

SUMMARY PLAN DESCRIPTION
HEALTH REIMBURSEMENT
ACCOUNT PLAN
OF THE ELECTRICAL INDUSTRY



MAY 10, 2007

TABLE OF CONTENTS

General Information	1
Establishment of Plan.....	3
Eligibility to Participate	3
Contributions	3
Fund	4
Participant Accounts.....	4
Maximum Balance	4
Benefits.....	5
Dependents	5
Covered Expenses	6
Ineligible Expenses	8
Coordination of Benefits	9
COBRA	10
Claims.....	10
Termination of Participation	13
Payments upon Death.....	13
Tax Status of Plan Benefits	14
Power to Amend.....	15
Participants' Rights	15
QMCSOs and QDROs	15
Nonassignment of Benefits	15
Your Rights under ERISA	16

This booklet contains the Summary Plan Description of the Health Reimbursement Account Plan of the Electrical Industry (“Plan”). This Summary Plan Description is presented to Participants in the Plan (“Participants”) to set forth in clear and concise language what benefits are available under the Plan, who may receive benefits, how to apply for benefits and what your rights are 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 May 10, 2007, unless specifically stated otherwise.

GENERAL INFORMATION

Name of Plan: Health Reimbursement Account Plan
of the Electrical Industry

**Plan Sponsor
Identification No:** 56-2489386

Plan Number: 513

Plan Year: January 1 through December 31

**Plan Administrator
and Agent for Legal
Process:** Joint Industry Board of the Electrical Industry
158-11 Harry Van Arsdale Jr. Avenue
Flushing, N.Y. 11365
(718) 591-2000

Service may also be made on any Trustee at
158-11 Harry Van Arsdale Jr. Avenue
Flushing, N.Y. 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 2002-65. Your benefits are based upon the amount of money in your account, which consists of contributions made by your Employer and income therein.

Type of Administration: The Plan is maintained by a Joint Board of Trustees made up of an equal number of Employer and Union Trustees. The names and office addresses are listed below:

GINA ADDEO
GMA Electrical
201 Edward Curry Avenue
Staten Island, N.Y. 10314

JOSEPH R. BECHTOLD
Recording Secretary
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

ROBERT AMABILE
S. J. Electric, Inc.
228 Merrick Road
Lynbrook, N.Y. 11563

CHRISTOPHER ERIKSON
Business Manager
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

CAROL KLEINBERG
Kleinberg Electric, Inc.
437 West 16th Street
New York, N.Y. 10011

WILLIAM HOFVING
Business Representative
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

STEVEN LAZZARO
Hellman Electric Corp.
855 Brush Avenue
Bronx, N.Y. 10465

JOHN E. MARCHELL
President
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

MICHAEL M. MAZZEO, JR.
Mazzeo Electric
41-24 24th Street
Long Island City, N.Y. 11101

VINCENT McELROEN
Financial Secretary
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

DAVID B. PINTER
Zwicker Electric Company, Inc.
360 Park Avenue South
New York, N.Y. 10010

RAYMOND MELVILLE
Assistant Business Manager
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

DAVID I. SAMUELS
Robert B. Samuels, Inc.
48 West 25th Street
New York, N.Y. 10010

LUIS RESTREPO
Business Representative
Local Union No. 3, I.B.E.W.
158-11 Harry Van Arsdale Jr. Ave.
Flushing, N.Y. 11365

ESTABLISHMENT OF PLAN

The Health Reimbursement Account Plan of the Electrical Industry (“HRA”) was established and is maintained pursuant to Collective Bargaining Agreements between Local Union No. 3, International Brotherhood of Electrical Workers, AFL-CIO, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365 (“Union”), the New York Electrical Contractors Association, Inc., 1430 Broadway, 8th Floor, New York, NY 10018, the Association of Electrical Contractors, Inc., 11-51 47th Avenue, P.O. Box 1707, Long Island City, NY 11101, and other employers who are not members of the two associations but who are obligated pursuant to their Collective Bargaining Agreements or Participation Agreements to contribute to the Plan (collectively referred to as “Employer”).

Upon a written request from any Participant or beneficiary, the Plan Administrator will state in writing whether a particular Employer is a participating Employer in the Plan and provide the Employer’s principal business address. The Plan Administrator will also provide, upon a written request from a Participant or beneficiary, a copy of the Collective Bargaining Agreement or Participation Agreement between the Union and the Participant’s Employer. Copies of Collective Bargaining Agreements and Participation Agreements are available for inspection at the office of the Plan Administrator during normal business hours.

