I.B.E.W., LOCAL NO. 456,
SUPPLEMENTAL WELFARE FUND

PLAN
AND
SUMMARY PLAN DESCRIPTION

ADOPTED JANUARY 13, 2004
AMENDED AND RESTATED AS OF JANUARY 1, 2017.

WHEREAS, the Board of Trustees of the I.B.E.W. Local No. 456 Supplemental Welfare Plan desire to pay the cost of all covered expenses and costs as determined under the I.B.E.W. Local 456 Welfare Fund which are incurred for Retired Employees and their eligible dependents from this I.B.E.W. Local No. 456 Supplemental Welfare Plan; and

WHEREAS, the Board of Trustees of the I.B.E.W. Local No. 456 Supplemental Welfare Plan also desire to establish a Medicare Premium Reimbursement Benefit for Eligible Retirees and their eligible dependent spouses; and

WHEREAS, the Board of Trustees of the I.B.E.W. Local No. 456 Supplemental Welfare Plan desire to remove those benefits, including a Drug Free Workforce benefit and a contribution benefit for those employees actively seeking work but in jeopardy of losing health coverage under the IBEW Local 456 Welfare Plan, and which were previously available under this Plan for active and/or disabled but non-retired employees of Contributing Employers whose employment is covered by a Collective Bargaining Agreement with the IBEW Local Union No. 456; and

WHEREAS, the only benefits and the only eligible participants remaining under the I.B.E.W. Local No. 456 Supplemental Welfare Plan are for eligible Retired Employees and their eligible dependents;

NOW THEREFORE, as amended and restated, the Trustees intend for the reconstituted Plan to be a "stand alone retiree plan" as that term is described in the Employee Retirement Income Security Act of 1974, as amended, the Affordable Care Act (ACA), the Public Health Services Act, and the Internal Revenue Code of 1986, as amended.

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1.0 SUMMARY OF PLAN INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires the following information pertaining to the establishment and administration of the Fund to be furnished to plan participants and their dependents and beneficiaries.

1.1 Name of Plan & Employer Identification Number: The plan name is the I.B.E.W. Local 456 Supplemental Welfare Fund. – E.I.N. 20-0500732.

1.2 Name and Address of Union Employer Association and Plan Sponsor: The Union is the International Brotherhood of Electrical Workers Local Union No. 456, located at 1295 Livingston Avenue, North Brunswick, New Jersey 08902. The Employer Association is Middlesex Division of the New Jersey Chapter, Inc., National Electrical Contractors Association, located at 213 Summit Road, Mountainside, New Jersey 07092-0081. The Plan Sponsor is the Board of Trustees of the International Brotherhood of Electrical Workers Local Union No. 456 Supplemental Welfare Fund c/o I.E. Shaffer & Co., P.O. Box 1028, 830 Bear Tavern Road, West Trenton, New Jersey 08628-1028. Phone (800) 792-3666

1.3 Type of Plan: Welfare Benefit Plan for Retirees Only: medical, dental, prescription drug, vision benefits and Medicare premium reimbursement for eligible retirees, their eligible spouse, and eligible dependents.

1.4 Operation and Administration: The operation and administration of the Plan is the joint responsibility of the Board of Trustees, consisting of:

Employee Trustees

Michael G. McLaughlin
IBEW Local 456
1295 Livingston Avenue
North Brunswick, NJ 08902

Francis T. Leake
IBEW Local 456
1295 Livingston Avenue
North Brunswick, NJ 08902

Dennis F. Cronin
IBEW Local 456
1295 Livingston Avenue
North Brunswick, NJ 08902

Employer Trustees

Harry C. Alexander
Maul Electric, Inc.
PO Box 386
Dayton, NJ 08810

Jeffrey J. Shaute, Sr.
Falcon Maintenance, Inc.
PO Box 282
South Amboy, NJ 08879

Terrance Craig, Jr.
Valiant Power Group
2 Commerce Street
Branchburg, NJ 08876

with offices at c/o I.E. Shaffer & Co., P.O. Box 1028, 830 Bear Tavern Road, West Trenton, N.J. 08628-1028, phone number 1-800-792-3666. I.E. Shaffer & Co. is the Third Party Administrator of the Plan and the agent for service of process and notices. The processing of claims for benefits under the terms of the Plan is provided though the Third Party Administrator which was

contracted by the Trustees. Legal process may be served upon the Third Party Administrator or the Trustees.

