and arch supports.

(WW) Routine physical examinations or screenings (except for annual physical examinations for Active Participants) and preventive care, except for mammograms/pap smears, prostatic specific antigen (PSA) tests and well-baby care, as established under the Plan.

(XX) Recreational, educational therapy or vocational rehabilitation.

(YY) Exercise equipment.

(ZZ) Treatment of complications arising from or connected in any way with a surgical or medical treatment or a procedure that is not an Eligible Expense under the provisions of this Plan.

(AAA) Palliative or cosmetic foot care, including treatment of weak, strained or flat feet, chronic foot strain, or instability or imbalance of the feet, treatment of corns, calluses or the free edge of toenails, except when necessitated for peripheral

vascular disease or other similar medical seriousness.

(BBB) Dental services are not covered under the Hospital, Surgical, Major Medical portion of the Plan except for (a) the repair of an injury to sound natural teeth (including their replacement) as a result of an accidental bodily injury and providing treatment is rendered within 90 days of the accident; and (b) oral surgery for the removal of fully boney-impacted wisdom teeth.

(CCC) Replacement of artificial limbs and artificial eyes.

(DDD) Massotherapy charges.

(EEE) Orthoptic therapy.

(FFF) Acupuncture procedures.

(GGG) For inpatient admission primarily for physical therapy.

(HHH) Services for which payment has been made under Medicare or would have been made if the Retired Participant or Eligible Dependent had applied for Medicare and claimed Medicare benefits.

(III) For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.

(JJJ) Outpatient audiometric testing.

(KKK) Dietary food supplements.

(LLL) Preventative care services, wellness services or programs, except as provided in this SPD and Plan Document.

(MMM) Inpatient admissions primarily for diagnostic study.

(NNN) Clinic visits.

(OOO) Services for which the Active or Retired Participant or his or her Eligible Dependents recover the costs by legal action or settlement.

(PPP) Charges for the completion of any insurance forms.

(QQQ) For any other medical, psychological, psychiatric or dental service or treatment, except as provided in this SPD and Plan Document.

XVII. COORDINATION OF BENEFITS

Coordination of Benefits may limit benefits when a Covered Person is covered for benefits under more than one plan. The benefits payable under this Plan may be reduced, in accordance with the following rules, so that from all plans a Covered Person will not receive payment for more than 100% of the Covered Charges.

Definition Of Terms

(A) For purposes of this Coordination of Benefits section, the term *"plan"* shall be considered separately for each plan and also between that part of any plan which applies to anti-duplication provisions and that plan which does not.

(B) The term *"Allowable Expenses"* means 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.

The following is a list of plans with which this Plan coordinates its benefits:

(A) Group, blanket or franchise insurance coverage;

(B) Group Blue Cross, Blue Shield and other pre-payment coverage provided on a group basis;

(C) Any coverage under collectively bargained labor-management trusteed plans, collectively bargained union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group;

(D) Any other plan which has a Coordination of Benefits provision within that plan;

(E) 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;

(F) Any governmental plan or program created by federal or state statute or regulation 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; and

(G) Individual auto insurance, by whatever name called.

Order Of Benefit Determination

(A) Any plan that does not have a Coordination of Benefits provision will be the primary plan and pay first.

(B) The following rules establish which plan is the primary payer and the order of benefit determination the other plans will follow:

(1) The Plan that covers the Covered Person as a dependent will be considered the secondary plan and pay after any other plan.

(2) If an Eligible Participant is covered as an Eligible Participant under another plan, this Plan will pay initially one-half of the allowable expense (based upon 80% of Traditional Amount (60% of Traditional Amount if out-of-network)). After the other plan has paid a share equal to this Plan's initial payment, this Plan shall then pay for the remaining allowable expenses, if any (based upon 80% of Traditional Amount (60% of Traditional Amount if out-of-network)).

(3) If a Dependent of an Eligible Participant is covered as an eligible participant (Employee) under another plan, this Plan will not pay any benefits towards the Dependent's claim until that person's benefits under the other plan are exhausted. Then, if there are additional expenses payable toward that claim, this Plan will pay the remaining allowable expenses, if any. If the Dependent, as a Participant in the other plan, fails to comply with the requirements of the other plan, or fails to utilize an HMO that has been selected by that person under the other plan which would have been the primary payer, this Plan will not pay any portion of the allowable expenses incurred by that person.

