SUMMARY PLAN DESCRIPTION

OF THE

JOINT INDUSTRY BOARD

HEALTH REIMBURSEMENT

ACCOUNT PLAN

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The following information constitutes the Summary Plan Description of the Joint Industry Board Health Reimbursement Account Plan (the "Plan" or "HRA"). This Summary Plan Description is presented to Participants in the Plan to set forth in clear and concise language the benefits available under the Plan, the eligibility requirements for those benefits, and the procedures for applying for those benefits. In addition, this booklet sets forth the rights of Participants under the Plan and under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This information applies to the Plan effective as of January 1, 2025 unless specifically stated otherwise.

GENERAL INFORMATION

Name of Plan:	Joint Industry Board Health Reimbursement Account Plan
Plan Sponsor	The Joint Industry Board of the Electrical Industry
Named Fiduciary	The Joint Industry Board of the Electrical Industry
Employer Identification Number ("EIN"):	13-0891035
Plan Number:	003
Plan Year:	January 1 – December 31
Plan Administrator and Agent for Legal Process:	Joint Industry Board of the Electrical Industry 158-11 Harry Van Arsdale Jr. Avenue Flushing, NY 11365 (718) 591-2000 Service may also be made on any Trustee at 158-11 Harry Van Arsdale Jr. Avenue Flushing, NY 11365 (718) 591-2000
Type of Plan:	This Plan is an employee welfare benefit plan and a health reimbursement arrangement as described in IRS Notice 2002-45. Your benefits are based

upon the amount of money in your Account, which consists of contributions made by the Employer and income thereon.

Type of Administration: The Plan is maintained by a board of trustees appointed by the Joint Industry Board of the Electrical Industry (the "Board of Trustees") whose names and office addresses are listed below.

Trustees: Humberto J. Restrepo, Chair
Scott Feldman, Vice Chair

ESTABLISHMENT OF PLAN

The Plan was established by the Joint Industry Board of the Electrical Industry ("Joint Industry Board" or "Employer") to permit a Covered Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from a Health Reimbursement Account as defined under IRS Notice 2002-45, and to qualify as an employer-provided medical reimbursement plan under Internal Revenue Code §§105 and 106 and regulations issued thereunder.

The Plan is a "welfare benefit plan" within the meaning of Section 3(1) of ERISA; benefits under this Plan do not vest in any participant or Dependent, and there is no guarantee that future reimbursements will occur.

DEFINITIONS

The following capitalized terms used in this Plan document have the meanings stated here for each such term:

"ACA" means the Patient Protection and Affordable Care Act.

"Account" means the bookkeeping account established for each Participant pursuant to this Plan and funded from Employer Contributions, from which Medical Care Expenses are reimbursed.

"Administrator," shall mean the Joint Industry Board.

"Benefits" means the reimbursement benefits for Medical Care Expenses.

"Board" or "Trustees" means the Board of Trustees of the Joint Industry Board Health Reimbursement Account Fund.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Covered Employee" or "Employee" means any employee on whose behalf the Employer agrees to contribute to the Plan.

"Covered Employment" means work performed by a Covered Employee.

"Dependent" means any individual who is the Participant's lawful Spouse or child, younger than age twenty-six (26). For purposes of this Section, a child shall include a stepchild, foster child and a child adopted by a Participant, effective as of the start of adoption proceedings.

"Effective Date" of this Plan means January 1, 2025.

"Employer" means the Joint Industry Board.

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

"Fund" means the Joint Industry Board Health Reimbursement Account Fund, a trust arrangement intended to fund the benefits provided to Participants under the terms of this Plan.

"Highly Compensated Individual" means an individual defined under Code §105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"Medical Care Expenses" means expenses incurred by you or your Dependents for medical care, as defined in Code Section 213, including non-prescription drugs as described in IRS Revenue Ruling 2003-102, but shall not include health insurance premiums for individual policies or for any other group health plan (including a plan sponsored by an Employer); provided, however, that COBRA premiums for another group health plan, Medicare Part B and Part D Premiums, and eligible long-term care premiums as described in Code §213(d)(10) are "Medical Care Expenses".