1.5 Collective Bargaining Agreements, other Agreements and Contributions: Parties to the Collective Bargaining Agreement and other agreements relating to the Plan are the Northern New Jersey Chapter, Inc., National Electrical Contractors Association (the Association) and the International Brotherhood of Electrical Workers, Local Union No. 456 (the Union), any other Contributing Employer who has a collective bargaining agreement with the IBEW Local Union No. 456 requiring periodic contributions to the IBEW Local Union No. 456 Supplemental Welfare Plan and who are accepted into participation by the Trustees, or any other Contributing Employer who now or hereafter has a written agreement with the IBEW Local Union No. 456 Supplemental Welfare Plan requiring periodic contributions to the IBEW Local Union No. 456 Supplemental Welfare Plan. Eligible retirees and their eligible dependents have a right to obtain a copy of the collective bargaining agreement or other agreement. A written request for such a copy should be submitted to the Plan Administrator. The collective bargaining agreement is available for examination in the Plan Administrator's office.

1.6 Funding Medium: Self-Funded - The International Brotherhood of Electrical Workers, Local Union No. 456 Supplemental Welfare Fund is the funding medium used for the accumulation of assets and through which benefits are provided and which is administered by the Board of Trustees.

1.7 Plan Fiscal Year: January 1st to December 31st.

1.8 Reservation of Rights: Plan benefits for Eligible Retirees, their eligible spouse, and eligible dependents are not guaranteed. The Trustees reserve the right to amend or change the Summary Plan Description and Plan Provisions at any time including terminating the Plan. The Trustees, by appropriate action also reserve the right to change any amounts contributed toward the cost of providing benefits, the level of benefits provided, and the class or classes of Participants eligible for Plan benefits. The Trustees, pursuant to the Agreement and Declaration of Trust has the sole and exclusive authority to interpret the terms and conditions of the Plan and this Summary Plan Description including but not limited to eligibility, participation and the benefits to be provided.

1.9 Procedures for Filing Claims: For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, "Claim Filing Procedures."

1.10 Statement of ERISA Rights: For detailed information on certain rights and protections afforded participants in the Plan, refer to the section entitled, "Rights and Protections under ERISA."

2.0 ELIGIBILITY REQUIREMENTS

2.1 Eligible Retirees: All individuals who are eligible for retiree benefits under the IBEW Local Union No. 456 Welfare Plan, are "Eligible Retirees" of the IBEW Local Union No. 456 Supplemental Welfare Plan. An Eligible Retiree's dependents shall be eligible under the IBEW Local Union No. 456 Supplemental Welfare Plan for so long as they remain eligible under the IBEW Local Union No. 456 Welfare Plan.

3.0 TERMINATION OF PARTICIPATION

3.1 Termination of Your participation: An Eligible Retiree's participation in the Plan will terminate upon:

(i) his/her death, or

(ii) his/her termination from eligibility under the IBEW Local Union 456 Welfare Plan.

3.2 Your spouse's participation: The Spouse of an Eligible Retiree shall terminate his/her participation in the Plan at the earliest to occur of the following events:

(i) Your Spouse's death;

(ii) Your Spouse opts-out of coverage;

(iii) Divorce from the Eligible Retiree; or

(iv) his/her termination from eligibility under the IBEW Local Union No. 456 Welfare Plan.