(C) For Dependent Children

(1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the other parent whose birthday falls later in that year, provided that the parents are not separated or divorced. (The word *"birthday"* refers to only the month and day in a Calendar Year, not the year in which the person was born.) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

(2) If the other plan does not have the *"Birthday Rule,"* as described above, but instead has a rule based on the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based on the birthday of the parent will determine the order of benefits.

(3) If the natural parents of a Dependent Child are divorced or otherwise separated, payment will be made as follows: (a) under the plan of the custodial parent before the plan of a step-parent or of the natural parent without custody; (b) if, however, there is a court decree establishing financial responsibility for the heatlh care expenses with respect to the

child, the plan that covers the child as a Dependent of the parent with financial responsibility will be considered before any other plan and in accordance with any Qualified Medical Child Support Order (QMSCO).

(D) Plans that provide benefits for a retired participant will pay as the secondary plan.

Coordination With Governmental Programs And Programs Required By Statute

(A) Benefits payable under this Plan for allowable expenses incurred during a claims determination period will be paid from the Plan, subject to the following limitations and in accordance with federal and state mandates:

(1) *Medicare:* This Plan will pay its benefits before Medicare for the following eligible persons, unless the individual specifically elects to have Medicare serve as the primary payer:

(a) an actively employed Eligible Participant who has reached the applicable Medicare eligible age or older and/or an actively employed Eligible Participant's Spouse who is age 65 or older; and

(b) a disabled Eligible Participant who is under the applicable Medicare eligible age and who has a relationship with an employer indicative of an employee status, or the actively employed Eligible Participant's disabled Spouse or Dependent who is under age 65 and who is eligible for benefits under Medicare.

If the individual elects to have Medicare serve as the primary payer, this Plan will not provide coverage, including deductibles and co-payments, for any benefits to which the individual is entitled under Medicare. This plan, however, shall provide coverage for eligible charges which are not eligible under Medicare.

(B) This Plan will be considered the primary payer of benefits for an Eligible Participant or Eligible dependent under age 65 who is disabled due to end-stage renal disease for the first thirty (30) months after the individual first becomes eligible for Medicare.

(C) For all other Covered Persons 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 eligible benefit payment.

(D) Other Governmental Programs

(1) For all other Covered Persons who are eligible for benefits under a governmental program or eligible for benefits as a result of any state or federal statute or regulation (other than Medicare), this Plan will pay its benefits in accordance with the requirements of any relevant regulatory

requirements.

Liability Of The Plan

In the event benefits are reduced as provided above, each benefit otherwise payable shall be reduced proportionately, and only the reduced amount shall be charged against any applicable benefit limit under the Plan. If benefits have been paid under any other plan which should have been reduced in accordance with an anti-duplication provision, the Plan may pay, at its option, to such other plan to the extent required to offset the deduction required by the existence of this Plan. Such payment shall reduce the liability of this Plan to the extent of such payment. If payment has been made by the Plan in excess of that permitted by this provision, the Plan shall have the right to recover such excess from any party acquiring same.

Subrogation

Subrogation shall mean the Plan's right to recover any policy payments:

(A) made because of an injury or illness to you or your Dependent caused by a third party's wrongful act of negligence; and

(B) you or your Dependent later recover from a third party or third party's insurer.

The term "third party" includes, but is not limited to, another person, organization, corporation, insurance carrier, governmental agency, uninsured and/or underinsured insurance coverage. The Plan's subrogation right shall extend to first-party and/or third-party contracts and claims.

The Plan reserves the right of subrogation. This means that, to the extent the Plan provides and pays benefits for Covered Services, the Plan assumes your legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including your own insurer, and any underinsured and uninsured coverage that may be legally obligated to pay you the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of subrogation shall have priority over your and anyone else's rights until the Plan recovers the total amount paid for Covered Services. The Plan's right of subrogation is for the total amount to which the Plan is entitled, irrespective of whether you are "made whole" by reason of recovery from another person or entity. These subrogation provisions are intended to supersede and hereby reject the so-called "make whole" rule, which might otherwise require that you be "made whole" before the Plan would be entitled to assert its right of subrogation.