ELIGIBILITY AND PARTICIPATION IN THE PLAN

If you work for a participating Employer in any form of employment covered by a Collective Bargaining Agreement or Participation Agreement (“Covered Employment”) requiring the Employer to contribute to the Plan, the Employer’s obligation to contribute to the Plan on your behalf will generally begin as of the date specified in your Collective Bargaining Agreement or your first day of work in Covered Employment. You will be able to begin participation as soon as an Employer has made contributions to the Plan on your behalf.

CONTRIBUTIONS

Under the terms of the Collective Bargaining Agreement, Employers are obligated to contribute to the Plan on behalf of each eligible Participant. The amount of contributions made on behalf of each Participant will vary, depending on the terms of the relevant Collective Bargaining Agreement. Employees are not allowed to contribute to the Plan, unless purchasing COBRA coverage.

FUND

All contributions to the Plan are held in the Health Reimbursement Account Fund of the Electrical Industry, a tax-exempt trust created for the purpose of providing benefits to covered Participants.

PARTICIPANT ACCOUNTS

Employers are also obligated to furnish the Plan Administrator with a list of Participants on whose behalf they are contributing. Once the Plan Administrator receives a contribution on behalf of an individual Participant, the Plan Administrator will establish a bookkeeping account (“Account”) on behalf of the Participant.

ACCOUNT BALANCE

A Participant’s Account balance is determined by crediting the Account for any contributions received by the Plan on behalf of the Participant, and 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.

MAXIMUM ACCOUNT BALANCE

The Trustees (or the provisions of a Collective Bargaining Agreement or Participation Agreement) will establish a maximum Account balance for each class of Participants. If 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).

If your Account balance equals or exceeds the maximum, your Collective Bargaining Agreement or Participation Agreement will provide where the contributions, which otherwise would have been made to the Plan and credited to your Account, will be deposited.

BENEFITS

Commencement of Benefits

You are generally eligible to receive benefits from the Plan as soon as contributions have been made to the Plan on your behalf. The Plan will reimburse you for any covered Medical Care Expenses that you or your eligible dependents incur. However, you must complete the enrollment materials, if applicable, required by the Plan Administrator before you can receive any reimbursements from the Plan.

DEPENDENTS

Your eligible dependents include:

- Your lawful spouse of the opposite sex.
- Your unmarried children (including stepchildren and adopted children) up to age 19. However, unmarried dependent children who are full-time students at approved institutions of higher learning will be covered until age 25. An original letter from the registrar's office of the applicable institution shall be required as proof of current college or school attendance after each spring and fall semester commences. Services rendered during the months of July and August will be reimbursed after receiving the necessary documentation of a child's full-time student status for the next semester.

Medical Care Expenses are considered "incurred" at the time the drugs, medical equipment, or medical care service is provided, not at the time you pay for them. The amount available to reimburse your Medical Care Expenses at any given time is limited to your Account balance.

Medical Care Expenses include all expenses related to medical care for which you can take a deduction on your taxes, (see examples in the following section) and that are not covered by any other accident or health plan (e.g., co-payments or deductibles).

COVERED EXPENSES

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 is shown below:

- Co-payments, co-insurance and deductibles
- Acupuncture
- Chiropractic visits
- Certain over-the-counter medications or products
- Crutches
- Dental Expenses
- Expenses that exceed medical, hospital, dental or vision plan limits
- Eye exams, glasses and contact lenses
- Hearing aids
- Laser eye surgery
- Orthodontia
- Orthopedic shoes
- Physical exams
- Physical therapy
- Prescription Drugs
- Psychotherapy
- Smoking Cessation programs
- Speech therapy
- Transportation expenses related to medical care
- Well baby and well childcare
- Wheelchairs

Covered Non-Prescription Drugs and Products:

Medical Care Expenses also include certain non-prescription drugs that are used to treat a specific condition or ailment.

Examples of non-prescription drugs that are reimbursable by the Plan are:

Allergy Medicine	Motion Sickness Pills
Analgesics	Muscle/Joint Pain Relief (e.g. Ben Gay)
Antacids	Nicotine Gum/Patches
Anti-Diarrhea Medication	Pain Reliever
Antihistamines	Reading Glasses
Aspirin	Rubbing Alcohol
Cold Medicine	Sinus Medications
Contact Lens Solution	Sleeping Aids
Cough Drops	Smoking Cessation Products
First Aid Cream (e.g., bactine, diaper rash ointments, bug bite medication)	Throat Lozenges
Hemorrhoid Medication	Visine
Laxatives	Wound Care Products

Health insurance premiums, Medicare Part B 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.