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

"Period of Coverage" means the Plan Year, except that for Employees who first become eligible to participate, pursuant to Section 3.1, it shall mean the portion of the Plan Year following the date Employer contributions begin to be paid on the Employee's behalf.

"Plan" means the Joint Industry Board Health Reimbursement Account Plan as set forth herein and as amended from time to time. This Plan does not provide major medical coverage as that term is defined in the ACA.

"Plan Sponsor" shall mean the Joint Industry Board of the Electrical Industry.

"Plan Year" means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Qualifying Medical Plan" means a group health plan that provides "minimum value," as defined by the ACA.

"Spouse" means an individual who is legally married (as determined under the law of the state where the marriage was celebrated) to the Participant.

"Union" means the Office and Professional Employees International Union, Local No. 153, AFL-CIO.

ELIGIBILITY AND PARTICIPATION IN THE PLAN

If you have worked for twenty-six (26) weeks in Covered Employment and meet the requirement to be enrolled in group health care coverage that meets certain criteria, you are a "Participant," and eligible to participate in the Plan. The Joint Industry Board's obligation to contribute to the Plan commences with your eligibility to participate in the Plan.

In order for you to participate in the Plan, you and your Dependents are also required to be actually covered under one or more group health plans (other than this Plan – for example, the Pension, Hospitalization and Benefit Plan) that is a Qualifying Medical Plan. To be a Qualifying Medical Plan, it must provide "minimum value" as that term is defined in the Affordable Care Act. A plan that provides only "excepted benefits" is not a Qualifying Medical Plan. "Excepted benefits" include accident-only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and certain health flexible spending accounts. If contributions are made to this Plan on your behalf before you become covered by a

Qualifying Medical Plan, you will not be permitted to withdraw any of those contributions until your coverage under the Qualifying Medical Plan begins. If you (or a Dependent) then lose coverage under the Qualifying Medical Plan, you will still be able to receive reimbursements from this Plan until your Account balance, as described below, is zero.

If you do not become enrolled in a Qualifying Medical Plan by the end of the Plan Year following the Plan Year for which contributions are first made to this Plan on your behalf, you will forfeit any contributions made on your behalf.

If you are enrolled in a Qualifying Medical Plan other than the Pension, Hospitalization and Benefit Plan, you will be required to affirm your coverage no less than annually.

When you become a Participant, an Account will be established for you (see "Participant Accounts", below). Benefits will be payable in the form of reimbursement for Medical Care Expenses. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

Your participation in the Plan will cease upon the latest of (a) the termination of this Plan, or (b) the date the Participant ceases (because of retirement, termination of employment, layoff, or any other reason) to be a Covered Employee, or (c) the date Participant no longer has an Account balance. If you terminate Covered Employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then resume Covered Employment, you will resume participation upon the resumption of Employer contributions to your Account.

CONTRIBUTIONS

The Joint Industry Board will contribute to the Plan on behalf of each Participant. The amount of contributions made on behalf of each Participant will vary, depending on the terms of any collective bargaining agreement then in force or such other agreement or resolution adopted by the Joint Industry Board. In the event that contributions are established by a collective bargaining agreement and no other resolution or action by the Joint Industry Board establishes a contribution rate for non-collectively bargained Employees, the rates established by the collective bargaining agreement shall apply to all Employees.

Employees are not allowed to contribute to the Plan, unless purchasing COBRA coverage.

Employer contributions will cease to be allocable to your Account upon the earlier of the termination of this Plan, or as of the date you are no longer a Covered Employee (because of retirement, termination of employment, layoff, or any other reason).

If you are no longer eligible to receive Employer contributions but still have an HRA Account balance, you may continue to be reimbursed for Medical Care Expenses up to the amount of your Account balance.

THE TRUST FUND

All contributions to the Plan are held in the Fund, a tax-exempt trust created for the purpose of providing benefits described herein to covered Participants.

PARTICIPANT ACCOUNTS

Once a Participant becomes eligible to participate in this Plan, the Joint Industry Board will establish an Account on behalf of the Participant.