3.3 Your Dependent's participation: The Dependent of an Eligible Retiree shall terminate his/her participation in the Plan at the earliest to occur of the following events:

(i) The Dependent's death,

(ii) The Dependent opts-out of coverage, or

(iii) The Dependent's termination from eligibility under the IBEW Local Union No. 456 Welfare Plan.

4.0 BENEFITS

4.1 Qualifying Health Coverage Payments: Effective July 1, 2017, all Eligible Retirees of the IBEW Local Union No. 456 Supplemental Welfare Plan, who are also Retired Employees eligible under the IBEW Local Union 456 Welfare Plan, shall have all covered medical expenses benefits, prescription drug program benefits, dental expense benefits, and vision expense benefits, and other costs and expenses of participation as defined and set forth under the IBEW Local Union 456 Welfare Plan, paid for themselves and for their eligible dependents / surviving covered dependents from the IBEW Local Union No. 456 Supplemental Plan to the IBEW Local Union 456 Welfare Plan only for so long as the Eligible Retiree or his/her dependents/ surviving covered dependents remain eligible under the IBEW Local Union 456 Welfare Plan. This benefit is reviewed periodically by the Trustees and is subject to cancellation or change in future years. No benefits shall be paid to any Eligible Retiree directly.

4.2 Partial Medicare Premium Reimbursement Benefit: For the plan year commencing 2017, the Plan will reimburse Eligible Retirees and his/her spouse/ surviving covered spouse, for so long as they remain eligible under the IBEW Local Union 456 Welfare Plan, and are enrolled in Medicare Part B, a significant portion of Eligible Retirees' and/or the spouse/ surviving covered spouse's Medicare Part B premiums by reimbursing $100 per month of the Medicare Part B monthly premiums incurred by the Eligible Retiree and $100 per month of the Medicare Part B monthly premiums incurred by the Eligible Retiree's dependent spouse / surviving covered spouse. This reimbursement benefit shall be paid once annually in arrears, for all months of Medicare Part B premiums which were incurred in the prior calendar year. Annual reimbursement will be prorated by the number of months in which the Eligible Retiree or their dependent spouse/ surviving covered spouse participate and incur Medicare Part B premiums. The reimbursement rate is reviewed periodically by the Trustees and is subject to cancellation or change in future years. The Plan will not reimburse any portion of premiums paid for Medicare Part B coverage that was incurred for coverage prior to January 1, 2017.

5.0 GENERAL LIMITATIONS

5.1 General Limitations: The circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g. by exercise of subrogation or reimbursement rights) of any benefits that a Eligible Retiree or eligible dependent might otherwise reasonably expect the plan to provide include loss of eligibility under the Plan or the expenditure of all assets of the Local Union No. 456 Supplemental Welfare Fund.

5.2 No Benefit Payment if Compromise Tax Exempt Status: The Trustees shall not be under any obligation to pay any benefits if the payment of such benefits will result in the loss of the Fund's tax-exempt status under the then applicable Internal Revenue Code and any regulations or rulings issued pursuant thereto.

5.3 Amendment of the Plan: The Plan may be amended by a) the Trustees, in their sole discretion, from time to time, or b) by the Union and the Association, provided that such amendments comply with all applicable federal laws and regulations and the provisions of the Trust Agreement. Nevertheless, no amendment may be adopted which will alter the general purpose of the Agreement and Declaration of Trust, or be contrary to any agreements entered into by the Trustees or, by the Union and the Association.

5.4 Agreements with Other Trustees: The Trustees are authorized, to the extent lawful, to enter into agreements with trustees of other welfare plans to permit such other welfare plans to merge or consolidate with this Fund, or provide reciprocal coverage and benefits.