Reimbursement

The Plan also reserves the right to reimbursement. This means that, to the extent the Plan provides or pay for benefits or expenses for Covered Services, you must repay any amounts recovered by lawsuit, claim, settlement, or otherwise from any third party or insurer of said third party and any underinsured and uninsured coverage, as well as from any other person, entity, organization, or insurer, including from your own insurer, from which you receive payments

(even if such payments are not designated as the payment of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of reimbursement shall have priority over your or anyone else's rights until the Plan recovers the total amount the Plan paid for the Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services is absolute and applies irrespective of whether you receive, or are entitled to receive, a full or partial recovery, and irrespective of whether you are "made whole" by reason of any recovery from any other person or entity. These reimbursement provisions are intended to supersed and hereby reject the so-called "make whole" rule, which might otherwise require that you be "made whole" before the Plan would be entitled to its right of reimbursement.

Your Duties

(A) You must provide the Plan's Administrative Manager or its designee any information requested by the Plan or its designee within five (5) days of the request;

(B) You must notify the Plan's Administrative Manager or its designee promptly of how, when and where the accident or incident resulting in injury to you occurred and all information regarding the parties involved;

(C) You must cooperate with the Plan's Administrative Manager or its designee in the investigation, settlement and protection of the Plan's rights;

(D) You must send the Plan's Administrative Manager or its designee copies of any police report, notice or other papers received in connection with the accident or incident resulting in the injury to you; and

(E) You must not settle or compromise any claims unless the Plan, the Plan's Administrative Manager or its designee is notified in writing at least thirty (30) days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Your benefits and the benefits of your Dependents may be suspended until the documents and other information requested by the Plan are received.

If you or your Dependents do not attempt a recovery of the benefits paid by the Plan or for which the Plan may be obligated, the Plan shall, at its sole discretion, be entitled to institute a legal action or claim against the third party in the name of the Plan or its Trustees in order that the Plan may recover all amounts that should have been paid to you or your Dependents.

In the event that you or your Dependents obtain a recovery by judgment or settlement or otherwise against the third party, the Plan's subrogation interest, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall be deducted from your and your Dependents' total recovery. The remainder of the balance of any recovery shall then be paid to you or your Dependents and your attorneys, if applicable. Once a settlement or judgment

is reached, additional medical bills cannot be submitted with respect to the same injury covered by said settlement.

To the extent of the aforesaid payments made or to be made by the Plan to you or your Dependents, any money that may be recovered by you or your Dependents as a result of such payments by the Plan, or otherwise, from any third party with respect to the matters giving rise to the above-referenced loss, whether by judgment, settlement or otherwise, together with such costs as are allowed by law, shall be repaid to the Plan by you or your Dependents. The Plan, however, shall not be obligated to share, set-off or reimburse any portion of your or your Dependents' attorneys' fees or any other costs and expenses associated with any lawsuit, judgment, settlement, or otherwise action that preceded such recovery by you or your Dependents.

If your acts or omissions compromise the Plan's rights of subrogation and reimbursement, the Plan will seek reimbursement of all appropriate benefits paid directly to you or your eligible Dependents, or will otherwise offset benefits payable to you or your Dependents under this Plan.

XVIII. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA

(A) The Plan will use protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

(B) "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost-sharing amounts (e.g., cost of a benefit, plan maximums, and co-payments as determined for an individual's claim).
- Coordination of benefits.
- Adjudication of health benefit claims (including appeals and other payment disputes).
- Subrogation of health benefit claims.
- Establishing employee contributions.
- Risk-adjusting amounts based on enrollee health status and demographic characteristics.
- Billing, collection activities and related health care data processing.
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives') inquiries about payments.
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary in the future.
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges.
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review.

- Reimbursement to the plan.

(C) "Health Care Operations" include, but are not limited to, the following activities:

- Quality Assessment.

- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives, and related functions.

- Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities.

- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).

- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

- Business management and general administrative activities of the entity, including, but not limited to:

    - Management activities relating to implementation of and compliance with the requirements of HIPAA's administrative simplification provisions.

    - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers.

    - Resolution of internal grievances.

    - Filing of governmental forms, including Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code.

(D) "Treatment" includes, but is not limited to, 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 the health care providers.

