SOUTHERN ILLINOIS ELECTRICAL RETIREE WELFARE PLAN

for EMPLOYEES
as Negotiated Between
INTERNATIONAL BROTHERHOOD
OF ELECTRICAL WORKERS
LOCAL UNION NO. 702
and

ILLINOIS CHAPTER, NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION, Inc.

SUMMARY PLAN DESCRIPTION

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TABLE OF CONTENTS

ARTICLE I – DEFINITIONS 1
SECTION 1 – ASSOCIATION 1
SECTION 2 – BARGAINING UNIT ALUMNI 1
SECTION 3 – ELECTRICAL INDUSTRY 1
SECTION 4 – EMPLOYEE 1
SECTION 5 – EMPLOYER 2
SECTION 6 – INSIDE/TELECOMMUNICATIONS BENEFIT PROGRAM 2
SECTION 7 – OUTSIDE BENEFIT PROGRAM 2
SECTION 8 – PARTICIPANT 2
SECTION 9 – TOTALLY AND PERMANENTLY DISABLED. 2
SECTION 10 – TRUST AGREEMENT 2
SECTION 11 – UNION 2
SECTION 12 – UNION AGREEMENT 2
SECTION 13 – ELECTRIC UTILITY BENEFIT PROGRAM 4
SECTION 14 – VISTRA BENEFIT PROGRAM 4
SECTION 15 – SCIRA BENEFIT PROGRAM 4
SECTION 16 – CLOCK HOUR 4

ARTICLE II – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES 5
SECTION 1 – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: AMOUNT OF RETIREE WELFARE BENEFITS 5
SECTION 2 – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: ELIGIBILITY RULES FOR RETIREE WELFARE BENEFITS 5
SECTION 3 – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: AMOUNT OF DISABILITY WELFARE BENEFITS 7
SECTION 4 – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: INITIAL AND CONTINUING ELIGIBILITY RULES FOR DISABILITY WELFARE BENEFITS 7
SECTION 5 – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: AMOUNT OF PRE AND POST RETIREMENT SURVIVING SPOUSE/CHILD WELFARE BENEFIT. 7
SECTION 6 – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: ELIGIBILITY RULES FOR PRE AND POST RETIREMENT SURVIVING SPOUSE/CHILD WELFARE BENEFITS. 8

ARTICLE III – OUTSIDE BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES 8
SECTION 1 – OUTSIDE BENEFIT PROGRAM: AMOUNT OF RETIREE WELFARE BENEFITS 9
SECTION 2 – OUTSIDE BENEFIT PROGRAM: ELIGIBILITY RULES FOR RETIREE WELFARE BENEFITS 9
SECTION 3 – OUTSIDE BENEFIT PROGRAM: AMOUNT OF DISABILITY WELFARE BENEFITS. 11
SECTION 4 – OUTSIDE BENEFIT PROGRAM: INITIAL AND CONTINUING ELIGIBILITY

Rules for Disability Welfare Benefits. 11
Section 5 – Outside Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefits. 12
Section 6 – Outside Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits. 12

ARTICLE IV – VISTRA BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES 14
Section 1 – Vistra Benefit Program: Amount of Retiree Welfare Benefits.....14
Section 2 – Vistra Benefit Program: Eligibility Rules for Retiree Welfare Benefits. 14
Section 3 – Vistra Benefit Program: Amount of Disability Welfare Benefits. 15
Section 4 – Vistra Benefit Program: Initial and Continuing Eligibility Rules for Disability Welfare Benefits. 16
Section 5 – Vistra Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefits. 16
Section 6 – Vistra Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits. 16

ARTICLE V – SCIRA BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES.....18
Section 1 – SCIRA Benefit Program: Amount of Retiree Welfare Benefits. ...18
Section 2 – SCIRA Benefit Program: Eligibility Rules for Retiree Welfare Benefits. 18
Section 3 – SCIRA Benefit Program: Amount of Disability Welfare Benefits. 19
Section 4 – SCIRA Benefit Program: Initial and Continuing Eligibility Rules for Disability Welfare Benefits. 19
Section 5 – SCIRA Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefit. 20
Section 6 – SCIRA Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits. 20

ARTICLE VI – ELECTRIC UTILITY BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES 22
Section 1 – Electric Utility Benefit Program: Amount of Retiree Welfare Benefits 22
Section 2 – Electric Utility Benefit Program: Eligibility Rules for Retiree Welfare Benefits. 22
Section 3 – Electric Utility Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefits. 23
Section 4 – Electric Utility Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits. 23

ARTICLE VII – GENERAL BENEFIT LIMITATIONS AND EXCLUSIONS FOR ALL WELFARE BENEFITS 25
SECTION 1 – CONTINUATION OF GROUP HEALTH WELFARE BENEFITS COVERAGE. 25
SECTION 2 – LIMITATION ON MONTHLY BENEFIT PAYMENT MADE BY PLAN. 25
SECTION 3 – EXCLUSION IF ELIGIBLE FOR BENEFITS UNDER A RETIREE MEDICAL PLAN. 25
SECTION 4 – EXCLUSION IF RETIREE RETURNS TO WORK IN THE ELECTRICAL INDUSTRY OR IF RETIREE OR SURVIVING SPOUSE BECOMES EMPLOYED AND COVERED BY AN EMPLOYMENT BASED GROUP HEALTH PLAN. 25
SECTION 5 – LOSS OF MONTHLY BENEFITS FOR LATE APPLICATIONS 26
SECTION 6 – EXCLUSIONS APPLICABLE TO PRE AND POST RETIREMENT SURVIVING SPOUSE WELFARE BENEFITS. 26
SECTION 7 – EXAMPLES OF HOW BENEFITS MAY BE LOST 26

ARTICLE VIII – GENERAL PLAN RULES ON CONTINUED WELFARE BENEFITS 28
SECTION 1 – DIRECT PAYMENT TO GROUP HEALTH PLAN. 28
SECTION 2 – ADVANCE SUBMISSION OF BENEFIT APPLICATION REQUIRED. 28
SECTION 3 – BARGAINING UNIT ALUMNI. 28
SECTION 4 – OPT OUT OF BENEFITS ONLY (NOT CONTRIBUTIONS). 28

ARTICLE IX – SERVICE WITH PUBLIC EMPLOYERS 29

ARTICLE X – GENERAL INFORMATION 30
SECTION 1 – CLAIM AND APPEAL PROCEDURES. 30
SECTION 2 - INFORMATION ABOUT THE PLAN. 34
SECTION 3 - STATEMENT OF RIGHTS UNDER ERISA. 36
SECTION 4 – INTERPRETATION OF THE PLAN. 37
SECTION 5 – TERMINATION PROCEDURE: ASSET DISTRIBUTION. 37
SECTION 6 – LIMITATION OF AUTHORITY. 38
SECTION 7 – BENEFIT CHANGES. 38
SECTION 8 – OBLIGATION OF ELIGIBLE RETIREES, EMPLOYEES, AND SURVIVING SPOUSES TO FURNISH INFORMATION TO THE TRUSTEES. 38
SECTION 9 – BENEFITS ARE NOT ASSIGNABLE. 38
SECTION 10 – RESTRICTION ON LAWSUITS. 39

INTRODUCTION

The Southern Illinois Electrical Retiree Welfare Plan ("Plan") was established in 1995 by the Union and the Association to provide retiree group health and related benefits to employees working in the inside electrical construction and telelcommunications industry and under Union Agreements between the Union and the Association. Since the Plan's inception, the Union and the Association, other employer associations and other employers have bargained for other bargaining units to participate in the Plan (Participant Groups). Since the establishment of the Plan for the inside electrical construction and telecommunications industry Participant Group, the other Participant Groups started on the following dates: effective July 1, 2009, employees working in the outside electrical construction industry; effective January 1, 2010 employees working in the line clearance industry; effective August 1, 2010 employees working for electric utilities (including REA cooperatives) (electric utility); effective July 1, 2015, employees working at the Newton Power Plant of Illinois Power Resources Generation (Vistra); and effective February 1, 2015, employees working under the South-Central Illinois Regional Agreement (SCIRA).

In consultation with the Plan's Actuary, the Trustees have established Benefit Programs (benefits and eligibility rules) for each Participant Group. All Benefit Programs under the Plan, however, have a basic eligibility rule of 20 Years of Service which are based on Clock Hours worked under a Union Agreement or an approved participation agreement between the Plan and Employers or as otherwise provided for under the Plan. **A<u>ll Clock Hours worked by a Participant will be applied towards determining whether the Participant meets the Years of Service required for each Benefit Program provided Employer contributions are received for those Clock Hours</u>**.

This document is both the Plan Document and the Summary Plan Description (SPD). This SPD states the Plan terms in effect starting on August 1, 2025. For Plan terms in effect before this date, such terms are provided in earlier SPDs, Benefit Programs, and Summaries of Material Modification.

ARTICLE I – DEFINITIONS

Section 1 – Association

Southern Illinois Division, Illinois Chapter, National Electrical Contractors Association, Inc.

Section 2 – Bargaining Unit Alumni

An Employee is a Bargaining Unit Alumni if in the past, he was a member of a bargaining unit covered by an Agreement with the Union and was an active Participant in this Plan, and his current employer is either currently party to a Union Agreement as defined in Article I, Section 12 below or is the Union. To earn future Years of Service, a Bargaining Unit Alumni must be covered by an approved participation agreement between the Plan and his Employer or must have elected self-pay in compliance with the current Regulation on Self-Pay for Bargaining Unit Alumni.