5.5 Termination of the Plan: The IBEW Local Union No. 456 Supplemental Welfare Plan may be terminated by an instrument in writing executed by all the Trustees when there is no longer in force and effect any Collective Bargaining Agreement or by an instrument in writing executed by the Union and the Association. In the event of termination of the Plan, the Trustees shall apply the Fund to pay or to provide for the payment of any and all obligations of the Fund, and shall distribute and apply any remaining surplus in the manner prescribed by applicable law; provided,

however, that no part of the corpus or income of the Fund shall be used for or diverted to purposes other than for the exclusive benefit of the Participants, their families, beneficiaries or dependents, for the administrative expenses of the Fund, or for other payments in accordance with the provisions of the Agreement and Declaration of Trust and the Plan. Under no circumstances shall any portion of the corpus or income of the Fund, directly or indirectly, revert or inure to the benefit of the Union, the Association, or any Employer.

5.6 Assignment: The benefits payable are provided exclusively for the benefit of Participants. No benefit payable at any time under the Plan will be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

5.7 Inability to Locate Payee: If the administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such person shall be forfeited after a reasonable time following the date any such payment first became due.

6.0 CLAIM PROCEDURES

6.1 Filing Claims: The Plan Administrator is able to independently verify eligibility for benefits under the Plan. However, a Participant may also choose to file a written request to the Board of Trustees for benefits. This written request shall include the name of the Participant, Social Security Number, the basis upon which eligibility for benefits is sought and the Plan benefit sought. Whether you submit claims and documentation by mail, fax or email, it is important that you make sure the documentation you submit is legible. Claim documentation can be an invoice or premium statement for you or your dependent spouse's Medicare Part B and must clearly identify:

1) The type of policy (Medicare Part B);
2) The name of the policy owner (you or your spouse);
3) The amount of premium; and
4) The period of coverage.

6.2 Payment of Claims: Partial Medicare Premium Reimbursement benefits will be paid directly to the Eligible Retiree. All other benefits under this Plan will be paid directly to the IBEW Local Union No. 456 Welfare Plan for the benefit of the Eligible Retiree and their qualifying dependents.

6.3 Errors in Benefit Payment: The Trustees specifically retain the right to recover all moneys paid in error to, or on behalf of any person, from such person, Plan or Fund. Upon discovery of a payment "made in error," the Trustees shall notify the Participant for whom the benefit was paid as well as the person, Plan or Fund to whom payment was made, indicating the circumstances and amount of such payment, together with a request for re-payment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as they deem necessary, or in the case of a Participant of the Fund, the amount of the

payment made in error may be deducted from any future benefit payment which such Participant or his Dependents or beneficiary may become entitled to under this Plan. The Plan may to the maximum extent permitted by law, apply the remedies of set off, garnishment, and other collection remedies to receive the overpayment or erroneous payment plus any interest.

6.4 Fraud: Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the Fund, may be prosecuted in such manner as the Trustees deem advisable or at the Trustees discretion, terminated from participation in the Plan until full restitution has been made by the Participant.

7.0 DENIAL AND APPEAL CLAIM PROCEDURES

7.1 Notification of Action on Claims: A Participant will be notified of any decision involving the denial or rejection of a claim within a reasonable period of time after receipt of the claim. If the claim has been wholly or partially denied, the notice will include specific references to the provisions of the Plan on which the denial is based, a description of any additional material or information necessary for the Participant to complete the claim including an explanation of why such material is necessary, and an explanation of the Plan's review procedure.

7.2 Review Procedure: A Participant who has received a notice that his claim has been denied may request a review of the denied claim within sixty (60) days of the receipt of the notice of denial. A Participant or his authorized representative may request a review, may have the opportunity to review pertinent documents, and may submit issues and comments in writing.

Requests for review must be made in writing and should be sent to the Fund Office.

7.3 Decision on Review: The Board will render a decision within one hundred and twenty (120) days after the receipt of the request for review. The decision of the Board of Trustees will be in writing and will include the specific reason(s) for the decision and specific references to the Plan provisions on which the decision is based.

7.4 Statute of Limitations: After receipt of the final written decision of the Board of Trustees, the Participant will have a period of one hundred and eighty day (180) days after the date of the written decision to commence any Legal action for a Court of appropriate jurisdiction to review the decision of the Trustees. If the Participant fails to commence such action he/she will be barred from further review.