(E) The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or Beneficiary. For purposes of this section, the Board of Trustees of the Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

(F) With respect to PHI, the Plan Sponsor agrees to:

(1) Not use or further disclose the information other than as permitted or required by the SPD and Plan Document or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(3) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

(4) Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

(5) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures of which the Plan Sponsor becomes aware;

(6) Make PHI available to the individual in accordance with the access requirements of HIPAA;

(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(8) Make available the information required to provide an accounting of disclosures;

(9) Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the group health plans with HIPAA;

(10) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such

information when no longer needed for which such disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

(G) In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI.

- The Plan's Administrative Manager;
- The staff designated by the Plan's Administrative Manager; and
- Board of Trustees of the Fund.

The persons described in this section may have access to and use and disclose PHI only for administrative functions performed on behalf of the Plan. If the persons described in this section do not comply with this SPD and Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

XIX. PROHIBITION AGAINST DISCRIMINATION BASED ON THE USE OF GENETIC INFORMATION

This section of the SPD and Plan Document is intended to implement the requirements of the Genetic Information Nondiscrimination Act of 2008, as amended (GINA).

"Genetic information" means, with respect to any individual, information about:

- such individual's genetic tests;
- the genetic tests of family members of such individual; and
- the manifestation of a disease or disorder in family members of such individual.

Pursuant to GINA, the Plan:

- may not adjust premium or contribution amounts on the basis of genetic information;
- may not request or require an individual or a family member of such individual to undergo a genetic test;
- may not request, require, or purchase genetic information for "underwriting purposes," as that term is defined under ERISA; and
- may not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment in the Plan or coverage in connection with such enrollment.

Notwithstanding the foregoing, the Plan may use genetic information as otherwise allowed by GINA.

XX. CLAIMS FILINGS AND BENEFIT DETERMINATIONS

(A) Any Participant, Beneficiary or authorized representative of such Participant or Beneficiary may file a claim for benefits under the Plan with the Fund. If you file a claim, it must be made in writing or be filed electronically, and it must state the basis of the claim and authorize the Fund or its representatives to conduct all necessary investigations into the claim. Such claims shall be sent to the Office of the Administrative Manager at:

I.B.E.W. Local 688 Health and Welfare Fund
Office of the Administrative Manager
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Toll Free: (800) 435-2388
Fax: (330) 270-0912

Otherwise, such claim may be submitted via electronic submission of paper claims by the provider of service, or it may be submitted directly to Medical Mutual of Ohio, Post Office Box 94648, Cleveland, Ohio 44401.

All claims shall be filed within one (1) year from the date of service. Claims received after that date shall be denied.

(B) If the Fund, upon receipt of your claim for benefits, needs additional information or the claim does not follow the Fund's procedures, the Fund will notify you within twenty-four (24) hours (for an urgent care benefit claim), five (5) days (for a non-urgent pre-service care benefit claims) or thirty (30) days (for non-urgent post-service benefits claims) of receipt of the claim that such information is necessary. In the case of a pre-service claim or an urgent care claim, notification of additional information may be oral, unless you request written notification. The Fund will allow you a minimum period of forty-eight (48) hours (for urgent care benefit claims) or forty-five (45) days (for non-urgent benefit claims) to furnish such information. For those claims where additional information is requested by the Administrative Manager, any partial or total denial of the claim shall be made by the Fund by delivery or mail of a Notice of Adverse Benefit Determination to you within forty-eight (48) hours (for an urgent care benefit claim), fifteen (15) days (for a non-urgent care pre-service benefit claim) or thirty (30) days (for a non-urgent post-service benefit claim) from the date the Fund receives the information requested from you. If additional information is requested, the time period for making a benefit decision is tolled from the date on which the notice is sent to you until the date you respond to the request. In the case of a non-urgent care benefit claim, the period for a benefit determination to be made may be extended for a period of thirty (30) days (for pre-service claims) or a period of fifteen (15) days (for post-service claims) if it is due to circumstances beyond the

Fund's control. However, you will be given notice of such extension prior to the original deadline for a determination.

(C) An "Urgent Care" claim is defined as any claim for medical care or treatment that cannot be decided under normal time frames because 1) it can seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or 2) it would, in the opinion of a physician with knowledge of claimant's medical condition, subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" under the meaning set forth above shall be treated as a claim involving urgent care. A "Pre-Service" claim is a benefit claim made under a group health plan that requires, in order to receive the benefit, that approval be obtained before medical care is received.