A Participant's Account balance is the amount available for reimbursement of Medical Care Expenses at the time of the submission of a claim for reimbursement. The Account balance for each Participant is determined by crediting the Account with any Employer Contributions received by the Plan on behalf of the Participant and, on an annual basis, a pro rata share of the Fund's investment earnings (net of administrative expenses) and debiting the Account for any benefits paid to the Participant.

You may review your Account balance on the Internet at any time at www.optumfinancial.com. After logging in, you can view your Account balance by clicking on the Plan name and selecting the "Contact Information" tab. Your Account balance will be updated on a daily basis.

MAXIMUM ACCOUNT BALANCE

There is not presently a maximum Account balance. If a maximum Account balance is later adopted and your Account balance equals or exceeds your maximum balance on any determination date, you will not receive additional Employer contributions to your Account until you are paid benefits that are sufficient to reduce your balance below the maximum. Your

Account will, however, continue to be credited with a pro rata share of the Fund's investment earnings (net of administrative expenses).

BENEFITS

Commencement of Benefits

Provided that you are covered by a Qualifying Medical Plan as noted above, you are generally eligible to receive benefits from the Plan after the later of (a) twenty-six (26) weeks of Covered Employment or (b) when contributions have been made to the Plan on your behalf. Once you are eligible, the Plan will reimburse you for any covered Medical Care Expenses (as defined below) that you or your eligible Dependents incur after becoming eligible.

PAYMENT AND SUBSTANTIATION

Debit Cards. The Plan Administrator may provide you with a debit card to be used for Medical Care Expenses, in lieu of submitting forms either electronically or in paper format for reimbursement.

- All participants including retirees are able to utilize a debit card to make allowable payments under the Plan's provisions. Examples include co-payments at the doctor's office, pharmacy and other facilities that accept debit cards. In addition, participants have the ability to submit forms either electronically or in paper format to Optum Financial for reimbursement of benefits in lieu of using the debit card. The payment card is a VISA debit card and it allows you to easily access your Account.

- The debit card will be issued to new Participants as soon as practicable after you are eligible and your account has been funded.

- At many retailers, your eligible health care expenses will be verified at the time of purchase, which will reduce or eliminate the need to submit receipts. **Though you will not always be required to submit receipts and other documentation (see "Claims Substantiation", below) when using a debit card, claims still must be reviewed to ensure they comply with IRS regulations and you may be required to provide receipts or documentation to substantiate a purchase made with your debit card. You must keep your itemized receipts and any other relevant documents in case they are required to**

confirm a purchase or for tax purposes. Failure to provide substantiation when asked may result in your purchase being disallowed for tax purposes and the amount paid will be deemed to be taxable income to you.

- **HRA Balances -** You will have online and phone access to account balances, claim and account information.

  You may access your account through the Optum Financial mobile app or portal to:

  - Check account balance view transactions
  - Pay a provider or reimburse themselves
  - Submit claims and check status
  - Update contact information
  - Set up important alerts

  All claims are submitted to Optum Financial. You can utilize your debit card, submit your claims online or use the mobile app. In addition, you can submit paper claims to Optum Financial. Claims can be submitted to the Optum Financial website at www.optumfinancial.com, or mailed to: Optum Financial Claims Department, P.O. Box 622337, Orlando, FL, 32862.

  Finally, you can receive reimbursement of approved claims by check or through direct deposit. Direct Deposit for claims reimbursement is available, and you will have to enroll your information with Optum Financial.

- **Questions** – Contact Optum Financial at (844) 286-8472 with any questions regarding your account. Optum Financial is available 24 hours a day 7 days a week.

Claims Substantiation. A Participant who seeks Benefits and is not using a debit card (or who has used a debit card and from whom the Plan Administrator Optum Financial has requested substantiation) may apply for reimbursement by submitting an application in writing to Optum Financial in the applicable claim form, which shall include the following information:

- the person or persons on whose behalf Medical Care Expenses have been incurred;

- the nature and date of the Expenses so incurred;

- the amount of the requested reimbursement;

- a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source;

- an explanation of benefits from the other group health plan with respect to the Expense; and

- a statement that the Participant is actually enrolled in another group health plan that provides "minimum value" (is designed to pay at least 60% of the total cost of medical services for a standard population).