8.0 RIGHTS AND PROTECTIONS UNDER ERISA

As a Participant in the Fund 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:

(1) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including

insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(2) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may assess a reasonable charge for the copies.

(3) 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.

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including, your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under this Plan or exercising your rights under ERISA. If your claim for a benefit under this Plan 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 suite 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.

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.

9.0 HIPAA PRIVACY STATEMENT

9.1 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

"Payment" includes activities undertaken by the *Plan* to obtain premiums or determine or fulfill its responsibility for coverage and provision of *Plan* benefits that relate to a *covered person* to whom health care is provided. These activities include, but are not limited to, the following:

• Determination of eligibility, coverage and *coinsurance* amounts (for example, cost of a benefit or *Plan* maximums as determined for a *covered person's* claim);
• Coordination of benefits;
• Adjudication of health benefit claims (including appeals and other payment disputes);
• Subrogation of health benefit claims;
• Establishing *employee* contributions;
• Risk adjusting amounts due based on enrollee health status and demographic characteristics;
• Billing, collection activities and related health care data processing;
• Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
• Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
• Medical necessity reviews or reviews of appropriateness of care or justification of charges;
• Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
• Reimbursement to the *Plan.*

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

• Quality assessment;
• Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
• Rating provider and *Plan* performance, including accreditation, certification, licensing or credentialing activities;
• Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
• Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

• Business Planning and development, such as conducting cost-management and Planning-related analyses related to managing and operating the *Plan,* including formulary development and administration, development or improvement of payment methods or coverage policies;
• Business management and general administrative activities of the *Plan,* including, but not limited to:
(a) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
(b) Customer service, including the provision of data analysis for policyholders, *Plan* sponsors or other customers;
• Resolution of internal grievances.

9.2 THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE COVERED PERSON

With an authorization, the *Plan* will disclose PHI to other health benefit Plans, health insurance issuers or HMOs for purposes related to the administration of these Plans.
The *Plan* will disclose PHI to the *Plan Administrator* only upon receipt of a certification from the *Plan Administrato*r that the *Plan* documents have been amended to incorporate the following provisions. With respect to PHI, the *Plan Administrator* agrees to certain conditions.
The *Plan Administrator* agrees to:
• Not use or further disclose PHI other than as permitted or required by the *Plan* document or as required by law;
• Ensure that any agents, including a subcontractor, to whom the *Plan Administrator* provides PHI received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Administrator* with respect to such PHI;
• Not use or disclose PHI for employment-related actions and decisions unless authorized by a *covered person;*
• Not use or disclose PHI in connection with any other benefit or employee benefit Plan of the *Plan Administrator* unless authorized by the *covered person;*
• Report to the *Plan* any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
• Make PHI available to a *covered person* in accordance with HIPAA's access requirements;
• Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
• Make available the information required to provide an accounting of disclosures;
• Make internal practices, books and records relating to the use and disclosure of PHI received from the *Plan* available to the Health and Human Services Secretary for the purpose of determining the *Plan's* compliance with HIPAA; and
• If feasible, return or destroy all PHI received from the *Plan* that the *Plan Administrator* still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
• Reasonable and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the *Plan Administrator* on behalf of the *Plan.* Specifically, such safeguarding entails an obligation to:
• Implement administrative, physical and technical safeguards that reasonably and appropriately

protect the confidentiality, integrity and availability of the electronic PHI that the *Plan Administrator* creates, receives, maintains or transmits on behalf of the *Plan;*
• Ensure that the adequate separation as required by 45 C.F.R. 164-504(f)(20)(iii) is supported by reasonable and appropriate security measures;
• Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
• Report to the *Plan* any security incident of which it becomes aware.