(D) If the Plan has notified you that an ongoing course of treatment must be reduced or terminated, your request to extend the course of treatment involving urgent care must be decided as soon as possible based upon the medical circumstances. The Administrative Manager must notify you as the claimant of the benefit decision, whether adverse or not, within twenty-four (24) hours after the Plan's receipt of the claim. The claim must be received by the Plan at least twenty-four (24) hours before the reduction or termination of the treatment. The Plan is not obligated to notify you when a previously approved ongoing course of treatment will end.

(E) For those claims where additional information is not necessary, the Fund shall make any determination regarding the validity of the claim, and upon any partial or total denial of your claim for benefits, the Fund shall deliver or mail a Notice of Adverse Benefit Determination to you within seventy-two (72) hours (for an urgent care benefit claim), fifteen (15) days (for a non-urgent pre-service claim) or thirty (30) days (for a non-urgent care post-service benefit claim) of the filing of your claim. In the case of non-urgent care benefit claim, the period for a benefit determination to be made may be extended for a period of fifteen (15) days if it is due to circumstances beyond the Fund's control. However, you will be given notice of such extension prior to the original deadline for a determination.

(F) The Notice of Adverse Benefit Determination shall be written in a manner calculated to be understood by you, and shall contain the following information:

(1) the specific reasons for the adverse benefit determination;

(2) a specific reference to pertinent plan provisions on which the adverse benefit determination was based;

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

(4) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on any appeal by you of the initial adverse benefit determination;

(5) in the case of an adverse benefit determination by a group health plan or a plan providing disability benefits:

(a) if applicable, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to you upon request; or

(b) if the adverse benefit determination is based upon a medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(6) In the case of an adverse benefit determination by a group health plan involving a claim for urgent care, a description of the expedited review process applicable to such claims.

SUMMARY OF DEADLINES FOR NOTIFYINGCLAIMANTS OF BENEFIT DECISIONS

Claims Procedures	Group Health (Urgent)	Group Health (Pre-Service)	Group Health (Post-Service)
Initial Benefit Determination	72 hours	15 days	30 days
Plan Notifies Claimant if Additional Information is Necessary	24 hours	5 days	30 days
Minimum Time for Claimant to Finish Information After Information Requested by Plan Benefit is Received	48 hours	45 days	45 days
Determination is Required (after Claimant submits any additional information)	48 hours	15 days plus potential 15 day extension	30 days plus potential 15 day extension

THE CLAIMS APPEALS PROCEDURES

(A) You or your authorized representative may appeal the final decision by written notice received by the Trustees within one hundred eighty (180) days of the mailing of the Fund's Notice of an Adverse Benefit Determination. ***The written notice only needs to state your name, address, and the fact that you are appealing from the decision of the Trustees, giving the date of the decision appealed from.*** The appeal shall be addressed as follows:

Board of Trustees
I.B.E.W. Local 688 Health and Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Toll Free: (800) 435-2388
Fax: (330) 270-0912

You may make an appeal request for an urgent care claim orally or in writing. Furthermore, necessary information can be transmitted between the Fund and you or your provider by telephone or facsimile.

(B) Prior to a determination on the appeal, you or your authorized representative may have an opportunity to review necessary and pertinent documents upon which the denial in whole or in part is based and may submit written issues and comments pertinent to the appeal. Furthermore, you or your representative may submit additional information prior to any determination on your appeal.

(C) If an appeal requires medical judgment, the Trustees shall consult "appropriate health professionals," including but not limited to medical or vocational experts, and will disclose the identity of such individual to you or your representative.

(D) During the appeals process, you will be afforded access to and copies, free of charge, of the following "relevant information":

(1) any information relied upon during the Fund's benefit determination process;

(2) any information submitted, considered or generated while making such a benefit determination; and

(3) statements of any policy or guidance concerning denied treatment or benefit, even if not relied upon in the benefit determination process.

(E) During the appeals process, the Plan shall demonstrate compliance in making the benefit decision with the requirement that the benefit determinations must follow the terms of the Plan and be consistent when applied to similarly situated

claimants. Furthermore, the review on appeal may not give deference to the initial adverse benefit determination and may not be conducted by either the individual who made the initial adverse benefit determination, or a subordinate of such individual.