Section 3 – Electrical Industry

Any and all types of work performed as an Employee, supervisor, owner, partner, officer, director, or adviser, involving or related to electrical construction, maintenance or repair of electricity or its apparatus, including but not limited to the trade jurisdiction of the IBEW as described in its Constitution of September, 2001, and as thereafter amended, work in the inside electrical construction, outside electrical construction, line clearance and electric utility industries, or the holding of an active electrical license if used directly or by others. It does not include work as an electrical inspector for a government or as an instructor in an apprentice or other education program sponsored by parties to the Trust Agreement for this Plan or as an instructor in an outside construction industry or line clearance industry apprenticeship program jointly established by the Union and employers.

Section 4 – Employee

A person working under the terms of a Union Agreement. A person otherwise meeting the definition of Employee is not to be excluded because the person has an ownership interest in or a management position with an Employer. The term "Employee" may also include, with the consent of the Trustees, Employees of a Union; Employees of any trust fund established by a Union and the Association; Employees working in any field represented by the Union (for example, instructors in electricity at vocational schools, Employees performing electrical work at Government institutions); persons working under the terms of other Union Agreements; other persons for whom contributions are required under the terms of a written agreement with a Union or the Trustees (for example, a foreman who may work from time to time outside the terms of a Union Agreement for an Employer), and Bargaining Unit Alumni under conditions approved by the Board of Trustees.

Section 5 – Employer

An Employer that is party to, has assented to, or is otherwise bound by a Union Agreement requiring contributions to this Plan or who agrees in writing to make contributions to this Plan pursuant to a participation agreement with the Trustees.

Section 6 – Inside/Telecommunications Benefit Program

The schedule of benefits and eligibility rules as set forth in Article II of this Plan.

Section 7 – Outside Benefit Program

The schedule of benefits and eligibility rules as set forth in Article III of this Plan .

Section 8 – Participant

Any Employee or former Employee who is or may become eligible to receive any benefit under the terms of the Plan or whose surviving spouse and/or child (natural, step-child or adopted child up to the end of the month of their 26th birthday) may be eligible to receive any benefit. An Employee becomes an eligible Participant when Employer contributions attributable to wages paid to the Employee by such Employer are first received by the Plan pursuant to a Union Agreement.

Section 9 – Totally and Permanently Disabled.

Totally and Permanently Disabled means the inability because of accident or illness to perform the duties of the job classifications of the last Union Agreement under which the Participant was working before the injury or illness causing his disability. The Trustees may require an examination of the Participant by a physician selected by the Trustees. The Trustees may accept the disability determination made by the Social Security Administration as sufficient evidence of being Totally and Permanently Disabled or the determination of the Participant's physician.

Section 10 – Trust Agreement

The Southern Illinois Electrical Retiree Welfare Plan Trust Agreement, as restated September 1, 2021 and as it may be amended thereafter.

Section 11 – Union

Local No. 702, International Brotherhood of Electrical Workers or any other union which, with the consent of the Trustees, agrees to participate in this Plan.

Section 12 – Union Agreement

(a) Inside and Telecommunications Benefit Program. For the Inside and Telecommunications Benefit Program, a Union Agreement is:

(1) On and after August 1, 1995, a collective bargaining agreement with the Union and the Association, or any other collective bargaining agreement between the Union and an Employer in the inside electrical construction industry or telecommunications industry which requires contributions to this Plan at the same contribution rate as the then current Union Agreement between the Union and the Association; and

(2) Prior to August 1, 1995, a collective bargaining agreement between the Union and the Association covering the inside electrical construction industry or telecommunications industry.

(b) **Outside Benefit Program**. For the Outside Benefit Program, a Union Agreement is:

(1) On and after July 1, 2009 in the case of Lineman Participants and on and after January 1, 2010 in the case of Tree Trimmer/Line Clearance Participants, a collective bargaining agreement with the Union and the American Line Builders Chapter of the National Electrical Contractors Association or any other collective bargaining agreement between the Union and an Employer in either the outside electrical construction industry or the line clearance industry which requires contributions to this Plan at the same rate as the then current Union Agreement between the Union and the American Line Builders Chapter of the National Electrical Contractors Association; and

(2) Prior to July 1, 2009 in the case of Lineman Participants and prior to January 1, 2010 in the case of Tree Trimmer/Line Clearance Participants, a collective bargaining agreement between the Union and the American Line Builders Chapter of the National Electrical Contractors Association or an Employer in the outside electrical construction industry or the line clearance industry.

(c) **Electric Utility Benefit Program**. For the Electric Utility Benefit Program, a Union Agreement is a collective bargaining agreement with the Union and Employers in the electric utility industry (including REA cooperatives) which provides for contributions to this Plan on or after August 1, 2010.

(d) **Vistra Benefit Program**. For the Vistra Benefit Program, a Union Agreement is a collective bargaining agreement with:

(1) the Union and Illinois Power Resources Generation, LLC (Newton Plant) (Vistra) which provides for either Employer or Employee contributions to this Plan on or after July 1, 2015; or

(2) the Union and Vistra or its predecessors at the Newton Power Plant (Ameren and CIPS) which expired on or before June 30, 2015.

(e) **SCIRA Benefit Program**. For the SCIRA Benefit Program, a SCIRA Union Agreement between the Union and the Association which is effective on or after February 1, 2015 and which provides for Employer contributions to this Plan.

Section 13 – Electric Utility Benefit Program

The schedule of benefits and eligibility rules as set forth in Article VI.

Section 14 – Vistra Benefit Program

The schedule of benefits and eligibility rules for As set forth in Article IV.

Section 15 – SCIRA Benefit Program

The schedule of benefits and eligibility rules as set forth in Article V.

Section 16 – Clock Hour

A Clock Hour is an hour worked by a Participant under a Union Agreement, as defined in Article I, Section 12, or under an approved participation agreement between the Plan and his Employer for which contributions have been received by the Plan. **All Clock Hours worked by a Participant will be applied towards determining whether the Participant meets the Years of Service required for each Benefit Program provided Employer contributions are received for those Clock Hours.**

Example: From 2005 to 2025, Smith worked 1,400 Clock Hours per year for which contributions were received by the Plan. For the first five (5) years, Smith worked under Union Agreements in the outside electrical construction industry as defined in Article I, Section 12(b). For the next fifteen (15) years, Smith worked under Union Agreements in the inside electrical construction industry as defined in Article I, Section 12(a). Smith retires from work in the Electrical Industry at age 58 and is eligible for retiree coverage under the NECA-IBEW Welfare Trust Fund. Under Article II, Section 2(b)(3) below, Smith earned a total of twenty (20) Inside/Telecommunications Years of Service which will be applied towards determining whether Smith is eligible for Retiree Welfare benefits under the Inside/Telecommunications Benefit Program as set forth in Article II, Section 2(a).

In addition, for a Participant who earned both (1) one Outside Year of Service, as defined in Article III, Section 2(b) below, in 2016 and (2) at least 10 Outside Years of Service prior to July 1, 2009, documented hours worked prior to July 1, 2009 under an outside labor agreement between IBEW Locals 309 or 51 and an employer who was also signatory to a Union Agreement as defined in Plan/SPD Article I, Section 12(b), will be treated as Clock Hours for a maximum of an additional three (3) Outside Years of Service prior to July 1, 2009 **provided that** the Participant submitted documentation of hours worked under a Local 309 or Local 51 outside labor agreement, either from records of the NEBF, IBEW Locals 309 and 51, or the employer, no later than December 31, 2018.

ARTICLE II – INSIDE AND TELECOMMUNICATIONS BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES

Section 1 – Inside and Telecommunications Benefit Program: Amount of Retiree Welfare Benefits

Payment will be made to a group health plan or insurance company on behalf of an Eligible Inside and Telecommunications Benefit Program Retiree up to the lesser of:

(a) 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree under the NECA-IBEW Welfare Trust Fund Base Plan; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the Eligible Retiree.

Section 2 – Inside and Telecommunications Benefit Program: Eligibility Rules For Retiree Welfare Benefits

(a) General. To be an Eligible Inside and Telecommunications Retiree, a Participant must meet all of the following requirements:

(1) Age and Retirement. A Participant must be at least age 58 and retired from any type of work in the Electrical Industry after August 31, 1996.

(2) 20 Inside/Telecommunications Years of Service. A Participant must have completed twenty (20) Inside/Telecommunications Years of Service as described in Article II, Section 2(b) below, or with Public Employers as described in Article IX below.

If after attaining age 56 a Participant is Totally and Permanently Disabled, as defined in Article 1, Section 9, each such year that the Participant is Totally and Permanently Disabled after attaining age 56 will be counted for up to two (2) years to meet this 20 Inside/Telecommunications Years of Service eligibility rule.

Example: A Participant reaches age 56 in 2026 with eighteen (18) Years of Service and last worked when he was age 55. He became Totally and Permanently Disabled at age 56 and remained Totally and Permanently Disabled for two (2)years. He meets the requirements of the 20 Years of Service because he had eighteen (18) Inside/Telecommunications Years of Service plus he had two (2) years when he was Totally and Permanently Disabled after attaining age 56.

(3) Final Two Years. At least two (2) Years of Service during the last five (5) years before a Participant becomes eligible for benefits under this Plan must meet the requirements for Inside/Telecommunication Years of Service as described in Article II, Section 2(b) below.

If a Participant is Totally and Permanently Disabled, as defined in Article I, Section 9, throughout any one (1) or more years during such last five (5) years, each such year that

the Participant is Totally and Permanently Disabled may be counted to meet this Final Two Inside/Telecommunications Years of Service requirement.

Example: A Participant reaches age 58 with more than 20 Inside/Telecommunications Years of Service and last worked when age 56. He became Totally and Permanently Disabled at age 57 and remained Totally and Permanently Disabled for one (1) year. He meets the requirements of Final Two Inside/Telecommunications Years of Service during the last five (5) years before age 58 because he had one (1) year of service while age 56 and the year that he was Totally and Permanently Disabled counts as the second required year.