The application shall be accompanied by bills, invoices, or other statements showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request.

Timing. Within 30 days after receipt of a reimbursement claim from a Participant, Optum Financial will reimburse the Participant for the Participant's or their Dependents' Medical Care Expenses (if the claim is approved), or Optum Financial notifies the Participant that their claim has been denied. This 30-day period may be extended for an additional 15 days for matters beyond the control of Optum Financial, including in cases where a reimbursement claim is incomplete. Optum Financial or the Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

Claims Denied. A Participant may appeal denied claim in accordance with the appeals procedures herein.

Missing Participants. If the Administrator or its designee 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, then such payment and the balance of such Participant's Account balance shall be forfeited following a reasonable time after the date that any such payment first became due. If,

after such forfeiture, the Participant is located by the Plan, the Participant's Account Balance shall be reinstated.

COVERED EXPENSES

Medical Care Expenses are considered "incurred" at the time the drugs, medical equipment, or medical care services are provided, not at the time you pay for them. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible for reimbursement under the Plan. The amount available to reimburse your Medical Care Expenses at any given time is limited to your Account balance. You may only receive reimbursement from your Account for Medical Care Expenses incurred during a Period of Coverage.

Medical Care Expenses shall be eligible for reimbursement by the Plan only to the extent that the person incurring the expense cannot be reimbursed for the expense through any other accident or health plan (including a Health FSA). If only a portion of a Medical Care Expense has been reimbursed or is reimbursable elsewhere (e.g., because the Qualifying Medical Plan imposes co-payment or deductible limitations), your Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Plan. In no event shall the combined reimbursement payable to a Participant with respect to any Medical Care Expense, from this Plan and all other sources, exceed one hundred percent of such Medical Care Expense.

Some expenses may require a doctor's certification indicating the medical disorder, the specific treatment and how the treatment will alleviate the disorder.

All items eligible for reimbursement must meet Internal Revenue Code regulations and are subject to its limits.

Covered Medical Care Expenses:

A partial list of Medical Care Expenses that are reimbursable under the Plan (assuming the expense is not reimbursable by another plan) is shown below:

- Co-payments, co-insurance and deductibles
- Acupuncture
- Chiropractic visits
- Crutches
- Dental expenses

- Expenses that exceed medical, hospital, dental or vision plan limits (these are known as "balance billed" amounts)
- Eye exams, glasses and contact lenses
- Hearing aids
- Laser eye surgery
- Menstrual care products
- Orthodontia
- Orthopedic shoes
- Over the counter medication
- Physical exams
- Physical therapy
- Prescription drugs
- Psychotherapy
- Smoking cessation programs
- Speech therapy
- Transportation expenses related to medical care
- Well baby and well childcare
- Wheelchairs

Medicare premiums, eligible long-term care premiums (as described in section 213(d)(10) of the Internal Revenue Code), and COBRA premiums are considered Medical Care Expenses that will be reimbursed by the Plan. Group health plan premiums are not covered.

You may request to receive reimbursements for COBRA premiums to the extent funds are available from your Account. If you made a payment to a health plan not administered by the Joint Industry Board on behalf of an ex-Spouse or Dependent child, you will be obligated to include a copy of the cancelled check to document the remittance.

Retirees who pay Medicare premiums will be eligible for reimbursement of the premiums upon the submission of Form SSA-1099, which is the annual benefit statement furnished by the Social Security Administration. Reimbursements will be distributed on an annual basis and may be made to the extent funds are available from your Account.

Ineligible Expenses

Expenses that are not considered reimbursable Medical Care Expenses for purposes of the Plan include, but are not limited to:

- Cosmetic services
- Expenses you claim on your income tax return
- Some expenses that are not tax-deductible
- Expenses that are reimbursed by other sources, such as insurance plans
- Fees for exercise or health clubs, unless medically necessary as determined by the Joint Industry Board
- Hair transplants
- Illegal treatments, operations or drugs
- Postage and handling fees
- Weight loss programs that are not medically necessary as determined by the Joint Industry Board
- Premiums for health insurance coverage unless premiums are paid pursuant to a COBRA election and participation.