(F) The Trustees shall consider your appeal of an urgent care benefit claim within seventy-two (72) hours and a non-urgent pre-service benefit claim within thirty (30) days of the Fund's receipt of an appeal request. In the case of post-service benefit claims, the Trustees or their agents shall consider your appeal by the next regular quarterly meeting of the Board of Trustees following the receipt of an appeal request. However, if the appeal request is received within thirty (30) days before the date of the next regular quarterly meeting, the benefit determination shall be made by the date of the second regular quarterly meeting that immediately follows the Fund's receipt of the original appeal request. If an extension of the time period for processing the appeal is needed, the determination of the appeal must be made by the date of the third regular quarterly meeting following the Fund's receipt of the original appeal request. Within five (5) days after consideration of the appeal, the Board of Trustees shall advise you of its decision in writing. The Board of Trustees, as Plan Administrator, is vested with all powers necessary to enable it to review all appeals of adverse benefit determinations and to determine all questions that may arise thereunder, including but not limited to all questions relating to the eligibility of Participants to participate in the Plan, reciprocity contributions and the amount of any benefit to which an Active Participant, Eligible Dependent, Retired Participant or Eligible Retiree Dependent may become entitled to hereunder. In so acting, the Trustees shall have full and complete authority and discretion to construe, interpret and apply all provisions of the Plan. Specifically, the Trustees shall have full and complete authority and discretion to make any determinations or findings of fact regarding any claims and appeals of any benefit determinations. The decision of the Board of Trustees shall set forth specific reasons for their conclusion, shall be written in a manner calculated to be understood by you and shall make reference to the pertinent Plan provisions upon which the decision is based. The decision shall be final and binding upon you, except to the extent that you may choose to pursue any rights provided by the Plan or ERISA Section 502(a) following an adverse benefit determination or appeal. The Notice of Benefit Determination on Appeal must be provided in written or electronic form. If the determination is adverse, the Notice must provide the following information, written in a manner to be understood by you:

(1) the specific reason(s) for the adverse determination;

(2) reference to the specific plan provisions on which the determination is based;

(3) a statement that you as the claimant are entitled to receive, upon request and free of charge, access to and copies of all documents, records and

other information relevant to the benefit claim. A document is considered relevant to the claim if it: (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard as to whether it was relied upon in making the decision; and (iii) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants;

(4) a description of any voluntary appeal procedures offered under the Plan, your right to obtain information about such procedures and a statement regarding your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal;

(5) if applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request;

(6) if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment of the determination of a statement that such explanation will be provided free of charge to you upon request; and

(7) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

The decision shall be final and binding upon you.

SUMMARY OF NOTIFICATION OF RESULT OF APPEAL

Appeals	Group Health **(Urgent)**	Group Health **(Pre-Service)**	Group Health Procedures **(Post-Service)**
Time to Appeal	180 days	180 days	180 days
Initial Review	72 hours	30 days	next regular quarterly meeting

(G) A full hearing and optional second level of appeal before the Board of Trustees shall be held when:

(1) The Participant requests a full hearing before the Board of Trustees by written notice within fifteen (15) days after receipt of the Board of Trustees' decision on appeal. The written notice needs to state only your name, address, and the fact that you are requesting a full hearing before the Board of Trustees, giving the date of the decision of the Board of Trustees.

Requests for a full hearing and optional second level appeal should be sent to the Fund's Administrative Manager at:

Board of Trustees
I.B.E.W. Local 688 Health and Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Toll Free: (800) 435-2388
Fax: (330) 270-0912

(2) The date for the hearing shall be the next regular quarterly meeting of the Board of Trustees following the receipt of the notice of appeal from a Notice of Benefit Determination on Appeal. However, if the appeal request is received within thirty (30) days before the date of the next regular quarterly meeting, the benefit determination shall be made by the date of the second regular quarterly meeting that immediately follows the Fund's receipt of the appeal request. If an extension of the time period for processing the second appeal is needed, the determination of a second appeal must be made by the date of the third regular quarterly meeting following the Fund's receipt of the original appeal request.

(3) ***The Hearing.*** A full written report shall be kept of the proceedings of the hearing.

(a) In conducting the hearing, the Board of Trustees shall not be bound by the usual common law or statutory rules of evidence.

(b) You or your attorney shall have the right to review the written record of the hearing, make a copy of it and file objections to it.

(c) There shall be copies made of all documents and records introduced at the hearing, attached to the record of the hearing, and made a part of it.