(4) Eligible for NECA-IBEW Welfare Trust Fund. The Participant must be eligible for retiree coverage under the NECA-IBEW Welfare Trust Fund.

(b) Inside/Telecommunications Years of Service Defined: An Inside/Telecommunications Year of Service is a calendar year during which a Participant meets the following requirements.

(1) Service Prior to 1965. Prior to 1965, any year during which a Participant performed any work under a Union Agreement as defined in Article I, Section 12 will count as one (1) Inside/Telecommunications Year of Service.

(2) Service from 1965 through 1995. A Participant will be credited with one (1) Inside/Telecommunications Year of Service for each 1,000 Clock Hours worked, disregarding Clock Hours during any year when the Participant had less than 300 Clock Hours. The total number of Inside/Telecommunications Years of Service credited may not exceed the number of years during which the person worked 300 or more Clock Hours.

Example: Fox worked 21,000 Clock Hours during a twenty (20) year period from 1976 through 1995 under Union Agreements as defined in Article I, Section 12. In 15 of those years, he worked at least 300 Clock Hours. In five (5) of those years, he worked only 200 Clock Hours a year; therefore, these 1,000 Clock Hours are not counted. This leaves 20,000 Clock Hours, potentially equal to 20 Inside/Telecommunications Years of Service (20,000 divided by 1,000), but Fox is entitled only to 15 Inside/Telecommunications Years of Service because that is the number of years during which he worked more than 300 Clock Hours.

(3) Service from 1996 Forward. From 1996 forward, a Participant will be credited with one (1) Inside/Telecommunications Year of Service for each 1,400 Clock Hours, disregarding Clock Hours during any year when the person had less than 300 Clock Hours. The total number of Inside/Telecommunications Years of Service credited may not exceed the number of years during which the Participant worked 300 or more Clock Hours.

Example: Fox worked these Clock Hours: 200 in 2019 , 800 in 2020, 2,200 in 2021, 1,900 in 2022, 1,200 in 2023, and 900 in 2024. The 200 in 2019 do not count. The remaining 7,000 Inside Clock Hours are divided by 1,400 producing five. Since Fox had five years with more than 300 Clock Hours, he is entitled to the five Inside/Telecommunications Years of Service.

Section 3 – Inside and Telecommunications Benefit Program: Amount of Disability Welfare Benefits

If an Eligible Inside and Telecommunications Benefit Program Participant becomes Totally and Permanently Disabled, any self-pay premium required for coverage of the Participant up to the lesser of:

(a) 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Participant under the NECA-IBEW Welfare Trust Fund Base Plan; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage

shall be payable to the group health plan or insurance company covering the Eligible Participant from the time that he became Totally and Permanently Disabled.

Disability Welfare Benefits shall be payable for a maximum of thirty-six (36) months or the date the Trustees determine that the Participant is no longer Totally and Permanently Disabled, whichever is earlier.

If a Participant becomes eligible for Retiree Welfare Benefits under Article II, Section 2 during a month that a Participant is eligible for Disability Welfare Benefits, the following month, Disability Welfare Benefits will end, and the Participant will be enrolled for Retiree Welfare Benefits.

Section 4 – Inside and Telecommunications Benefit Program: Initial and Continuing Eligibility Rules for Disability Welfare Benefits.

The Participant must be eligible for coverage under the NECA-IBEW Welfare Trust Fund and must have five (5) Inside/Telecommunications Years of Service, as defined in Article II, Section 2(b), with at least one (1) Inside/Telecommunications Year of Service during the two (2) calendar years immediately preceding the date of the Participant's Total and Permanent Disability as defined in Article I, Section 9. During the thirty-six (36) months period of Disability Welfare Benefits, the Participant must meet the Plan's definition of Totally and Permanently Disabled.

Section 5 – Inside and Telecommunications Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefit.

An eligible surviving spouse and/or child of an Inside and Telecommunications Benefit Program Participant or Retiree will receive a Surviving Spouse/Child Welfare Benefit of premium payments to a group health plan or insurance company on behalf of the surviving spouse and/or child up to the lesser of:

(a) 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the surviving spouse/child under the NECA-IBEW Welfare Trust

Fund Base Plan; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the surviving spouse/child.

Section 6 – Inside and Telecommunications Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

(a) Eligibility Rules for Pre-Retirement Surviving Spouse/Child Welfare Benefits. The surviving spouse and/or child of an Inside and Telecommunications Benefit Program Participant in the Inside and Telecommunications Benefit Program who dies before starting to receive Retiree Welfare Benefits under this Plan may be eligible for a Surviving Spouse/Child Welfare Benefit under the terms of this Section. The surviving spouse and/or child must be eligible for coverage under the NECA-IBEW Welfare Trust Fund and the Participant must have met either Section 6(a)(1) or 6(a)(2) below at the time of his death:

(1) The Participant must have had five (5) Inside/Telecommunications Years of Service and met the Final Two Years requirements of Article II, Section 2(a)(3) except that the required two (2) Inside/Telecommunications Years of Service must be within the last five (5) years before the Participant's death; or

(2) An apprentice indentured in the Local 702 Inside Wireman's JATC who has completed his probationary period, so long as he remains as an indentured apprentice. After completion of apprenticeship, eligibility will be continued for one (1) year for each year during his apprenticeship that the Employee worked less than 1,400 Clock Hours – provided that the former apprentice is continuously working for an Employer as defined in Article I, Section 5 above or a Public Employer described Article IX below.

(b) Eligibility Rules for Post-Retirement Surviving Spouse/Child Welfare Benefits. To be eligible for Post-Retirement Surviving Spouse Welfare Benefits, a surviving spouse must be: (1) married to an Inside and Telecommunications Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the Inside and Telecommunications Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

To be eligible for Post-Retirement Surviving Child Welfare Benefits, a surviving child must be: (1) the child of an Inside and Telecommunications Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the Inside and Telecommunications Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

(c) Continuing Eligibility Rules for All Surviving Spouse Welfare Benefits. The surviving spouse must satisfy the general conditions in Article VII, and the continuing eligibility rules for surviving spouse benefits appearing Article VII, Section 6.

ARTICLE III – OUTSIDE BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES

Section 1 – Outside Benefit Program: Amount of Retiree Welfare Benefits

Payment will be made to a group health plan or insurance company on behalf of an Eligible Outside Benefit Program Retiree up to the lesser of:

(a) 100% of the monthly premium that the Line Construction Benefit Fund ("Lineco") requires for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and their dependents;

(b) or the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and his dependents.

For the Outside Benefit Program, this Plan follows the Lineco definition of "child."

Section 2 – Outside Benefit Program: Eligibility Rules for Retiree Welfare Benefits

(a) General. To be an Eligible Retiree for Outside Retiree Welfare Benefits, a Participant must meet all of the following requirements:

(1) Age, Retirement, and Initial Participation. A Participant must be at least age 58, retired from any type of work in the Electrical Industry on or after July 1, 2009 for linemen Participants and January 1, 2010 for tree trimmer/line clearance Participants, and have earned at least 1,400 Clock Hours.

(2) 20 Outside Years of Service. A Participant must have completed twenty (20) Outside Years of Service as described in Article II, Section 2(b) below, or with Public Employers as described in Article IX below.

If after attaining age 56 a Participant is Totally and Permanently Disabled, as defined in Article 1, Section 9, each such year that the Participant is Totally and Permanently Disabled after attaining age 56 will be counted for up to two (2) years to meet this 20 Outside Years of Service eligibility rule.

Example: A Participant reaches age 56 in 2020 with eighteen (18) Outside Years of Service and last worked when he was age 55. He became Totally and Permanently Disabled at age 56 and remained Totally and Permanently Disabled for three (3) years. He meets the requirements of the 20 Outside Years of Service because he had eighteen (18) Outside Years of Service plus he had two (2) years when he was Totally and Permanently Disabled after attaining age 58.

(3) Final Two Years. At least two (2) Outside Years of Service during the last five (5) years before a Participant becomes eligible for benefits under this Plan must meet the requirements for Outside Years of Service as described in Article III, Section 2(b) below.

If a Participant is Totally and Permanently Disabled, as defined in Article I, Section 9 throughout any one or more years during such last five (5) years, each such year that Participant is Totally and Permanently Disabled may be counted to meet this Final Two Outside Years of Service requirement.

Example: A Participant reaches age 58 with more than 20 Outside Years of Service and last worked when age 56. He became Totally and Permanently Disabled before he became injured at age 57 and remained Totally and Permanently Disabled for one (1) year. He meets the requirements of Final Two Years of Service during the last five (5) years before age 60 because he had one year of service while age 56 and the year that he was Totally and Permanently Disabled counts as the second required year.

(4) Eligible for Lineco. The Participant must be eligible for retiree coverage under Lineco.

(b) Outside Years of Service Defined: An Outside Year of Service is a calendar year during which a Participant meets the following requirements.

(1) Service Prior to 1965. Prior to 1965, any year during which a Participant performed any work under a Union Agreement as defined in Article I, Section 12 will count as one (1) Outside Year of Service.

(2) Service from 1965 through and before July 1, 2009 in the case of Linemen Participants, and before January 1, 2010 in the case of Tree Trimmer/Line Clearance Participants.

(i) From 1965 through 1995, a Participant will be credited with one (1) Outside Year of Service for each 1,000 Clock Hours, disregarding Clock Hours during any year when the Participant had less than 300 Clock Hours.

(ii) From 1996 and before July 1, 2009 in the case of Linemen Participants and before January 1, 2010 in the case of Tree Trimmer/Line Clearance Participants, a Participant will be credited with one (1) Outside Year of Service for each 1,400 Clock Hours worked, disregarding Clock Hours during any year when the Participant had less than 300 Clock Hours.