10.0 THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

This *Plan* is for Retired Employees and their dependents eligible under the IBEW Local Union 456 Welfare Plan (hereinafter a "covered person") to pay "covered expenses" (hereinafter defined as those benefits which Retired Employees and their dependents are eligible under the IBEW Local Union 456 Welfare Plan) directly to the IBEW Local 456 Welfare Plan for the payment of claims and for which payment is not available from anyone else, including any responsible third party, insurance company or another health Plan. In order to help a *covered person* in a time of need, however, the *Plan* may pay *covered expenses* to the IBEW Local 456 Welfare Plan that may be or become the responsibility of another person, provided that the *Plan* later receives reimbursement for those payments. Therefore, by enrolling in the *Plan,* as well as by applying for payment of *covered expenses,* a *covered person* is subject to, and specifically agrees to, the following terms and conditions with respect to the amount of *covered expenses* paid or payable by the *Plan:*

10.1. Payment Condition:
a. The *Plan,* in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an *injury*, *sickness*, *disease* or disability is caused in whole or in part by, or results from the acts or omissions of *covered persons,* and/or their *dependents,* beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the *Plan* may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
b. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the *Plan's* conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the *Plan's* conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the *Plan* or the *Plan's* assignee. By accepting benefits the Participant(s) agrees the *Plan* shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the *Plan's* name as a co-payee on any and all settlement drafts.

c. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the *Plan* for all benefits paid or that will be paid by the *Plan* on behalf of the Participant(s). If the Participant(s) fails to reimburse the *Plan* out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the *Plan's* attempt to recover such money.
d. If there is more than one party responsible for charges paid by the *Plan,* or may be responsible for charges paid by the *Plan,* the *Plan* will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

10.2. Assignment of Rights (Subrogation): The *covered person* automatically assigns to the *Plan* any rights the *covered person* may have to recover monies in connection with an *illness, injury,* accident, *sickness,* occurrence, condition or other loss from any third party. These rights of recovery or causes of action against any third party includes, but is not limited to, a claim of any type whatsoever, whether the claim exists or may exist, or the monies are or may be recovered from a third party through a claim, lawsuit, settlement, insurance policy or pool, uninsured or underinsured motorist or other policy or pool, governmental or private right of recovery, Workers Compensation or disability award or order, judgment, no-fault program, or personal injury protection, financial responsibility, medical benefit reimbursement insurance coverage not purchased by the covered person, by compromise, or in any other way from any third party, person, agency, organization or fund of money whether or not the payor caused or is legally responsible or liable for it, and regardless of whether such liability or responsibility is or is not denied or is in dispute (hereinafter called "any third party").

10.3. Right to Reimbursement, Equitable Lien, and Constructive Trust: The *Plan* is granted and the *covered person* specifically consents to an equitable lien by agreement, or a constructive trust over, and the *Plan* has the right to reimbursement from, any monies that a *covered person* receives from or through any third party to the extent of *Plan* benefits paid or payable by the *Plan* on behalf of the *covered person.*

The *Plan's* right to reimbursement, equitable lien and constructive trust extends to any *covered person* who is a participant or beneficiary under the *Plan,* including any individuals or entities that may receive a recovery on behalf of a participant or beneficiary, such as the *covered person's* spouse, parents, and *dependents,* heirs, estates, trusts, representatives, trustees, or guardians of the *covered person* including attorneys, representatives, agents, successors or assigns (hereinafter "Covered Individuals").

10.4. First Priority / Rejection of Make Whole Doctrine: This assignment, right to subrogate, equitable lien by agreement, constructive trust, and right to reimbursement (hereinafter called "Rights of Recovery") applies on a first-dollar basis (i.e. has priority over other rights), applies whether the monies paid to (or for the benefit of) the *Covered Person* constitute a full or partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, expert fees, litigation expenses or other costs and expenses. As such, the *Plan* is entitled to its full lien and its full recovery of the total amount of benefits paid or payable,