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 Administrator 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 the Medicare Part B premium will be eligible for reimbursement 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

Ineligible Medical Expenses: A Partial List

Expenses that are not considered Medical Care Expenses for purposes of the Plan include:

- Certain over-the-counter medications or products (see below)
- 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
- Hair transplants
- Illegal treatments, operations or drugs
- Postage and handling fees
- Weight loss programs that are not medically necessary

The following over-the-counter products are not considered Medical Care Expenses, and will not be reimbursed by the Plan:

Cosmetics	Moisturizers
Cotton Balls/Swabs	Nutritional Supplements/Vitamins (unless recommended by a doctor for a specific condition)
Face Cream	Suntan lotion
Hair loss products (e.g. Rogaine)	Toothbrush/toothpaste/tooth whitener
Medicated Shampoo/Soap	

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 should always call the Joint Industry Board for verification as to a covered service.

COORDINATION OF BENEFITS

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, that other source should pay before submitting the Medical Care Expense to this Plan unless otherwise stated.

If your Medical Care Expenses are covered by a Health Flexible Spending Account, then this Plan will pay reimbursements only after the maximum annual amount available under the Health Flexible Spending Account has been paid out. You cannot be reimbursed for more than one hundred percent of any Medical Care Expense that you incur, regardless of whether the reimbursement comes only from this Plan, or from a combination of this Plan and other sources.

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 after your termination under the continuation coverage provisions of a federal law known as COBRA. Additionally, your spouse or child will be allowed to contribute to the Plan should you die, or get divorced from your spouse, or if your child no longer qualifies as your dependent under the Plan.

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 Medical Care Expenses until your Account balance is zero.

You or your covered dependents (including your spouse) must notify the Administrator 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 Plan Administrator that you wish to continue coverage.

There is no financial advantage to a Participant or beneficiary to purchase COBRA under this particular Plan because the required contributions, which must be paid with after-tax dollars, would cost more than the Plan will reimburse in medical expenses. Although federal law requires the Plan to provide for such continuation coverage, the IRS has not yet issued final regulations as to the calculation of the monthly cost, which is supposed to equal 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

Submission of a Claim

Claims for reimbursement of benefits must be on the form provided by the Plan Administrator, and must be accompanied by the verifying information or documents (e.g., detailed original receipt or Explanation of Benefits) required by the Plan Administrator.

Minimum Claims

The Plan Administrator generally will only process claims of \$100 or more. If you have an expense of less than \$100, you may submit it with other Medical Care Expenses, so that in the aggregate the claim covers Medical Care Expenses that exceed \$100. However, if by December you still have not incurred \$100 worth of Medical Care Expenses in the interim, you may submit any Medical Care Expenses you have incurred for reimbursement at the beginning of each December, even if they do not exceed the \$100 threshold.

Claims Deadline

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

Timing

The Plan Administrator will generally process your claim within 30 days of receiving it. Generally, before the end of the 30 day period the Administrator will either approve your claim, in which case you will receive a payment, or will let you know your claim has been denied. If the Administrator cannot process your claim during the 30 day period due to reasons beyond their control, the 30 day period may be extended for an additional 15 days. The Administrator will provide you with written notice of any extension, including the reasons for the extension. If the reason the Administrator 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, the Administrator 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 the Administrator 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 the Administrator'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 Administrator for a review of the denied claim and of pertinent documents and (ii) submit written issues and comments to the Administrator.

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 5 days after the date of the meeting of the Board of Trustees next following the receipt of the claim. (If you filed your appeal within 30 days of the next regularly scheduled Board meeting, the notice will be given no later than 5 days after the date of the second Board meeting following the receipt of the claim).

If special circumstances require an extension of time for reviewing your claim, written notice of such extension, and a description of the special circumstances, will be given to you prior to the end of the review period. If such an extension is required, you will receive notice of a decision on the claim no later than 5 days following the third regularly scheduled Board meeting following the initial submission of the claim. If notification of the decision is not given within a period described herein, the claim will be considered denied.

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 Administrator.

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

PAYMENTS UPON DEATH

Upon the death of the Participant, the Plan will pay to the designated beneficiary or beneficiaries the lesser of \$7,500 or the balance of the Participant's account based upon the understanding that the named beneficiary or beneficiaries will be responsible for the payment of the Participant's outstanding medical expenses. This disbursement will be deemed as a final "Medical Care Expense" disbursement, and shall be in lieu of Medical Care Expenses incurred by the Participant but not submitted to the Plan at the time of the Participant's death.