(iii) The total number of Outside Years of Service credited may not exceed the number of years during which the person worked 300 or more Clock Hours.

Example: Fox worked 29,000 Clock Hours during a twenty (20) year period from 1996 through 2015 under Union Agreements as defined in Article I, Section 12(b). In 15 of those years, he worked at least 300 Clock Hours. In five of those years, he worked only 200 Clock Hours a year; therefore, these 1,000 Clock Hours are not counted. This leaves 28,000 Clock Hours, potentially equal to twenty (20) Outside Years of Service (28,000 divided by 1,400), but Fox is entitled only to fifteen (15) Outside Years of Service because that is the number of years during which he worked more than 300 Clock Hours.

(3) Service from July 1, 2009 Forward in the case of Lineman Participants and from January 1, 2010 Forward in the case of Tree Trimmer/Line

Clearance Participants. On and after July 1, 2009 in the case of Lineman Participants and on and after January 1, 2010 in the case of Tree Trimmer/Line Clearance Participants forward, a Participant will be credited with one (1) Outside Year of Service for each 1,400 Clock Hours worked, disregarding Clock Hours during any year when the person had less than 300 Clock Hours. The total number of Outside Years of Service credited may not exceed the number of years during which the Participant worked 300 or more Clock Hours.

Example: Fox worked these Clock Hours: 200 in 2019, 800 in 2020, 2,200 in 2021, 1,900 in 2022, 1,200 in 2023, and 900 in 2024. The 200 in 2019 do not count. The remaining 7,000 Clock Hours are divided by 1,400 producing five (5). Since Fox had five (5) years with more than 300 Clock Hours, he is entitled to the five (5) Outside Years of Service.

Section 3 – Outside Benefit Program: Amount of Disability Welfare Benefits.

If an Eligible Outside Benefit Program Participant becomes Totally and Permanently Disabled, any self-pay premium required for coverage of the Participant and his dependents up to the lesser of:

(a) 100% of the monthly premium that Lineco requires for medical, prescription drug, dental, and vision coverage of the Eligible Participant and his dependents; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the Eligible Participant and his dependents shall be payable to the group health plan or insurance company covering the Participant from the time that he became disabled.

This Benefit shall be payable for a maximum of thirty-six (36) months or the date the Trustees determine that the Participant is no longer Totally and Permanently Disabled, whichever is earlier.

If a Participant becomes eligible for Retiree Welfare Benefits under Article III, Section 2 during a month that a Participant is eligible for Disability Welfare Benefits, the following month, Disability Welfare Benefits will end, and the Participant will be enrolled in Retiree Welfare Benefits.

Section 4 – Outside Benefit Program: Initial and Continuing Eligibility Rules for Disability Welfare Benefits.

The Participant must be eligible for coverage under Lineco and must have five (5) Outside Years of Service, as defined in Article II, Section 2(b), with at least one (1) Outside Year of Service during the two (2) calendar years immediately preceding the date of the Participant's disability. In addition, the Participant must have earned at least 1,400 Clock Hours and the disability must commence after the Participant earned these 1,400 Clock Hours. During the thirty-six (36) months period of Disability Welfare Benefits, the Participant must meet the Plan's definition of Totally and Permanently Disabled.

Section 5 – Outside Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

An eligible surviving spouse and/or child of an Outside Benefit Program Participant or Retiree will receive a Surviving Spouse/Child Welfare Benefit of premium payments to a group health plan or insurance company on behalf of the surviving spouse and/or child up to the lesser of:

(a) 100% of the monthly premium that Lineco requires for medical, prescription drug, dental, and vision coverage of the surviving spouse/child; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the surviving spouse/child.

Section 6 – Outside Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

(a) Eligibility Rules for Pre-Retirement Surviving Spouse/Child Welfare Benefits. The surviving spouse and/or child of an Outside Benefit Program Participant who dies before starting to receive Retiree Welfare Benefits under this Plan, may be eligible for a Surviving Spouse/Child Welfare Benefit under the terms of this Subsection. A Participant must have earned at least 1,400 Clock Hours and the Participant's death must have occurred after the Participant earned these 1,400 Clock Hours. In addition, the surviving spouse and/or child must be eligible for coverage under Lineco and the Participant must have met either Section 6(a)(1) or 6(a)(2) below at the time of his death:

(1) The Participant must have had five (5) Outside Years of Service and met the Final Two Years requirements of Article III, Section 2(a)(3), except that the required two (2) Outside Years of Service must be within the last five (5) years before the Participant's death or

(2) The Participant must have been an apprentice indentured in an outside construction industry or line clearance industry apprenticeship program jointly established by the Union and employers, who has completed his probationary period, so long as he remains as an indentured apprentice. After completion of apprenticeship, eligibility will be continued for one (1) year for each year during apprenticeship that the Participant worked less than 1,400 Clock Hours - provided that the Participant is continuously working for an Employer as defined in Article I, Section 5 above or a Public Employer described Article IX below.

(b) Eligibility Rules for Post-Retirement Surviving Spouse Welfare Benefits. To be eligible for Post-Retirement Surviving Spouse Welfare Benefits, a surviving spouse must be: (1) married to an Outside Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the Outside Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

To be eligible for Post-Retirement Surviving Child Welfare Benefits, a surviving child

must be: (1) the child of an Outside Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the Outside Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

(c) Continuing Eligibility Rules for All Surviving Spouse/Child Welfare Benefits. The surviving spouse and/or child must satisfy the general conditions in Article VII, and the continuing eligibility rules for surviving spouse/child benefits appearing Article VII, Section 6.

ARTICLE IV – VISTRA BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES

Section 1 – Vistra Benefit Program: Amount of Retiree Welfare Benefits.

Payment will be made to a group health plan or insurance company on behalf of an Eligible Vistra Benefit Program Retiree up to the lesser of the following amounts per month or the monthly amount that the group health welfare plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and his dependents:

(a) Age 58 through 64: 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree under the NECA/IBEW Family Medical Care Plan.

(b) Age 65 plus: 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree under the NECA/IBEW Family Medical Care Plan.

(c) Retiree or spouse under age 65 and the other over age 65: 73.91% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and spouse under the NECA/IBEW Family Medical Care Plan.

(d) Retiree and spouse over age 65: 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and spouse under the NECA/IBEW Family Medical Care Plan.

Section 2 – Vistra Benefit Program: Eligibility Rules for Retiree Welfare Benefits.

(a) General. To be an Eligible Retiree for Vistra Retiree Welfare Benefits, a Participant must meet all of the following requirements:

(1) Age, Retirement, and Initial Participation. A Participant must be (i) at least age 58, (ii) actively employed under the Union Agreement defined in Article I, Section 12(d) on and after July 1, 2015, and (iii) retired from any type of work in the Electrical Industry including employment with Vistra after July 1, 2015.

(2) Twenty (20) Vistra Benefit Program Years of Service. A Participant must have completed twenty (20) Vistra Years of Service as described in Article IV, Section 2(b) below or with Public Employers as described in Article IX below.

If after attaining age 56 a Participant is Totally and Permanently Disabled, as defined in Article 1, Section 9, each such year that the Participant is Totally and Permanently Disabled after attaining age 58 will be counted for up to two (2) years to meet this 20 Vistra Years of Service eligibility rule.

Example: A Participant reaches age 56 in 2025 with eighteen (18) Vistra Years of Service and last worked when he was age 55. He became Totally and Permanently

Disabled at age 56 and remained Totally and Permanently Disabled for two (2) years. He meets the requirements of the twenty (20) Vistra Years of Service because he had eighteen (18) Vistra Years of Service plus he had two (2) years when he was Totally and Permanently Disabled after attaining age 56.

(3) Eligible for NECA/IBEW Family Medical Care Plan. The Participant must be eligible for retiree coverage under the NECA/IBEW Family Medical Care Plan.

(b) Vistra Years of Service Defined: A Vistra Year of Service is a July 1/June 30 year during which a Participant meets the following requirements.

(1) Service Prior to July 1, 2015. Prior to July 1, 2015, any year during which a Participant worked full-time will count as one (1) Vistra Year of Service. Full-time work is defined as 1,000 Clock Hours or more in a July 1/June 30 year.

(2) Service from July 1, 2015 Forward-Future Service. On and after July 1, 2015, a Participant will be credited with one (1) Vistra Year of Service for each year (measured from July 1 to June 30) that the Participant worked full-time on and after July 1, 2015. Full-time work is defined as 1,000 Clock Hours or more in a July 1/June 30 year.

(c) Excluded Participation. Employees who have met the eligibility requirements for the Ameren Retiree Medical Plan on the date of 2013 sale of the Newton Power Plant from Ameren to Vistra are excluded from participation in this Plan.

Section 3 – Vistra Benefit Program: Amount of Disability Welfare Benefits.

If an Eligible Vistra Benefit Program Participant becomes Totally and Permanently Disabled, the lesser of the following amounts per month or the monthly amount that the group health welfare plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the Participant and his spouse shall be payable to the group health plan or insurance company covering the Participant from the time that he became Totally and Permanently Disabled:

(a) Age 58 through 64: 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree under the NECA/IBEW Family Medical Care Plan.

(b) Age 65 plus: 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree under the NECA/IBEW Family Medical Care Plan.

(c) Retiree or spouse under age 65 and the other over age 65: 73.91% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and spouse under the NECA/IBEW Family Medical Care Plan.

(d) Retiree and spouse over age 65: 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and spouse under the NECA/IBEW Family Medical Care Plan.