(d) All information upon which the Board of Trustees based its original decision shall be disclosed to you at the hearing.

(e) In the event that additional evidence is introduced by the Trustees which was not made available to you prior to the hearing, you shall be granted a continuance of as much time as you desire, not to exceed thirty (30) days.

(f) You shall be afforded the opportunity of presenting any evidence on your behalf. If you offer new evidence, the hearing may be adjourned for a period of not more than thirty (30) days so the Trustees may, if they wish, investigate the accuracy of your new evidence or determine whether additional evidence should be introduced.

(g) After consideration of the appeal, the Trustees shall advise you of its decision in writing within five (5) days following the hearing at which the appeal was considered. The Board of Trustees, as Plan Administrator, is vested with all powers necessary to enable it to review all appeals of adverse benefit determinations and to determine all questions that may arise thereunder, including but not limited to all questions relating to the eligibility of Participants to participate in the Plan, reciprocity contributions and the amount of any benefit to which an Active Participant, Eligible Dependent, Retired Participant or Eligible Retiree Dependent may become entitled to hereunder. In so acting, the Trustees shall have full and complete authority and discretion to construe, interpret and apply all provisions of the Plan. Specifically, the Trustees shall have full and complete authority and discretion to make any determinations or findings of fact regarding any claims and appeals of any benefit determinations. The decision of the Board of Trustees shall set forth specific reasons for their conclusion, shall be written in a manner calculated to be understood by you and shall make reference to the pertinent Plan provisions upon which the decision is based. This decision shall be final and binding upon you, except to the extent that you as the claimant may choose to pursue any rights provided for by the Plan or Section 502(a) of ERISA following an adverse benefit determination or appeal.

STATUTE OF LIMITATIONS

If you should choose to pursue your right to file a lawsuit or legal proceeding against the Plan, the Fund or the Board of Trustees, you must do so within three (3) years of the date of any such alleged cause of action accrued. Accordingly, a three (3) year statute of limitations shall apply to any and all claims against the Plan, the Fund or the Board of Trustees, including any claims for benefits and/or claims pursuant to Section 502(a) of ERISA.

XXI. STATEMENT OF YOUR RIGHTS AS A PARTICIPANT UNDER ERISA

As a Participant or Eligible Dependent in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

ERISA provides that all plan participants shall be entitled to the following information:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Office or Office of the Administrative Manager and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Administrative Manager, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Administrative Manager may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and Plan Document which governs the Plan on the rules for your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when you 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. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or

any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan's 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.

Mothers' And Newborns' Health Protection Act

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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator (i.e., the Office of the Administrative Manager or Plan Office). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration at the following locations:

U.S. Department of Labor
Employee Benefits Security Administration
1885 Dixie Highway, Suite 210
Ft. Wright, KY 41011-2664
Phone: (606) 578-4680

Or

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street, Suite 556
Washington, D.C. 20006
Phone: (202) 254-7013

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 Employee Benefits Security Administration.

XXII. ADDITIONAL INFORMATION REQUIRED BY ERISA

1. ***Name Of Plan:*** I.B.E.W. Local 688 Health & Welfare Plan

2. ***Plan Established And Maintained by:***

Board of Trustees
LB.E.W. Local 688 Health and Welfare Fund
67 S. Walnut Street
Mansfield, Ohio 44902

3. ***Participating Employers:***

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

4. ***Employer Identification Number (EIN):*** 23-7003732

5. ***Plan Number:*** 501

6. ***Type Of Plan:*** Welfare Plan

This Plan is maintained for the purpose of providing death, dismemberment, disability, hospitalization, surgical, medical and other related benefits.

7. ***Type Of Administration Of The Welfare Plan:***

Although this plan technically is administered and maintained by the joint Board of Trustees of the I.B.E.W. Local 688 Health & Welfare Plan, the Trustees have delegated certain administrative functions to a professional Administrative Manager, Compensation Programs of Ohio, Inc. Address all communications with the Board of Trustees to:

Board of Trustees
I.B.E.W. Local 688 Health & Welfare Plan
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Toll Free: (800) 435-2388
Fax: (330) 270-0912

Hospital, surgical, medical and weekly accident and sickness benefits are self-funded and administered by I.B.E.W. Local 688 Health & Welfare Plan., c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515.

