IBEW 292 HEALTH CARE PLAN
PARTICIPATION AGREEMENT FOR NON-BARGAINING EMPLOYEES

AGREEMENT by and between the employer identified on page seven (7) of this Agreement ("Employer") and the Board of Trustees of the IBEW 292 Health Care Plan ("Plan") (each a "Party", collectively the "Parties").

WHEREAS, the Plan is an employee benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), is a voluntary employee benefits association exempt from federal income taxation under section 501(c)(9) of the Internal Revenue Code, is a trust established and maintained pursuant to an Agreement and Declaration of Trust originally executed on March 1, 1980 ("Trust Agreement"), and is governed by the IBEW 292 Health Care Plan Plan Document and Summary Plan Description, as amended ("SPD"), and the rules and regulations of the Board of Trustees; and,

WHEREAS, the Employer is a party to a collective bargaining agreement with a local union affiliated with the International Brotherhood of Electrical Workers, which is a party to the Trust Agreement ("Union"); and,

WHEREAS, the Employer desires its employees to become Participants in the Plan according to the terms of this Agreement.

NOW, THEREFORE, the Parties agree as follows:

1. Definitions. Capitalized terms used but not defined in this Agreement have the meaning given in the SPD.

2. Participation in the Plan. Subject to the terms and conditions of this Agreement, the Plan will enroll each Eligible Person listed in the attached IBEW 292 Health Care Plan Application For Coverage Of Non-Bargaining Employees ("Application"), and any individual who becomes eligible under this Agreement after the Effective Date, as a Participant in the Plan.

3. Eligibility. Each Eligible Person will participate in the Plan under this Agreement.

    a. Eligible Person. An individual is an "Eligible Person" when:

        i. The individual is an employee of the Employer or a former employee entitled to COBRA coverage under a group health plan maintained by the Employer; and,

        ii. The Employer has notified the Plan that the individual desires coverage under this Agreement by submitting to the Plan the Application or the Employee Information Update Form attached to this Agreement; and,

        iii. The Employer has paid the first required contribution for the individual's coverage; and,

iv. The individual has not waived coverage under the Plan.

4. Coverage Commencement. An individual will receive coverage from the Plan under this Agreement beginning on the first day of the calendar month following the month in which the individual becomes an Eligible Person.

5. Coverage Termination. Except as provided below, the Plan will terminate coverage of an individual in accordance with the Trust Agreement, SPD, and the Trustees' rulings and regulations. The Plan will cease covering an individual under this Agreement as follows:

   a. The Plan will cease covering an individual at the end of the calendar month for which contributions were last made when the Employer fails to remit contributions to the Plan required under this Agreement on behalf of the individual.

   b. The Plan will immediately cease covering all individuals under this Agreement when the Employer's account with the Plan is placed for collection in accordance with the Plan's regular procedures.

   c. The Plan will cease covering all individuals under this Agreement (or the individual who violated the Agreement) at the end of the calendar month in which the Plan notifies the Employer that the Employer or the individual covered under this Agreement violated the terms of this Agreement.

   d. The Plan will cease covering an individual at the end of the calendar month in which the Plan receives notice from the Employer that the individual is no longer an Eligible Person. Until the Plan receives such notice, the Employer will remain responsible to pay contributions on behalf of the employee.

   e. The Plan will immediately cease covering all individuals under this Agreement when the Employer fails to timely and properly remit contributions on behalf of its employees participating in the Plan pursuant to a collective bargaining agreement.

   f. The Plan will cease covering all individuals under this Agreement as of the last day of the calendar month in which the Plan provides notice to the Employer that the Plan has exceeded or is in danger of exceeding restrictions of any applicable federal statutes or regulations.

   g. The Plan will immediately cease covering all individuals under this Agreement when either Party terminates this Agreement.

   h. The Plan will cease coverage as directed by the Trustees when, in their absolute discretion, the Trustees determine to cease coverage for some or all individuals covered under this Agreement.

6. Benefits. Eligible Individuals covered under this Agreement will receive medical, dental, and vision coverage only. Except as this Agreement otherwise provides, individuals

covered by the Plan pursuant to this Agreement will receive the same benefits under the same conditions as other Participants in the Plan.

7. Contributions. The Employer will contribute monthly to the Plan on behalf of each Eligible Person (determined without reference to Sections 3(a)(iii) of this Agreement) the premiums provided in the attached IBEW 292 Health Care Plan Non-Bargaining Participation Notice Of Premiums, which the Trustees may amend at any time. Changes to premiums will be effective as provided in the notice. The Employer will remit contributions to the Administrative Manager (also called the "Benefits Office") together with a remittance report on forms provided by the Administrative Manager. Contributions are due and payable on the first day of each month. The Plan will accept contributions under this Agreement only if the Employer timely and properly remits contributions on behalf of its employees participating in the Plan pursuant to a collective bargaining agreement.