This Benefit shall be payable for a maximum of thirty-six (36) months or the date the Trustees determine that the Employee is no longer Totally and Permanently Disabled, whichever is earlier. Disability Welfare Benefits will not start until the Employee has exhausted employer funded medical benefits under the active group medical plan or insured medical benefits or premium payments under an employer funded long term disability plan.

If a Participant becomes eligible for Retiree Welfare Benefits under Article IV, Section 2 during a month that a Participant is eligible for Disability Welfare Benefits, the following month, Disability Welfare Benefits will end, and the Participant will be enrolled in Retiree Welfare Benefits.

Section 4 – Vistra Benefit Program: Initial and Continuing Eligibility Rules for Disability Welfare Benefits.

The Participant must be eligible for coverage under the NECA/IBEW Family Medical Care Plan and must have five (5) Vistra Years of Service, as defined in Article IV, Section 2 (b). In addition, the Participant must have been actively employed on or after July 1, 2015 under the Union Agreement defined in Article I, Section 12(d) and his Total and Permanent Disability must commence after July 1, 2015 while the Participant was actively employed under a Union Agreement defined in Article I, Section 12(d). During the thirty-six (36) months period of Disability Welfare Benefits, the Participant must meet the Plan's definition of Totally and Permanently Disabled.

Section 5 – Vistra Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

An eligible surviving spouse and/or child of a Vistra Benefit Program Participant or Retiree will receive a Surviving Spouse/Child Welfare Benefit of premium payments to a group health plan or insurance company on behalf of the surviving spouse and/or child up to the lesser of:

(a) 100% of the monthly premium that the NECA/IBEW Family Medical Care Plan requires for medical, prescription drug, dental, and vision coverage of the surviving spouse/child; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the surviving spouse/child.

Section 6 – Vistra Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

(a) Eligibility Rules for Pre-Retirement Surviving Spouse/Child Welfare

Benefits. The surviving spouse and/or child of a Vistra Benefit Program Participant who dies before starting to receive Retiree Welfare Benefits under this Plan, may be eligible for a Surviving Spouse/Child Welfare Benefit under the terms of this Section. The Participant must have five (5) Vistra Years of Service, as defined in Article IV, Section 2(b). In addition, the Participant must have been actively employed on or after July 1, 2015 under the Union Agreement defined in Article I, Section 12(d) and his death must occur after July 1, 2015 while he was actively employed under a Union Agreement defined in Article I, Section 12(d). Furthermore, the surviving spouse and/or child must be eligible for coverage under the NECA/IBEW Family Medical Care Plan.

(b) Eligibility Rules for Post Retirement Surviving Spouse Welfare Benefits. To be eligible for Post Retirement Surviving Spouse Welfare Benefits, a surviving spouse must be (1) married to an Vistra Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the Vistra Benefits Program; and (2) a covered dependent under a group health plan or insurance policy.

To be eligible for Post Retirement Surviving Child Welfare Benefits, a surviving child must be (1) the child of an Eligible Retiree who dies while receiving Retiree Welfare Benefits under the Vistra Benefits Program that are payable to a group health plan or insurance company; and (2) a covered dependent under the group health plan or insurance policy.

(c) Continuing Eligibility Rules for All Surviving Spouse/Child Welfare Benefits. The surviving spouse and/or child must satisfy the general conditions in Article VII, and the continuing eligibility rules for surviving spouse/child benefits appearing Article VII, Section 6.

ARTICLE V – SCIRA BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES

Section 1 – SCIRA Benefit Program: Amount of Retiree Welfare Benefits.

Payment will be made to a group health plan or insurance company on behalf of an Eligible SCIRA Benefit Program Retiree of up to the lesser of:

(a) 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Retiree under the NECA-IBEW Welfare Trust Fund Base Plan; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the Eligible Retiree.

Section 2 – SCIRA Benefit Program: Eligibility Rules for Retiree Welfare Benefits.

(a) **General**. To be an eligible Retiree for SCIRA Retiree Welfare Benefits, a Participant must meet all of the following requirements:

(1) **Age, Retirement, and Initial Participation**. A Participant must be (i) at least age 58, (ii) actively employed under the Union Agreement defined in Article I, Section 12(e) on and after February 1, 2015, and (iii) retired from any type of work in the Electrical Industry .

(2) **Twenty (20) SCIRA Benefit Program Years of Service**. A Participant must have completed twenty (20) SCIRA Years of Service as described in Article V, Section 2(b) or with Public Employers as described in Article IX below.

If after attaining age 56 a Participant is Totally and Permanently Disabled, as defined in Article 1, Section 9, each such that the Participant is Totally and Permanently Disabled after attaining age 56 will be counted for up to two (2) years to meet this 20 SCIRA Years of Service eligibility rule.

Example: A Participant reaches age 56 in 2020 with eighteen (18) SCIRA Years of Service and last worked when he was age 55. He became Totally and Permanently Disabled at age 56 and remained Totally and Permanently Disabled for two (2) years. He meets the requirements of the 20 SCIRA Years of Service because he had eighteen (18) SCIRA Years of Service plus he had two (2) years when he was Totally and Permanently Disabled after attaining age 56.

(3) **Final Two Years.** At least two (2) SCIRA Years of Service during the last five (5) years before a Participant becomes eligible for benefits under this Plan must meet the requirements for SCIRA Years of Service, and not be Service with Public Employers.

If a Participant is Totally and Permanently Disabled, as defined in Article I, Section 9 below throughout any one (1) or more years during such last five (5) years, each

such year of disability may be counted to meet this Final Two Years of Service requirement.

Example: A Participant reaches age 58 with more than 20 SCIRA Years of Service and last worked when age 56. He became Totally and Permanently Disabled at age 57 and remained Totally and Permanently Disabled for one (1) year. He meets the requirements of Final Two Years of Service during the last five (5) years before age 58 because he had one year of service while age 56 and the year that he was Totally and Permanently Disabled counts as the second required year.

(4) Eligible for NECA-IBEW Welfare Trust Fund. The Participant must be eligible for retiree coverage under the NECA-IBEW Welfare Trust Fund.

(b) SCIRA Years of Service Defined: A Participant will be credited with one (1) SCIRA Year of Service for each 1400 Clock Hours, disregarding Clock Hours during any year when the person had less than 300 Clock Hours. The total number of SCIRA Years of Service credited may not exceed the number of years during which the Participant worked 300 or more Clock Hours.

Example: Jones worked these Clock Hours: 200 in 2019, 800 in 2020, 2,200 in 2021, 1,900 in 2022, 1,200 in 2023, and 900 in 2024. The 200 in 2019 do not count. The remaining 7,000 Clock Hours are divided by 1,400 providing five (5). Since Jones had five years of more than 300 Clock Hours, he is entitled to five (5) SCIRA Years of Service.

Section 3 – SCIRA Benefit Program: Amount of Disability Welfare Benefits.

If an Eligible SCIRA Benefit Program Participant becomes Totally and Permanently Disabled, any self-pay premium required for coverage of the Participant up to the lesser of:

(a) 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the Eligible Participant under the NECA-IBEW Welfare Trust Fund Base Plan; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage

shall be payable for a maximum of thirty-six (36) months or the date the Trustees determine that the Employee is no longer Totally and Permanently Disabled, whichever is earlier.

If a Participant becomes eligible for Retiree Welfare Benefits under Article V, Section 2 during a month that a Participant is eligible for Disability Welfare Benefits, the following month, Disability Welfare Benefits will end, and the Participant will be enrolled in Retiree Welfare Benefits.

Section 4 – SCIRA Benefit Program: Initial and Continuing Eligibility Rules for Disability Welfare Benefits.

The Participant must be eligible for coverage under the NECA-IBEW Welfare Trust Fund and must have five (5) SCIRA Years of Service, as defined in Article V, Section 2(b). In addition, the Participant must have been actively employed on or after February 1, 2015 under the Union Agreement defined in Article I, Section 12(e). The Participant's Total and Permanent Disability as defined in Article I, Section 9 must commence after February 1, 2015 while the Participant was actively employed under a Union Agreement defined in Article I, Section 12(e). During the thirty-six (36) months period of Disability Welfare Benefits, the Employee must meet the Plan's definition of Totally and Permanently Disabled.

Section 5 – SCIRA Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefit.

An eligible surviving spouse and/or child of an SCIRA Benefit Program Participant or Retiree will receive a Surviving Spouse/Child Welfare Benefit of premium payments to a group health plan or insurance company on behalf of the surviving spouse and/or child up to the lesser of:

(a) 100% of the monthly premium required for medical, prescription drug, dental, and vision coverage of the surviving spouse/child under the NECA-IBEW Welfare Trust Fund Base Plan; or

(b) the monthly amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the surviving spouse/child.

Section 6 – SCIRA Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

(a) Eligibility Rules for Pre-Retirement Surviving Spouse/Child Welfare Benefits. The surviving spouse and/or child of a SCIRA Benefit Program Participant who dies before starting to receive Retiree Welfare Benefits under this Plan, may be eligible for a Surviving Spouse/Child Welfare Benefit under the terms of this Section. The Participant must have five (5) SCIRA Years of Service, as defined in Article V, Section 2(b). In addition, the Participant must have been actively employed on or after February 1, 2015 under the Union Agreement defined in Article I, Section 12(e) and his death must occur after February 1, 2015 while the Participant was actively employed under a Union Agreement defined in Article I, Section 12(e). Furthermore, the surviving spouse and/or child must be eligible for coverage under the NECA-IBEW Welfare Trust Fund.