regardless of the amount of monies paid or awarded to you by the third party, even if those monies are less than the full amount which you do seek or could seek against the third party, regardless of whether the monies are or are described as for medical expenses, and regardless of how they are described or what they are for, and regardless of whether full compensation from the third party is obtained or available. The *Plan's* Rights of Recovery shall be a prior lien against any proceeds recovered by any Covered Individuals, which right shall not be defeated or reduced by the application of any so-called "Make Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the *Plan's* recovery rights by allocating the proceeds exclusively to non-medical expenses damages. No reduction of the *Plan's* full right to recover the total amount of *Plan* benefits is effective without the *Plan's* written consent. The *Plan* retains the sole and final discretion to decide whether and in what case such consent will be granted, if requested.

10.5. Rejection of Common Fund Doctrine: The *Plan's* Rights of Recovery apply to any recovery by the *covered person* without regard to legal fees and expenses (including litigation expenses, expert fees, court costs) of the *covered person.* The *covered person* shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying *injury, sickness*, accident, or condition, and the *Plan's* recovery shall not be reduced by such legal fees or expenses unless the *Plan Administrator,* in his or her sole discretion, agrees in writing to discount the *Plan's* claim by an agreed-upon amount of such fees or expenses. The *Plan* specifically disavows any claims that a *covered person* may make under any federal or state common law defense including, but not limited to, the "Common Fund Doctrine", "Fund Doctrine" or "Attorney's Fund Doctrine."

10.6. Obligation to Cooperate: The *covered person*, as well as the *covered person's dependent,* attorney, representative or agent shall assist and cooperate with representatives the *Plan* designates, shall do everything necessary to enable the *Plan* to enforce its rights of subrogation and reimbursement, and shall do nothing to impair, release, discharge or prejudice the *Plan's* Rights of Recovery. The *Plan Administrator* may require the *Covered Person* to complete and/or execute certain documentation the *Plan* deems necessary, helpful or appropriate to assist the *Plan* in the enforcement of its subrogation rights including, but not limited to, a Reimbursement and Subrogation Questionnaire, and a Repayment Agreement. Failure to procure such forms will not preclude the *Plan* from enforcing its rights under this *Reimbursement and Subrogation* provision.

10.7. Obligation to Notify: The *covered person* shall immediately notify the *Plan* if the *covered person* is involved in or suffers an *illness, injury,* accident, *sickness,* occurrence, condition or other loss for which any third party may be liable and shall provide the *Plan* with any information concerning the *covered person's* other insurance (whether through automobile insurance, other group insurance or otherwise) and any other person or entity (including their insurer's) that may be obligated to provide payments or benefits to or for the benefit of the *covered person.* The *covered person* as well as the *covered person's dependent,* attorney, representative or agent shall again notify the *Plan* if the *covered person* pursues a claim to recover damages or other relief relating to any *illness, injury,* accident, *sickness,* occurrence, condition or other loss for which the *Plan* may make payments on the *covered person's* behalf

and shall provide information as to the status of any claim against any third party and such documentation requested by the *Plan* every 3 months thereafter, whenever settlement is proposed, and whenever requested by the *Plan.* The *covered person* shall also notify the third party's attorney of the *Plan's* equitable lien, constructive trust, and right to reimbursement. The *covered person* as well as the *covered person's dependent,* attorney, representative or agent shall immediately notify the *Plan* upon receiving any monies, award, judgment, settlement offer or compromise offer, or in any other way from any third party, person, agency, organization or fund of money and shall not settle or compromise any claims without the *Plan's* consent. The Participant agrees and shall include the *Plan's* name as a co-payee on any and all settlement drafts.