Any exclusions under this section will not apply to the extent that coverage is otherwise specifically provided in this document. Excluded charges will not be used when determining reimbursement.

The above list of exclusions is provided for illustrative purposes and is not all-inclusive. You may call the Joint Industry Board or Optum Financial for verification as to a covered expense.

Other Source of Reimbursement/Tax Deduction

Benefits under this Plan are intended to pay benefits for Medical Care Expenses that are not reimbursable from another source, such as from insurance or any other benefit plan. If a Medical Care Expense is reimbursable from another source, you may not receive a payment from this Plan for the reimbursed expense (or, if payment was made, the payment will be deemed taxable income). Similarly, if you deduct medical expenses on your income tax returns, payments made to you under this Plan for those same expenses may be deemed to be taxable income.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Administrator may, to the extent that it deems administratively possible and otherwise permissible under Code Section 105 and the regulations issued

thereunder or other applicable law, cause such amounts to be allocated to, or withheld from, or otherwise adjust a Participant's Account, that, in the Administrator's judgment, result in such Participant or other person receiving the credits to their Account or distributions to which he or she is properly entitled under the Plan.

COBRA

If you are a Participant in the Plan, and you stop receiving contributions to the Plan due to a voluntary or involuntary termination of your Covered Employment, you may elect to contribute to the Plan for up to 18 months after your termination (which is a "qualifying event") under the continuation coverage provisions of a federal law known as COBRA. Additionally, your Spouse or covered child will be allowed to contribute to the Plan should you die, or get divorced from your Spouse, or if your child turns 26 or no longer qualifies as your Dependent under the Plan (which are qualifying events) for up to 36 months. You, your Spouse, former Spouse or Dependent may experience more than one such qualifying event but in no case shall coverage extend beyond 36 months from the first qualifying event.

If you or your Dependents do not choose to continue coverage by making your own contributions to the Plan, you will still be able to submit claims for reimbursement of Medical Care Expenses until your Account balance is zero.

You or your covered Dependents (including your Spouse) must notify the Joint Industry Board of a divorce or a child's loss of Dependent status under the Plan within 60 days of the date of the divorce or loss of Dependent status. You have 60 days from the date your contributions cease or you lose coverage for one of the reasons described above, or the date you are sent notice of your right to make continuing contributions, whichever is later, to inform the Joint Industry Board that you wish to continue coverage. You then have 45 days from the date of the election to make the required contribution.

There is no financial advantage to a Participant or Dependent to purchase COBRA under this Plan because the required contributions, which must be paid with after-tax dollars, could cost more than the Plan will reimburse in medical expenses. Although federal law requires the Plan to provide for such continuation coverage, the monthly cost permitted by law can be up to 102% of the cost to the Plan for similarly situated active employees. If you are interested in electing COBRA continuation coverage, call or write to the

Members' Records Department at the Joint Industry Board, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, (718) 591-2000 for further information.

CLAIMS

Claims Deadline

All requests for benefits must be submitted within two years of the date that you incurred the Medical Care Expense for which you are seeking reimbursement.

Timing

Optum Financial will generally process your claim within 30 days of receiving it. Generally, before the end of the 30-day period Optum Financial will either approve your claim, in which case you will receive a payment, or will let you know your claim has been denied. If Optum Financial cannot process your claim during the 30-day period due to reasons beyond its control, the 30-day period may be extended for an additional 15 days (for a total of 45 days). Optum Financial will provide you with written notice of any extension, including the reasons for the extension. If the reason that Optum Financial cannot process your claim is because it is incomplete, you will be informed of this in the extension notice, and you will have 45 days in which to complete your claim.

Denial of Claim

If your claim is denied, Optum Financial will give you written notice of the denial within the 30 (or 45) day period described above. The notice will be written in a manner reasonably calculated by Optum Financial to be understood by the average person and will contain (i) specific reasons for the denial, (ii) a description of any additional material or information necessary for you to complete your claim, and an explanation of why such material or information is necessary and (iii) information as to the steps to be taken if you wish to appeal the denial.