(b) Eligibility Rules for Post-Retirement Surviving Spouse/Child Welfare Benefits. To be eligible for Post-Retirement Surviving Spouse Welfare Benefits, a surviving spouse must be (1) married to a SCIRA Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the SCIRA Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

To be eligible for Post-Retirement Surviving Child Welfare Benefits, a surviving child must be (1) a child of a SCIRA Benefit Program Retiree who dies while receiving Retiree

Welfare Benefits under the SCIRA Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

(c) <u>Continuing Eligibility Rules for All Surviving Spouse/Child Welfare Benefits</u>. The surviving spouse and/or child must satisfy the general conditions in Article VII, and the continuing eligibility rules for surviving spouse/child benefits appearing Article VII, Section 6.

ARTICLE VI – ELECTRIC UTILITY BENEFIT PROGRAM: BENEFITS AND ELIGIBILITY RULES

Section 1 – Electric Utility Benefit Program: Amount of Retiree Welfare Benefits

Payment will be made to a group health plan or insurance company on behalf of an Electric Utility Benefit Program Retiree up to the lesser of:

(a) 100% of the monthly premium that Lineco or Family Medical Care Plan requires for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and their dependents; or

(b) the amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the Eligible Retiree and his dependents.

For the Electric Utility Benefit Program, this Plan follows the Lineco definition of "child."

Section 2 – Electric Utility Benefit Program: Eligibility Rules for Retiree Welfare Benefits.

(a) General. To be an Eligible Retiree for Electric Utility Retiree Welfare Benefits, a Participant must meet all of the following requirements.

(1) Age, Retirement, and Initial Participation. A Participant must (i) be at least age 58, (ii) have retired from any type of work in the Electrical Industry, and (iii) have earned at least 1,400 Hours under a Union Agreement defined in Article I, Section 12(c).

(2) Twenty (20) Electric Utility Benefit Program Years of Service. A Participant must have completed twenty (20) Electric Utility Years of Service as described in Article VI, Section 2(b) below or with Public Employers as described in Article IX below.

If after attaining age 56 a Participant is Totally and Permanently Disabled, as defined in Article 1, Section 9, each such year of disability after attaining age 56 will be counted for up to two (2) years to meet this 20 Electric Utility Years of Service eligibility rule.

Example: A Participant reaches age 56 in 2020 with 18 Electric Utility Years of Service and last worked when he was age 55. He became Totally and Permanently Disabled at age 56 and remained Totally and Permanently Disabled for two (2) years. He meets the requirements of the 20 Electric Utility Years of Service because he had 18 Electric Utility Years of Service plus he had two (2) years when he was disabled after attaining age 56.

(3) Final Two Years. At least two (2) Years of Service during the last five (5) Years of Service before a Participant becomes eligible for benefits under this Plan must

meet the requirements for Electric Utility Years of Service as described in Article in Article VI, Section 2(b) below.

If a Participant is Totally and Permanently Disabled, as defined in Article I, Section 9 throughout any one (1) or more years during such last five (5) years, each such year of disability may be counted to meet this Final Two Electric Utility Years of Service requirement.

Example: A Participant reaches age 58 with more than 20 Electric Utility Years of Service and last worked when age 56. He became Totally and Permanently Disabled at age 57 and remained Totally and Permanently Disabled for one year. He meets the requirements of Final Two Years of Service during the last five (5) years before age 58 because he had one year of service while age 56 and the year that he was Totally and Permanently Disabled counts as the second required year.

(4) Eligible for Lineco or NECA/IBEW Family Medical Care Plan. The Participant must be eligible for retiree coverage under Lineco or NECA/IBEW Family Medical Care Plan.

(b) Electric Utility Years of Service Defined: A Participant will be credited with one (1) Electric Utility Year of Service for each 1,400 Clock Hours, disregarding Clock Hours worked during any year when the person had less than 300 Clock Hours. The total number of Electric Utility Years of Service credited may not exceed the number of years during which the Participant worked 300 or more Clock Hours.

Section 3 – Electric Utility Benefit Program: Amount of Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

An eligible surviving spouse and/or child of an Electric Utility Benefit Program Participant or Retiree will receive a Surviving Spouse Welfare Benefit of premium payments to a group health plan or insurance company on behalf of the surviving spouse/child up to the lesser of:

(a) 100% of the monthly premium that Lineco or Family Medical Care Plan requires for medical, prescription drug, dental, and vision coverage of the surviving spouse/child (based upon the age of the surviving spouse/child); or

(b) the amount that the group health plan or insurance company may require for medical, prescription drug, dental, and vision coverage of the surviving spouse/child.

Section 4 – Electric Utility Benefit Program: Eligibility Rules for Pre and Post Retirement Surviving Spouse/Child Welfare Benefits.

(a) Eligibility Rules for Pre-Retirement Surviving Spouse/Child Welfare Benefits. The surviving spouse and/or child of an Electric Utility Benefit Program Participant who dies before starting to receive Retiree Welfare Benefits under this Plan may be eligible for a Surviving Spouse/Child Welfare Benefit under the terms of this Subsection. A Participant must have earned at least 1,400 Clock Hours under a Union Agreement defined

in Article II, Section 2(c) and the Participant's death must have occurred after the Participant earned these 1,400 Clock Hours. In addition, the Participant must have had five (5) Electrical Utility Years of Service and met the requirements of Article VI, Section 2(a)(3) on Final Two Years, except that the required two (2) Electrical Utility Years of Service must be within the last five (5) years before the Employee's death. Furthermore, the surviving spouse and/or child must be eligible for coverage under Lineco or Family Medical Care Plan.

(b) Eligibility Rules for Post-Retirement Surviving Spouse/Child Welfare Benefits. To be eligible for Post-Retirement Surviving Spouse Welfare Benefits, a surviving spouse must be (1) married to an Electric Utility Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the Electrical Utility Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

To be eligible for Post-Retirement Surviving Child Welfare Benefits, a surviving child must be (1) the child of an Electric Utility Benefit Program Retiree who dies while receiving Retiree Welfare Benefits under the Electrical Utility Benefit Program; and (2) a covered dependent under a group health plan or insurance policy.

(c) Continuing Eligibility Rules for All Surviving Spouse/Child Welfare Benefits. The surviving spouse and/or child must satisfy the general conditions in Article VII, and the continuing eligibility rules for surviving spouse/child benefits appearing Article VII, Section 6.

ARTICLE VII – GENERAL BENEFIT LIMITATIONS AND EXCLUSIONS FOR ALL WELFARE BENEFITS

Section 1 – Continuation of Group Health Welfare Benefits Coverage.

The Participant or his surviving spouse/child must be eligible for continuation of group health welfare benefits coverage under a group medical plan maintained pursuant to a Union Agreement.

As required by rules of the Internal Revenue Service, effective January 1, 2014, the Plan will not provide a Participant or surviving spouse/child group health benefit/premium for an individual health insurance policy purchased through the healthcare exchanges established under the Affordable Care Act.

Section 2 – Limitation on Monthly Benefit Payment Made by Plan.

Notwithstanding the above, no Welfare Benefits provided by this Plan will exceed the applicable premium charged by the group health plan or insurance company providing medical, prescription drug, dental, and vision benefits to the Eligible Retiree or surviving spouse/child.

Section 3 – Exclusion if Eligible for Benefits Under a Retiree Medical Plan.

No benefit will be payable to an Eligible Retiree or surviving spouse/child if that Eligible Retiree or surviving spouse/child is eligible for any type of retiree medical benefit from any employer sponsored group health plan or by an employer other than the NECA-IBEW Welfare Trust, Lineco, or the NECA/IBEW Family Medical Care Plan.

Section 4 – Exclusion If Retiree Returns to Work in the Electrical Industry or If Retiree or Surviving Spouse Becomes Employed and Covered by an Employment Based Group Health Plan.

If an Eligible Retiree returns to work in the Electrical Industry or an Eligible Retiree or a surviving Spouse works elsewhere and becomes eligible as an active employee for group health coverage, while so eligible, the benefit from this Plan is forfeited; otherwise benefits from this Plan will continue during such employment. The Eligible Retiree or surviving spouse must notify the Plan Office when he becomes covered as an active employee and when such coverage stops.

Example: A Participant retires at age 58 and begins to receive the Retiree Welfare Benefit. He returns to work 12 months later and becomes eligible for group health benefits 15 months later with his new Employer and such coverage continues to the 25th month when he stops work again. Retiree Welfare Benefits from this Plan are forfeited during the ten-month period (from the 15th month through the 25th month, while he is covered by the group health plan where he was employed). Benefits from this Plan resume starting with the 26th month.

Section 5 – Loss of Monthly Benefits for Late Applications.

If a Participant or surviving spouse is otherwise eligible and fails to timely file an application for benefits with the Fund Office, he will lose benefits for the months before his application is filed and processed.

Section 6 – Exclusions Applicable to Pre and Post Retirement Surviving Spouse Welfare Benefits.

(a) Exclusion if Surviving Spouse Covered by Another Employer-Sponsored Welfare Plan. No Surviving Spouse Welfare Benefit is payable if the surviving spouse is covered by a welfare plan sponsored by their employer.

(b) Exclusion if Surviving Spouse Remarries. Surviving Spouse Welfare Benefits will cease at the end of any month during which the surviving spouse remarries.

Section 7 – Examples of How Benefits May Be Lost.

The following is a list of examples of how benefits may be lost under the Plan.

(a) Return to Work – Suspension for Benefits.

If an Eligible Retiree returns to work in the Electrical Industry or works elsewhere and becomes eligible as an active employee in a group health plan, while so eligible the benefit from this Plan is forfeited.

(b) Disabled Employee Benefits

Benefits payable on behalf of an Employee who is Totally and Permanently disabled will cease after thirty-six (36) months or, if earlier, the date the Trustees determine that the Employee is no longer Totally and Permanently Disabled.

(c) Surviving Spouse Benefits

Benefits payable on behalf of a surviving spouse upon the death of an Eligible Retiree or Participant will cease at the end of any month during which the surviving spouse (a) remarries; (b) becomes eligible for benefits under an employer-sponsored welfare plan, including but not limited to any type of active employee or retiree medical benefit provided by an employer sponsored group health plan or by an employer; or (c) dies.