Prescription drug benefits are provided and administered through Sav-Rx Prescription Services, 224 N. Park Avenue, Fremont, NE 68025.

Life Insurance and Accidental Death and Dismemberment benefits are insured and administered by Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500 Philadelphia, PA 19103.

The Fund provides Participants the ***option*** of seeking medical/surgical and other major medical care through providers that have contracted with Medical Mutual of Ohio ("MMO"). As you know, a PPO is a network of doctors, diagnostic facilities and other health care providers who discount their charges in exchange for prompt payment of claims and more patient volume. Your Plan is not an HMO. There are no referrals nor is it necessary to select a primary care physician. MMO was added to our Plan in an effort to save hard earned contribution dollars and to reduce your out-of-pocket expenses. If you seek care from a provider that is participating in MMO's PPO on the date of service, the provider's charge will be discounted in accordance with the PPO allowance.

- Medical Claims are to be submitted via electronic submission or paper claims by the provider of service or you may submit them directly to Medical Mutual of Ohio, P.O. Box 94648, Cleveland, Ohio 44101.

- You may obtain a provider list (free of charge) upon your request to MMO. However, MMO's provider network is always growing. Therefore, new providers are regularly being added to the program. It is also possible that a provider is listed in the directory but since the print of that directory may not have renewed its contract with MMO. ***As such, providers are advised to call MMO at (800) 601-9208 before providing medical procedures***. In addition, if a provider is not listed in your directory, you can call the same number to see if that provider is a participant of the MMO network. Also, you may obtain a more current list of medical care providers by accessing MMO's website at www.supermednetwork.com.

8. ***Agent For Service Of Legal Process:*** The Board of Trustees have designated themselves as the agent for service of legal process. Service of legal process may also be made upon any individual Trustee.

9. ***Name, Title And Address Of Principal Place Of Business Of Each Trustee:***

Union Trustees

Carl Neutzling
IBEW 688 Union Hall
67 S. Walnut St.
Mansfield, Ohio 44902

Douglas Anderson
717 St. Rte. 852
Ashland, Ohio 44805

Employer Trustees

Steve Palmer
Spring Electric
1500 East Lindaire Lane
Mansfield, Ohio 44906

Mark Bosko
Alpine Electric, Inc.
57 East 6th St.
Mansfield, Ohio 44902

Lance Biglin
7833 St. Rte. 96
Crestline, Ohio 44827

Brian Damant
Central Ohio Chapter, NECA Inc.
PO Box 163128
Columbus, Ohio 43216

Hubert Rice
1870 Cunning Dr.
Mansfield, Ohio 44907

William Lucas
Owens Electric Co.
146 South Greenwood St.
Marion, Ohio 43302

10. ***Collective Bargaining Agreements:*** This Plan is maintained pursuant to a collective bargaining agreement between the participating local unions and the various participating employers. You may obtain a copy of the collective bargaining agreement by writing to the Office of the Administrative Manager, or you may examine it at the Plan Office.

11. ***Sources Of Contributions:*** The Plan is funded through contributions by the Employers on behalf of their Employees under the terms of a collective bargaining agreement, and by investment income earned on a portion of the Fund's assets. The Plan is subject to periodic actuarial review to assure that the relationship between income and benefit costs meets the standards required by ERISA.

12. ***Funding Medium For The Accumulation Of Plan Assets:*** Assets are accumulated and medical benefits are provided by the Fund. A portion of the Plan assets are invested in certificates of deposit with insured financial institutions and a portion are invested primarily in fixed income securities with Fifth Third Bank.

13. ***Date Of The Plan's Fiscal Year End:*** May 31

14. ***Grandfathered Health Plan:*** 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, such as the requirement to provide preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under the Affordable Care Act, such as the elimination of annual and lifetime limits on essential health benefits.

Questions regarding which protections 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 Boulevard, Austintown, Ohio 44515 (Toll Free: (800) 435-2388; Fax: (330) 270-0912). You also may contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or on its website at www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered health plans.

SIGNATURE PAGE

In witness whereof, the trustees of the I.B.E.W. Local No. 688 Health & Welfare plan have adopted and approved this summary plan description and plan document on this 13th day of May, 2011, to be effective June 1, 2011.

EMPLOYER TRUSTEES	UNION TRUSTEES