10.8. Right to Exclude, Withhold or Suspend Covered Expenses: If any *covered person,* or the *covered person's dependent,* attorney, representative or agent fails or refuses to cooperate with this Third Party Recovery, Subrogation and Reimbursement provision and the Plan's rights by disputing the *Plan's* lien, failing to advise the *Plan* of the status of the claim against any third party, withholding necessary information, failing to execute requested documentation, or in any way interfering with the *Plan's* rights, the *Plan* may withhold, suspend and exclude payment of any *covered expenses* otherwise available to the *covered person* under the *Plan.* At the discretion of the *Plan Administrator,* the *Plan* may withhold or suspend payment of any or all *covered expenses* pending reimbursement, pending guaranteed recognition of the *Plan's* reimbursement, or pending court order. The *Plan* may also reduce any future *covered expenses* otherwise available to the *covered person* under the *Plan,* by an amount up to the total amount of monies recoverable from any third party for *Plan* benefits paid or payable by the *Plan* on behalf of the *covered person.*

10.9. Set Aside of Funds: Unless and until the *Plan* has received reimbursement in full, no monies from or through any third party may be distributed to the *covered person* without the *Plan's* written consent and these monies are, to the extent of benefits paid or payable by the *Plan* on behalf of the *covered person,* assets of and debts owed to the *Plan.* The *covered person* agrees to hold in the attorney trust account of the attorney representing the *covered person,* the portion of the total recovery from any third party that is due for benefits paid or payable by the *Plan* on behalf of the *covered person.* The *covered person* shall reimburse the *Plan* immediately upon receipt of any recovery. The monies held in the attorney trust account shall remain in escrow and shall not be released until the *Plan* receives full satisfaction of its lien or right to reimbursement and provides written consent for the release of the monies. Both the *covered person* and his or her attorney will be personally liable if the monies subject to the *Plan's* lien are not held in an attorney trust account; released without the *Plan's* written consent; and/or dissipated on non-traceable items, such as debt obligations.

10.10. Sole Discretion: The *Plan* has sole and final discretion to determine whether to assert its rights under this *Reimbursement and Subrogation* provision as an equitable lien, through subrogation, or through reimbursement, to advance payments of benefits and require repayment, to offset against future payments, or through any combination or variation of these methods. The determination of which method or methods will be used in a particular case will be made to protect the interest of the *Plan* and its participants and is in the *Plan's* sole discretion.

10.11. Excess Insurance: If at the time of *injury, sickness, disease* or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the *Plan's Coordination of Benefits* section.
The *Plan's* benefits shall be excess to:
a. The responsible party, its insurer, or any other source on behalf of that party;
b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c. Any policy of insurance from any insurance company or guarantor of a third party;
d. Workers' compensation or other liability insurance company; or
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

10.12. Separation of Funds: Benefits paid by the *Plan,* funds recovered by the Participant(s), and funds held in trust over which the *Plan* has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the *Plan's* equitable lien, the funds over which the *Plan* has a lien, or the *Plan's* right to subrogation and reimbursement.

10.13. Wrongful Death: In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the *Plan's* subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these *Plan* rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

10.14. Offset: If timely repayment is not made, or the Plan Participant and/or his/her attorney fails to comply with any of the requirements of the *Plan,* the *Plan* has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the *Plan.* To do this, the *Plan* may refuse payment of any future medical benefits and any funds or payments due under this *Plan* on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the *Plan.*

10.15. Minor Status:
a. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the *Plan* to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
b. If the minor's parents or court-appointed guardian fail to take such action, the *Plan* shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court appointed guardian.

10.16. Language Interpretation: The *Plan Administrator* retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the *Plan's* subrogation and reimbursement rights. The *Plan Administrator* may amend the *Plan* at any time without notice.

10.17. Severability: In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and *Plan.* The section shall be fully severable. The *Plan* shall be construed and enforced as if such invalid or illegal sections had never been inserted in the *Plan.*

Adopted this _____ day of _____, 2017, effective as of _____, 2017.

Union Trustees

BY:_____
Michael G. McLaughlin

BY:_____
Francis T. Leake

BY: _____
Dennis F. Cronin

Employer Trustees

BY:_____
Harry C. Alexander

BY:_____
Jeffrey J. Shaute, Sr.

BY: _____
Terrance Craig, Jr.