(d) Surviving Child Benefits

Benefits payable on behalf of a surviving child upon the death of an Eligible Retiree or Participant will cease at the end of the month of the surviving child's 26th birthday or upon death.

(e) Failure to Make Timely Application for Benefits

If an Eligible Retiree, Employee, or surviving spouse/child fails to make an application for benefits, the benefits will not be paid.

(f) Plan Termination

If the Plan is terminated, whether by action of the Trustees, the Union, and the Association, or by requirements of any law, benefits may be reduced or otherwise changed, or benefits may be reduced if the assets of the Plan are insufficient to pay all benefits.

(g) Benefit Changes

If the Plan is amended so as to change the benefits or any of the terms or conditions under which benefits are paid, benefits may be reduced or otherwise changed.

ARTICLE VIII – GENERAL PLAN RULES ON CONTINUED WELFARE BENEFITS

Section 1 – Direct Payment to Group Health Plan.

This Plan will pay Retiree Welfare Benefits directly to the group health plan or insurance company providing medical, prescription drug, dental, and vision benefits to an eligible Participant and his dependents or a surviving spouse/child. Any remaining balance due for coverage must be promptly paid by the eligible participant or surviving spouse to the group health plan or insurance company.

Section 2 – Advance Submission of Benefit Application Required.

An application should be submitted to this Fund at least sixty (60) days before the first medical benefit payment is required for continued coverage of the eligible Participant.

Applications for Surviving Spouse/Child Welfare Benefits should be submitted within 30 days following the death of the eligible Participant or Retiree.

Section 3 – Bargaining Unit Alumni.

An Employee who meets the Plan's definition of Bargaining Unit Alumni may resume or continue participation in the Plan under either an approved bargaining unit alumni participation agreement between the Board of Trustees and the Employee's Employer or under the Plan's current Regulation on Bargaining Unit Alumni Self-Pay. Contact the Fund Office for further details.

Section 4 – Opt Out of Benefits Only (Not Contributions).

Effective January 1, 2014, a Participant, former Participant, or surviving dependent is permitted to permanently opt out of and waive future benefits under the Plan. This opt out feature is intended to permit individuals to claim a Code Section 36B premium tax credit which may be available under the Affordable Care Act.

ARTICLE IX – SERVICE WITH PUBLIC EMPLOYERS

Subject to the special effective date for the SCIRA Benefit Program provided for in Article V, if a Participant has at least five (5) Years of Service under Article II, Section 2(b), Article III, Section 2(b), Article IV, Section 2(b), Article V, Section 2(b), or Article VI, Section 2(b) and is performing work in the Electrical Industry for the State of Illinois, any of its agencies or departments, a unit of local government, a school district, an instrumentality, or a political subdivision ("Public Employer") where he is represented by the Union in dealing with the Public Employer (e.g., Southern Illinois Edwardsville), such Public Employer work may be counted in computing the remaining Years of Service required to meet the 20 Years of Service requirement of Article II, Section 2(a)(2), Article III, Section 2(a)(2), Article IV, Section 2(a)(2), Article V, Section 2(a)(2), or Article VI, Section 2(a)(2) (the "20 Year of Service Rule"), on the following basis:

(a) **Service Prior to 1965.** Prior to 1965 any year during which a Participant performed any work under an Agreement between the Union and a Public Employer, or in a Public Employer bargaining unit represented by the Union will count as one (1) Year of Service.

(b) **Service from 1965 through 1995.** From 1965 through 1995, a Participant will be credited with one (1) Year of Service for each 1,000 hours worked under an Agreement between the Union and a Public Employer, or in a Public Employer bargaining unit represented by the Union ("Public Clock Hours"), disregarding Public Clock Hours during any year when the person had less than 300 Public Clock Hours; the total number of years credited may not exceed the number of years during which the person worked 300 or more Public Clock Hours.

(c) **1996 Forward**. From 1996 forward, a Participant will be credited with one (1) Year of Service for each 1,400 Public Clock Hours worked under an Agreement between the Union and a Public Employer, or in a Public Employer bargaining unit represented by the Union, disregarding Public Clock Hours during any year when the Participant had less than 300 Public Clock Hours. The total number of years credited may not exceed the number of years during which the Participant worked 300 or more Public Clock Hours.

ARTICLE X – GENERAL INFORMATION

Section 1 – Claim and Appeal Procedures.

(a) Applying for Benefits

A Participant should contact the Fund Office or his Union office to secure an application for benefits and submit the completed application to the Fund Office at least sixty (60) days before the first month for which he is seeking a benefit. Applications for surviving spouse Welfare Benefits should be submitted within 30 days following the death of the eligible Participant or Retiree.

The application must clearly identify the group health plan or insurance company where you are eligible to self-pay for continuation coverage (such as the NECA-IBEW Welfare Trust Fund at Decatur, Illinois, or the Line Construction Benefit Fund).

(b) Claim Processing

If a properly-completed application is denied, in whole or in part, a claimant will be notified within ninety (90) days (normally within forty-five (45) days) after receipt of the written claim. In some cases, additional time may be needed; if so, the claimant will be advised of the special circumstances requiring more time and when an answer may be expected. If it is determined that a claimant is not entitled to benefits under this Plan, or that a claimant is entitled to a lesser benefit than the amount claimed, the claimant will be furnished with a written statement which includes:

(1) The specific reason or reasons for the denial or reduction;

(2) A specific reference to the pertinent Plan provisions on which the denial or reduction is based;

(3) A description of any additional material or information necessary for you to establish your right to benefits and an explanation of why such material or information is necessary; and

(4) An explanation of the Plan's claim review procedure, (known as "Appeal Procedure") including the time limits for filing an appeal and how long the Plan has to make a determination on an appeal.

(c) Appeal Procedure

The claimant or a person authorized to act for the claimant (“representative”) may appeal any denial of a request for benefits by filing a request for review addressed to the Trustees of Southern Illinois Electrical Retiree Welfare Plan at the Fund Office. In connection with such a request, documents pertaining to the claim may be reviewed and copied, free of charge by the claimant.

A request for review must be filed within six (6) months after receipt of the written

notice of denial of a claim for benefits. The claimant or his representative may request that the Trustees hold a hearing on the request for review. If such a request is approved by the Trustees, the claimant or his representative will be given at least ten (10) days written notice of the hearing date by certified mail, unless waived with consent. Continuance of the date of any hearing may be granted for good cause.

A written decision will be rendered no later than sixty (60) days after receipt of a request for review. If there are special circumstances requiring more time, the decision may be delayed, but not later than one-hundred and twenty (120) days after receipt of the request for review If the Trustees have designated a party or parties to decide the issues, the Trustees may review (and may change) the decision. The decision will be mailed to claimant or his representative by certified mail. If the decision is adverse, it will include:

(1) The specific reason or reasons for the adverse determination;

(2) A reference to the specific Plan provisions on which the adverse determination is based;

(3) A statement that the claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the adverse determination; and

(4) A statement of the claimant's right to bring a court action under Section 502(a) of ERISA.

Use of this appeal procedure is mandatory. No court action may be brought against the Trustees until the Plan's appeal procedures have been exhausted.

(d) Disability Claims and Appeals

(1) Claims Processing. Claims for Disability Welfare Benefits will be ruled on within forty-five (45) days after receipt of a completed application. In some cases, additional time may be needed, up to another thirty (30) days. **The Plan may extend the time to resolve the claim for only two (2) additional thirty (30) day periods**.

If the Plan needs to extend the time period to resolve the claim, the Participant (or his authorized representative) will receive a notice of the extension explaining the standards for entitlement to the benefit, why an extension is needed (what issues are unresolved), and what additional information is needed. The Participant will have at least forty-five (45) days to supply the requested information. The period of time to make a determination (the original time and the up to two (2) additional periods), however, may be tolled if the Plan requests additional information. In addition to asking for additional information, the Plan may have the Participant examined in connection with the claim of disability.

The denial of a claim or part of a claim will be provided to the Participant in writing, in a culturally and linguistically appropriate manner (as described in 29 C.F.R. § 2560.503-1(o)) that is calculated to be understood by the Participant, and will include:

(A) The specific reason or reasons for the denial;

(B) A reference to pertinent Plan provisions on which the denial is based;

(C) An explanation of the basis for disagreeing with or not following:

(i) The views presented by the Participant or health care professionals treating the Participant and vocational professionals who evaluated the Participant;

(ii) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Participant‘s claim, without regard to whether the advice was relied upon in making the adverse determination; or

(iii) A disability determination made by the Social Security Administration regarding the Participant;

(E) The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

(F) A description of any additional information necessary for the Participant to perfect the claim; and

(G) An explanation of the steps to be taken if the Participant wishes to appeal the denial.

(2) <u>Appeal Procedure</u>.

The Participant (or his authorized representative) may appeal any denial of a request for Disability Welfare Benefits by filing a written request for review. The written appeal must be filed with the Fund Office within one-hundred and eighty (180) days from the date of receipt of written denial of an application for Disability Welfare Benefits. Use of this Disability Claims and Appeals Procedure is mandatory.

The Participant may submit in writing issues, comments, and evidence for consideration by the reviewing party. The Participant may request copies of all documents, records, and other information relied on by the Plan in making the adverse determination including any internal rule, guideline, protocol, or other criteria. There is no charge to the Participant for these copies. The Participant may also supply additional medical or other information in support of his claim. The Participant may request a personal appearance on the appeal. If a hearing is requested the Trustees or person appointed by them will decide whether a hearing is to be held. If a hearing will be held, the Participant will be given at least ten days’ notice of such a hearing.

