SUMMARY PLAN DESCRIPTION

HEALTH REIMBURSEMENT

ACCOUNT PLAN

OF THE ELECTRICAL INDUSTRY

May 11, 2016

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The following information constitutes the Summary Plan Description of the Health Reimbursement Account Plan of the Electrical Industry (the "Plan"). 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 May 11, 2016 unless specifically stated otherwise.

GENERAL INFORMATION

Name of Plan:	Health Reimbursement Account Plan of the Electrical Industry
Plan Sponsor Employer Identification Number ("EIN"):	56-2489386
Plan Number:	513
Plan Year:	January 1 – December 31
Plan Administrator and Agent for Legal Process:	Joint Industry Board of the Electrical Industry (the "Joint Board") 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 your Employer and income thereon.

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

GINA ADDEO
ADCO Electrical
201 Edward Curry Avenue
Staten Island, NY 10314

KEN BROUWER
Welsbach Electric Corp.
111-01 14th Avenue
College Point, NY 11356

KRISTINE DE NAPOLI
KND Electric
120 Brook Avenue, Unit B
Deer Park, NY 11729

STEPHEN GIANOTTI
Arcadia Electrical Contractors
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Kleinberg Electric, Inc.
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New York, NY 10013

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Uptown Electric, Inc.
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Local Union No. 3, IBEW
158-11 Harry Van Arsdale Jr. Avenue
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158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365

The Health Reimbursement Account Plan of the Electrical Industry believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Questions can be directed to the Plan Administrator at the Joint Industry Board of the Electrical Industry at 718-591-2000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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., 633 Third Avenue, Suite 9F, New York, NY 10017, the Association of Electrical Contractors, Inc., 36-36 33rd Street #402, Long Island City, NY 11106, 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 "Employers").

Upon a written request from any Participant or beneficiary, the Joint Board will state in writing whether a particular Employer is a participating Employer in the Plan and provide the Employer's principal business address. The Joint Board 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 Joint Board during normal business hours.

ELIGIBILITY AND PARTICIPATION IN THE PLAN

If you work for a participating Employer in employment covered by a collective bargaining agreement or participation agreement ("Covered Employment") requiring the Employer to contribute to the Plan on your behalf, you are a "Participant," and so are eligible to participate in 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, if no date is specified, your first day of work in Covered Employment.

In order for you to participate in the Plan, you are also required to be actually covered under another group health plan (other than this Plan – for example, the Pension, Hospitalization and Benefit Plan or the Employees Security Fund Health and Welfare Plan) that does not provide only "excepted benefits." "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 another group health plan, you will not be permitted to withdraw any of those contributions until your coverage under the other plan begins. If you then lose coverage under the other group health plan, you will still be able to receive reimbursements from this Plan until your Account balance is zero.

If you do not become enrolled in another group health plan by the end of the Plan Year following the Plan Year for which contributions are first made to this Plan on your behalf on or after January 1, 2014, you will forfeit any contributions made on your behalf on or after January 1, 2014.

CONTRIBUTIONS

Under the terms of the collective bargaining agreement, Employers are obligated to 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 the applicable collective bargaining agreement.

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

THE TRUST 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 described herein to covered Participants.

PARTICIPANT ACCOUNTS

Employers are obligated to furnish the Joint Board with a list of Participants on whose behalf they are contributing. Once the Joint Board receives a contribution on behalf of an individual Participant, the Joint Board will establish a bookkeeping account ("Account") on behalf of the Participant.

ACCOUNT BALANCE

A Participant's Account balance is determined by crediting the Account with any 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.ibenefitcenter.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 weekly basis.

MAXIMUM ACCOUNT BALANCE

The Trustees will establish a maximum Account balance for each class of Participants unless the maximum is provided for in a collective bargaining agreement or participation agreement. 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 Employer's 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 (either the 401(k) Plan (also known as the Deferred Salary Plan) or the Annuity Plan).

BENEFITS

Commencement of Benefits

Provided that you are covered by another group health plan as noted above, 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 (as

defined below) that you or your eligible Dependents incur. However, you must complete the enrollment materials, if applicable, required by the Joint Board before you can receive any reimbursements from the Plan.

DEPENDENTS

Eligible Dependents are defined as the individual who is legally married to the Participant (the participant's "Spouse") and the Participant's children (biological, legally adopted or in active process of legal adoption, and stepchildren) up to the last day of the month in which the child reaches age 26.

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. The amount available to reimburse your Medical Care Expenses at any given time is limited to your Account balance.

If you are enrolled in a plan providing "minimum value"

As long as the other group health plan in which you are enrolled provides "minimum value," as defined by the Affordable Care Act ("ACA"), Medical Care Expenses include all tax-deductible expenses related to medical care (see examples in the following section) that are not covered by any other accident or health plan (*e.g.*, co-insurance, co-payments or deductibles).

"Minimum value" under the ACA means that the plan is designed to pay at least 60% of the total cost of medical services for a standard population.