If you do not receive written notice of Optum Financial's decision on your claim within the 30 (or 45) day period, the claim will be considered denied as of the last day of such period, and you can proceed to appeal the denial of your claim. You must appeal the denial of your claim before you can seek benefits from the Plan in court.

Appeals

You (or your duly authorized representative) have until 180 days after the date on which you received the written notice denying your claim (or, if applicable, 180 days after the date on which your claim denial is considered to have happened) to (i) file a written request with the Joint Industry Board for a review of the denied claim and of pertinent documents and (ii) submit written issues and comments to the Joint Industry Board.

The Board of Trustees will review your request and notify you of its decision in writing. The notice will be written in a manner calculated to be understood by the average person and will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. The notice will be given as soon as possible after the decision is made, but no later than sixty (60) days following the receipt of the claim.

You must seek review of a denied claim under these claim procedures before seeking Benefits in court. You may not file a civil action in court until the Administrator has made a final adverse determination. Any civil action seeking review of a final adverse determination by the Administrator may only be brought in the federal district court for the Eastern District of New York and may not be brought later than one (1) year from the date of the Administrator's final adverse determination.

PRIVACY

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans such as the HRA and the third-party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. For a copy of the Plan's "Notice of Privacy Practices" please contact the Joint Industry Board.

TERMINATION

Termination of Contributions

Once you leave Covered Employment, you are no longer eligible to receive Employer contributions to the Plan on your behalf.

Termination of Right to Receive Reimbursements

Your right to receive reimbursements of Medical Care Expenses generally ends when you are no longer receiving Employer contributions to the Plan, and you no longer have an Account balance. If you terminate Covered Employment and still have an Account balance, you may submit Medical Care Expenses for reimbursement until such time as your Account balance is drawn down to zero, even after you retire. In the event of your death, your estate may submit claims for reimbursement for covered expenses incurred before your death. In addition, your surviving Dependents who were covered by this Plan at the time of your death may submit claims for covered expenses incurred after your death until the Account balance is drawn to zero. Except as set forth herein, after your death, any remaining funds are forfeited, and no amount shall be paid to your survivors or estate on account of your death.

If the Plan erroneously pays you any benefits after your Account balance has been drawn to zero, you, your estate or your surviving Dependents are obligated to repay such amounts to the Plan.

Waiver of Benefits

You may at any time permanently opt out of the Plan and waive any future Benefits by submitting a form to the Joint Industry Board. Contact the Joint Industry Board for a copy of the required form. If you permanently opt out of the Plan and waive future benefits, any amounts in your Account will be forfeited. Note that this Plan constitutes minimum essential coverage under the ACA, and coverage under this Plan will make you ineligible for a premium subsidy to purchase health insurance on the Marketplace (also known as the exchange). Therefore, you may wish to opt out of coverage under this Plan if you have no other group health plan coverage and would otherwise qualify for premium assistance to purchase coverage on the Marketplace.

TAX STATUS OF PLAN BENEFITS

All benefits paid from this Plan are intended to be tax-exempt reimbursements of medical expenses. However, neither the Board of Trustees nor the Joint Industry Board is making any commitment or guarantee that any given expense reimbursement is, in fact, excludable from your gross income for federal, state or local income tax purposes. Each Participant is obligated to determine whether each reimbursement paid by

this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable. If you receive one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for tax-exempt treatment under the Code, such Participant shall indemnify and reimburse the Plan for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements. If you have any questions as to whether reimbursements received from this Plan are taxable to you, please consult your personal tax advisor.

POWER TO AMEND AND TERMINATE

The Plan Trustees have the power to amend and/or terminate the Plan, and the Joint Industry Board may terminate the Plan at any time and for any reason. If the Plan is terminated, Fund assets shall be used to satisfy any outstanding liabilities, including pending claims for benefit and administrative expenses. If Fund assets remain after the satisfaction of all liabilities, the Trustees will direct how those assets are to be used, but in no event will the assets revert to the Employer or the Union.