The appeal will be reviewed by the Trustees, (or an authorized committee or agent of the Trustees), who are fiduciaries of the Plan and not the persons who made the original determination on the claim or subordinates of those persons. If the Trustees have designated a party or parties to decide the appeal the Board of Trustees may review (and may change) the decision. If the adverse determination on the claim was based in whole or in part on a medical judgment, then the Trustees shall consult with an appropriately trained health care professional with experience in the relevant field of medicine who was not consulted in making the initial determination on the claim. Any decisions regarding the hiring, compensation, termination, promotion, or other similar matters with respect to any individual involved in any decision made pursuant to this Permanent Disability Claims and Appeals Procedure may not be made based upon the likelihood that the individual will support the denial of benefits.

If, in considering an appeal, the Trustees (or any party designated by the Trustees to decide the appeal) become aware of any new or additional evidence that was considered, relied upon, or generated by the Plan in making the adverse determination or any new or additional rationale for making the adverse determination, copies of such new or additional evidence or rationale will be provided to the Participant, as soon as possible. The Participant will then have thirty (30) days after receiving such new or additional evidence or rationale to submit a written response to the Trustees (or any party designated by the Trustees to decide the appeal).

A decision deciding the appeal will be provided to the Participant in writing, in a culturally and linguistically appropriate manner (as described in 29 C.F.R. § 2560.503-1(o)) that is calculated to be understood by the Participant within 45 calendar days after receipt of the written statement constituting the appeal. If special circumstances require an extension of time for processing the appeal, then the Plan will notify the Participant of the reason for the extension within the initial forty-five (45) day period. This extension can be for no more than forty-five (45) days. The period of time to make a determination (the original time and any extension), however, may be tolled if the Plan requests additional information.

The written decision on the appeal will be mailed to the Participant. If the decision is adverse to the Participant, it will include:

(A) The specific reason or reasons for the adverse determination;

(B) A reference to the specific Plan provisions on which the adverse determination is based;

(C) An explanation of the basis for disagreeing with or not following:

(i) The views presented by the Participant of health care professionals treating the Participant and vocational professionals who evaluated the Participant;

(ii) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Participant ‘s claim, without

regard to whether the advice was relied upon in making the adverse determination; or

(iii) A disability determination made by the Social Security Administration regarding the Participant;

(D) The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

(E) A statement that the Participant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits; and

(F) A statement of the Participant's right to bring a court action under Section 502(a) of ERISA.

(e) Where to File Claims and Other Communications - Fund Office

All claims, appeals and other communications should be addressed to the Fund Office. See Article V, Section 2(e) below.

Section 2 - Information About The Plan.

(a) Name of Plan

Southern Illinois Electrical Retiree Welfare Plan ("Plan").

(b) Plan Identification Numbers

The IRS Identification Number is EIN 43-1724421. The Plan Number is 501.

(c) Type of Plan

It is a welfare plan providing premium payments to group health plan for eligible retirees, surviving spouses, and disabled employees.

(d) Type of Administration

The Plan is administered by the Board of Trustees. The day-to-day administration of the business of the Plan is provided by the IBEW-NECA Service Center, Inc., which provides services as contract administrator on behalf of the Trustees of the Plan.

(e) Plan Administrator and Sponsor

The Plan Administrator and Sponsor maintaining the Plan is the Board of Trustees

of the Southern Illinois Electrical Retiree Welfare Plan which has its business office (also called the "Fund Office") at this address:

Southern Illinois Electrical Retiree Welfare Plan
5735 Elizabeth Avenue
St. Louis, Missouri 63110
Telephone: 314 752-2330

(f) Agent for Service for Legal Process

Mr. Corey J. Wirth, CEBS, Executive Director, IBEW-NECA Service Center, Inc., at above address. Service may also be made upon any Trustee.

(g) Board of Trustees

Management Trustees	Union Trustees
Mr. David Conder All Electric Services, Inc. 290 East Miller Court Carbondale, Illinois 62901	Mr. Steve Hughart Local Union No. 702, IBEW 106 North Monroe Street West Frankfort, Illinois 62896
Mr. Andy Hipsher Clinton Electric, Inc. Box 117, Route 37 N Ina, Illinois 62846	Mr. Monte Russell 8 Brogan Lane Villa Ridge, Illinois 62996
Mr. Brent Sizemore Big D Electric 1203 Barton, P.O. Box 56 El Dorado, Illinois 62930	Ms. Kelly McCord 13449 County Line Road West Frankfort, Illinois 62896
Mr. Shane Sullivan Brown Electric, Inc. 437 Route 37 Goreville, Illinois 62939	Mr. Tate Wright Local Union No. 702, IBEW 106 North Monroe Street West Frankfort, Illinois 62896

(i) Union Agreements

The Plan is maintained under the various Union Agreements between the Union and the Association and Employers which have provided and continue to provide for the establishment and maintenance of this Plan under the Trust Agreement. A list of the Employers who have signed a Union Agreement and/or a copy of any such Union Agreement is available to any Participant during normal business hours at the Fund Office.

(j) Source of Contributions to Support Plan

All Employers party to a Union Agreement providing for adherence to the Plan are required to make contributions on behalf of Employees working under the Union Agreement.

Employer contributions at specified rates as required by the applicable Union Agreement; contribution rates may change as a Union Agreement is altered.

(k) Funding Medium Used to Provide Benefits

All of the benefits under the Plan are provided directly from the Plan's assets by the Board of Trustees.

(l) Calendar Year

The Plan's fiscal and other records are maintained on a calendar year commencing January 1 and ending December 31.

Section 3 - Statement Of Rights Under ERISA.

As a Participant in the Southern Illinois Electrical Retiree Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and Union 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 plan administrator, copies of documents governing the operation of the plan, including insurance contracts and Union Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator 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.

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

ENFORCE YOUR RIGHTS

If your claim for a Plan 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 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 4 – Interpretation of the Plan.

The Trustees have the right to issue regulations. The Trustees or their designee have full discretionary authority to rule on all applications, claims and appeals, and their decision shall be final and binding, unless clearly arbitrary. In applying and interpreting this Plan Document/Summary Plan Description, the Trust Agreement, forms and regulations, the Trustees have discretionary authority. The decision of the Board of Trustees shall be final and binding on all parties — including but not limited to Eligible Retirees, Employees, surviving spouses, Employers, and the Union.

Whenever the masculine gender is used, it shall also apply to the feminine gender.

Section 5 – Termination Procedure: Asset Distribution.

The Plan may be terminated: (a) by mutual consent of the Trustees one year after the date when there is no longer in force any Union Agreement requiring contributions to this Plan, or in the absence of such Union Agreement, at such earlier or later date as the Trustees decide; or (b) by mutual consent of the Union and Association.

In the event of such termination, the Trustees shall continue to serve until all of the trust property has been expended; they shall continue benefits in some form (to the degree and for the time feasible considering the funds available, liabilities to be incurred, and other relevant factors, in the judgment of the Trustees) for the benefit of one or more classes of persons or their dependents, or both, who are eligible for benefits at the time of termination and in the discretion of the Trustees to persons in the process of becoming eligible. The Trustees shall endeavor to pay or set aside funds to pay all of the obligations of the Plan. The Trustees may establish reserves or escrow accounts for liabilities that cannot fully be determined. The Trustees may purchase insurance to provide benefits or may adopt some form of special benefit as a means of more expeditiously and more efficiently winding up the affairs of the Plan. Upon expenditure or distribution of all of the monies and property in the Plan, the Trustees shall stand discharged of any further obligation under the Trust Agreement.

Section 6 – Limitation of Authority.

In the event of any conflict between this Plan Document/Summary Plan Description and the Trust Agreement, the Trust Agreement shall control. No agent, representative, officer, or other party from any Union or from any Employer or the Association, or any individual Trustee has authority to speak on behalf of the Board of Trustees of this Plan. If you have any questions pertaining to this Plan, the Administrative Manager in the Fund Office will try to assist you by referring you to the pertinent provisions of this Summary Plan Description or other Plan documents. Matters that are not clear or which require interpretation will be referred by the Administrative Manager to the Board of Trustees. Neither the Administrative Manager nor any other party may authorize actions contrary to the written terms of this Summary Plan Description and the Trust Agreement.

Section 7 – Benefit Changes.

The Trustees have the authority to change the form and amount of benefits, rules of eligibility, classes of persons covered, or other aspects of the Benefit Program; the Trust Agreement requires that certain changes be approved by the Union and The Association. Changes may involve reduction or elimination of benefits or classes of persons eligible for benefits and may apply to persons who have established eligibility for benefits or who are receiving benefits. **No benefits are vested or guaranteed; all benefits are subject to termination or reduction.**

Section 8 – Obligation of Eligible Retirees, Employees, and Surviving Spouses to Furnish Information to the Trustees.

Eligible Retirees, Employees, and surviving spouses are required to furnish the Trustees with such information as will aid the Trustees in the administration of the Plan and Trust, including but not limited to all pertinent data for purposes of determining their status under this Plan.

Section 9 – Benefits Are Not Assignable.

No Eligible Retiree, Employee, or surviving spouse has the right to assign, transfer,

sell, pledge or in any other way dispose of any right to benefits which he or she may have from this Plan.

Section 10 – <u>Restriction on Lawsuits.</u>

No party may file a lawsuit against the Plan, the Trustees, their agents or employees unless the party has filed an appeal and followed the requirements of the Appeal Procedures in Article X, Section 1 and the Appeal Procedures have been concluded. Any action by any Participant, Beneficiary, Alternate Payee, Employer or other third-party relating to or arising under the Plan shall be brought only in the venue where the plan is administered which is the United States District Court for the Eastern District of Missouri.