If a Participant fails to designate a beneficiary, or a beneficiary dies before the Participant, the benefits shall be paid to a survivor of the highest priority as listed below:

1. Surviving spouse
2. Children of the deceased Participant
3. Grandchildren of the deceased Participant
4. Parents of the deceased Participant
5. Brothers or sisters of the deceased Participants
6. Estate of the deceased Participant

A priority survivor who receives a payment from this Plan shall be responsible to pay the medical expenses incurred by the Participant prior to his or her death, which are not covered by insurance, up to the amount of the payment received from the Plan.

In the event there is more than one person at a specific priority level, it shall be paid out in equal shares to each person in that group, unless directed by each person in that group to be paid in another manner.

Designation of Beneficiary forms can be obtained from the Plan Administrator. A designation of beneficiary shall only become effective upon its receipt by the Plan Administrator. The last effective designation received by the Plan Administrator shall replace all prior designations. An effective designation of a beneficiary shall remain in effect only if the designated beneficiary survives the Participant. **(If a married Participant obtains a divorce, the divorce does not automatically revoke a previous designation of that spouse as a beneficiary).**

The Plan will not pay benefits based upon a Designation of Beneficiary form submitted to any other employee benefit plan.

TAX STATUS OF PLAN BENEFITS

All benefits paid from this Plan are intended to be tax-exempt reimbursements of medical expenses. However, neither the Plan Sponsor nor the Plan Administrator are making any guarantee that any given expense reimbursement is, in fact, exempt from federal, state or local income taxes. If you have any questions as to whether reimbursements received from this Plan are taxable to you, please consult your personal tax advisor.

If any benefits paid under this Plan are taxable to you, you are obligated to notify the Plan Administrator so that they can withhold the proper amount from your distribution. If you do not notify the Plan Administrator, you are responsible for indemnifying the Plan Sponsor for any penalty it may incur for failing to withhold taxes from your distribution.

POWER TO AMEND AND TERMINATE

The Plan Trustees have the power to amend and/or 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 Employers or the Union.

PARTICIPANTS' RIGHTS

Rights available to Participants under the Plan are limited to claims for benefits. Claims for benefits are the only claims available to Participants or beneficiaries against the Trust or its Trustees based on the provisions of the Plan. Neither the establishment of this Plan nor amendment thereof will be construed as granting a Participant, beneficiary, or any other person a legal or equitable right against any Employer, the Trustees or the Plan Administrator.

QMCSOs and QDROs

If the Plan Administrator receives a medical child support order relating to the Plan, and the Plan Administrator 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 Plan Administrator 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 Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing QMCSOs.

The Trustees of the Plan have promulgated rules to determine whether an order served upon the Plan is a Qualified Domestic Relations Order ("QDRO") with which it must comply. You may obtain a copy of this procedure from the Plan Administrator.

NONASSIGNMENT OF BENEFITS

All 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. A QMCSO is not considered an assignment of benefits.

The primary exception is provided for under the Retirement Equity Act of 1984. The Plan may be required to pay all or a part of your contribution 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, or valid tax levy.

SCOPE OF SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to summarize the principal terms of the Plan. It does not, however, purport to be the complete Plan. In case of any conflict between the terms of the Plan and this Summary Plan Description, the terms of the Plan shall be controlling. A copy of the complete Plan document is available at the office of the Plan Administrator.

ERISA RIGHTS

As a Participant in the Health Reimbursement Account Plan of the Electrical Industry 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 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 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 make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage risks.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 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 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 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.

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 ELECTRICAL INDUSTRY**

JOINT INDUSTRY BOARD
OF THE ELECTRICAL INDUSTRY
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365
718-591-2000
www.jibei.org

OFFICERS AND TRUSTEES

Steven Lazzaro
Chairman

Christopher Erikson
Secretary

John E. Marchell
Trustee

Employer Trustees

Gina Addeo
Robert Amabile
Carol Kleinberg
Steven Lazzaro
Michael M. Mazzeo, Jr.
David B. Pinter
David I. Samuels

Employee Trustees

Joseph R. Bechtold
Christopher Erikson
William Hofving
John E. Marchell
Vincent McElroen
Raymond Melville
Luis Restrepo

Dr. Gerald Finkel
Chairman, Joint Industry Board
of the Electrical Industry

Vito V. Mundo
Counsel