PARTICIPANTS' RIGHTS

Participants' rights under the Plan are limited to claims for benefits of eligible Medical Care Expenses as described above. Neither the establishment of this Plan nor amendment hereof will be construed as granting a Participant, Dependent, or any other person a legal or equitable right against the Employer, the Trustees, or the Union. Nothing in this document or any other document establishing or administering the Plan, nor any act by the Plan Administrator, shall modify the terms of employment for any Participant, nor interfere with the rights of the Employer to take any action with respect to an Employee that exists notwithstanding the existence of this Plan.

QMCSOs

If the Joint Industry Board receives a medical child support order relating to the Plan, and the Joint Industry Board determines that the order is a "Qualified Medical Child Support Order" ("QMCSO"), the Plan will provide the health benefit specified in the QMCSO. If the Joint Industry Board receives a medical child support order relating to your Account, it will notify you in writing and will inform you of its determination of whether or not the order is qualified. Upon request to the Joint Industry

Board, you may obtain, without charge, a copy of the Plan's procedures governing QMCSOs.

NONDISCRIMINATION

For Plan Participants whose employment and participation in the Plan are not governed by a collective bargaining agreement, then the Plan shall not discriminate in favor of Highly Compensated Employees in terms of eligibility to participate in the Plan or the availability of benefits. The Plan, and Employer shall at all times comply with the nondiscrimination requirements set forth in Code §105(h).

Incompetence or Incapacity of a Participant or Dependent

In the event any person to whom Benefits under this Plan are payable is declared incompetent or is otherwise unable to care for their affairs because of mental or physical incapacity, and a guardian, conservator, or other person legally charged with the care of the person or of their estate is appointed, any benefits to which an incompetent or incapacitated payee is entitled shall be paid to the person legally charged with the care of the incompetent or incapacitated person or their estate.

NONASSIGNMENT OF BENEFITS

Benefits payable under the Plan are generally nontransferable and nonassignable, and any effort to assign the benefits of a Participant to a third party, including creditors, or service providers whose fees may be reimbursed under this Plan, shall be null and void. Neither a QMCSO nor a valid tax levy is considered an assignment of benefits. The Plan may be required to pay all or a part of your Account to your Spouse, ex-Spouse, children or other Dependents if ordered to do so by a court of law as part of a divorce, separation, support or other domestic relations proceeding.

INTERPRETATION OF THIS PLAN DOCUMENT

This Summary Plan Description serves as the Plan's governing document and is intended to set out the terms of the Plan in a readily understandable format as required under ERISA. The Trustees, and to the extent of the Trustees' delegation, the Administrator, have discretion to interpret any provisions of this Plan and the Trust Agreement. Please note that the headings of the various Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision thereunder. Other terms and

provisions governing the Plan and its management are included in the Trust Agreement for the Fund. In case of any conflict between the terms of the Trust Agreement and this Summary Plan Description, the terms of the Trust Agreement shall be controlling. A copy of the Trust Agreement is available at the office of the Joint Industry Board.

GOVERNING LAW PRINCIPLES

This Plan shall be construed, administered and enforced according to the laws of the State of New York to the extent not superseded by the Code, ERISA or any other federal law.

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of said provision.

ERISA RIGHTS

As a Participant in the Joint Industry Board Health Reimbursement Account 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 Joint Industry Board'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.

Obtain, upon written request to the Joint Industry Board, 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 Joint Industry Board may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Joint Industry Board is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your Spouse, or your children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage risks.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Joint Industry Board 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 Joint Industry Board.

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 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 Joint Industry Board. If you have any questions about this statement or about your rights under ERISA, or you need assistance in obtaining documents from the Joint Industry Board, 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.

PLEASE NOTE THAT COPIES OF THE TRUST AGREEMENT ARE AVAILABLE FOR YOUR INSPECTION DURING REGULAR BUSINESS HOURS IN THE OFFICE OF THE PLAN ADMINISTRATOR.

HEALTH REIMBURSEMENT ACCOUNT PLAN OF THE JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

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