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
- 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
- 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 child care
- Wheelchairs

Group health plan 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 Joint 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 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.

Over the Counter Medicines

Over-the-counter ("OTC") medicines are not reimbursable under the Plan unless you have a valid prescription. An original prescription must be submitted for reimbursement.

Following is a list of examples of OTC medicines categories that are not covered for reimbursement without a prescription by the Plan:

Allergy Medicine	Antihistamines	Analgesics
Antacids	Anti-Diarrhea Medication	Aspirin
Cold Medicine	Contact Lens Solution	Cough Drops
Hemorrhoidal Medications	Laxatives	Menstrual Cycle Products
Calcium Supplements (only covered if recommended by a doctor for a specific condition)	First Aid Cream (Bactine, special diaper rash ointment, calamine lotion, bug bite medication, wart remover treatments)	Motion Sickness Pills
Muscle/Joint Pain Relief	Nasal Sinus Spray	Nicotine Gum/Patches
Pain Reliever	Pedialyte	Lactose Intolerance Pills
Reading Glasses	Rubbing Alcohol	Sinus Medication
Smoking Cessation Products	Throat Lozenges	Visine
Band-Aid Products		

Exceptions

Insulin still qualifies for reimbursement without a prescription.

Equipment, supplies, and diagnostic devices such as bandages, hearing aid batteries, and blood sugar test kits remain eligible for reimbursement without a prescription.

If you are not enrolled in an another plan providing minimum value:

If the other group health plan in which you are enrolled does not provide "minimum value," the Medical Care Expenses for which the Plan will reimburse you will be limited to:

1. Co-payments, co-insurance, and deductibles payable by you or your Dependent under, or premiums (including COBRA premiums) payable for, the other group health plan;
2. Medical care that does not constitute essential health benefits; and
3. Medicare Part B Premiums and eligible long-term care premiums.

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 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 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

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

- Over-the-counter medications or products (other than the exceptions listed above)
- 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 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 Board
- Premiums for health insurance coverage in the individual market, for example, coverage purchased in a State or Federal Marketplace.

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 expense.

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 or also known as a Section 125 plan, then this Plan will pay reimbursements only after the maximum annual amount available under the Health Flexible Spending Account or Section 125 Plan 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.

When this Plan does not have a sufficient balance when it is primary, the Additional Security Benefit Plan ("ASBP") will automatically act as the

secondary plan and pay any remaining balance, if funds are available. If you would like, you may opt out of this process by completing the form available at http://www.jibei.org/hra.asp. Once both your Account balance with this Plan and your account balance with the ASBP are exhausted, you can withdraw money from your 401(k) Plan to reimburse your medical expenses, although such distributions to active participants under age 59 1/2 are subject to a 10% tax.

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 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.

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 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 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 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 Joint Board, and must be accompanied by the verifying information or documents (e.g., detailed original receipt, website copies of prescription co-payments or Explanation of Benefits) required by the Joint Board. You can find claim forms online at http://www.jibei.org/hra.asp

Minimum Claims

The Joint Board generally will process claims only of $100 or more. If you have an expense of less than $100, you may submit it with other Medical Care Expenses, so that the total Medical Care Expenses exceed $100. However, if by December in any year you still have not incurred $100 worth of Medical Care Expenses, 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 two years of the date that you incurred the Medical Care Expense for which you are seeking reimbursement.

Timing

The Joint Board will generally process your claim within 30 days of receiving it. Generally, before the end of the 30-day period the Joint Board 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 Joint Board 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. The Joint Board will provide you with written notice of any

extension, including the reasons for the extension. If the reason the Joint Board 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 Joint Board 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 Joint Board 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 Joint Board'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 Board for a review of the denied claim and of pertinent documents and (ii) submit written issues and comments to the Joint 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 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 Joint 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. 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.

You may at any time permanently opt out of the Plan and waive any future Benefits by submitting a form to the Joint Board. Contact the Joint Board for a copy of this form. If you permanently opt out of the Plan and waive future benefits, any amounts in your Account will be forfeited and your Account balance will be treated as if it had reached the maximum Account balance. Future contributions that otherwise would

have been made to the Plan on your behalf after you opt out will be deposited as provided for in your Employer's collective bargaining agreement or participation agreement. 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.

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 benefit 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 Participant
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, the benefit 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 Joint Board or online at http://www.jibei.org/hra.asp. A designation of beneficiary shall only become effective upon its receipt by the Joint Board. The last effective designation received by the Joint Board 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. Instead, you must submit a new Designation of Beneficiary form if you wish to change your designation following the divorce).**

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 Board of Trustees nor the Joint Board is 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 Joint Board so that they can withhold the proper amount from your distribution. If you do not notify the Joint Board, 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, the Union, or the Joint Board.

QMCSOs

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

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.

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 Joint Board.

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 Joint 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 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 Board may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Joint 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 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 Joint 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 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 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 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 AND THE PLAN DOCUMENT 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

Stephen Gianotti
Chairman

Christopher Erikson
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