8. Employer Representations, Warranties, and Covenants. The Employer represents, warrants, and covenants as follows:

   a. The Employer is regularly and primarily engaged in the electrical construction industry with a principal place of business within the geographic area covered by the Union.

   b. The Employer is signatory to one or more current and valid collective bargaining agreements that require the Employer to make contributions to the Plan on behalf of the employees who are covered by the collective bargaining agreement.

   c. The Employer is conducting its business in full compliance with the requirements of the collective bargaining agreement(s), and the Employer has taken no action to abrogate, repudiate, or otherwise terminate any collective bargaining agreement with the Union.

   d. The Employer has included on the attached Application all of its employees and former employees entitled to COBRA coverage under a group health plan maintained by the Employer, has fully and accurately completed the Application and any associated forms, and will fully and accurately complete all forms and notices required under this Agreement.

   e. The Employer will immediately notify the Plan when an individual becomes or ceases to be a Eligible Individual (due, for instance, to a change in employment classification, hire, termination, or waiver of coverage).

   f. The Employer will timely provide, upon request by the Trustees or their agent, all information necessary for the Plan to complete statistical testing for non-discrimination testing and other similar matters. This Section will survive any termination or expiration of this Agreement.

   g. Except as this Agreement otherwise provides, the Trust Agreement, the SPD, and the Trustees' rules and regulations and (any subsequent additions or

modifications to the foregoing) will apply to and be binding on the Employer and the individuals covered under this Agreement.

h. The Employer consents to the appointment of the current and former Trustees, and ratifies, approves, and consents to all prior acts and omissions of the Trustees in connection with the creation and administration of the Plan. Entering this Agreement has no effect on the Employer's right (if any) to participate in appointing Trustees.

i. The Employer will permit the Plan to examine the Employer's payroll records regarding individuals covered under this Agreement on the same terms that apply to bargaining Employees. This Section will survive any termination or expiration of this Agreement.

j. The information provided by the Employer to the Plan in or in connection with this Agreement is, to the best of its knowledge having undertaken reasonable investigation, accurate, complete, and not misleading.

The Employer will notify the Plan immediately and in no event later than five (5) days of becoming aware that any of the above representations, warranties, or covenants are materially false or misleading or have been breached.

9. Employer's Legal Obligations. Employers have various legal obligations that relate to providing employee benefits. Internal Revenue Code Section 105(h) and related Internal Revenue regulations provide non-discrimination standards for self-insured welfare benefit plans such as the Plan. These laws provide that if too few of an employer's employees are enrolled in such a plan, the employer's highly compensated employees may be subject to income tax on the value of their benefits under the plan. Additionally, Section 18B of the Fair Labor Standards Act (FLSA), as amended by the Patient Protection and Affordable Care Act (ACA), requires employers to provide notice to employees regarding the availability of subsidized coverage through state or federal insurance exchanges. FLSA Section 18C prohibits employers from retaliating against employees for lodging complaints that the employer violated provisions of the ACA or for receiving subsidized coverage. The ACA may also impose other obligations on employers, such as coverage and reporting requirements. Finally, the ACA imposes on the Plan requirements that the Plan may fail to satisfy if the Employer fails to discharge its duties under this Agreement. For instance, Section 2708 of the Public Health Service Act as amended by the ACA requires the Plan to provide coverage to an individual by the 91st day following the day on which the individual meets the substantive conditions of eligibility for coverage by the Plan. Late or inaccurate reporting or payment by the Employer could cause the Plan to violate this provision. The Plan does not provide legal advice to employers. This section merely constitutes notice to the Employer that it must ensure compliance with all law that applies to the Employer. The Plan does not represent that providing coverage under this Agreement will prevent the Employer from violating any legal obligations. The Plan has no liability to the Employer in connection with providing coverage under this Agreement. The Employer indemnifies the Plan against any fines, penalties, or other costs resulting from non-compliance with applicable law that the Plan incurs in connection with providing coverage under this Agreement. This Section will survive any termination or expiration of this Agreement.

10. Liability and Indemnification. The Employer is liable to the Plan, present and former Trustees, and their employees, agents, or designees (collectively, “Indemnitees”) for any claim, expense, fine, penalty, or other loss of any kind (including, without limitation, attorneys' fees) except claims for Covered Medical Expenses (collectively, “Losses”) that any Indemnitee may incur in connection with this Agreement. The Employer will indemnify, defend, save, and hold harmless the Indemnitees against any claim for Losses, however raised. The Indemnitees may, at their sole discretion, designate counsel for the defense of a claim for Losses. The Employer will not settle any claim for Losses without the written consent of the Plan, which it may withhold at its sole discretion. The Indemnitees will not be liable to the Employer, its employees, agents, or designees for any act or omission connected to this Agreement, except for claims of Covered Individuals for Covered Medical Expenses. This Section will survive any termination or expiration of this Agreement.

11. Miscellaneous.

a. Amendment. Except as otherwise provided in this Agreement, the terms of this Agreement may not be modified by any means other than a written amendment executed by both Parties. No amendment will be effective to the extent that it is contrary to the Trust Agreement, as amended, or applicable law. The Trustees may amend this Agreement from time to time without the Employer’s consent to the extent necessary or appropriate to comply with applicable law.

b. Merger. As of the Effective Date of this Agreement, the provisions contained in this Agreement set forth the entire agreement of the Parties with respect to the subjects of this Agreement. No other document, agreement, or understanding addressing those subjects, oral or otherwise, will be of any effect with respect to the Parties unless specifically made a part of this Agreement by means of a writing signed by both Parties after the Effective Date.

c. Attachments. The attachments to this Agreement, including all forms and notices the Employer submits to the Plan in accordance with this Agreement, are incorporated into and form a part of this Agreement.

d. Waiver. The waiver by either Party of a breach or violation of any term of this Agreement will not operate as, or be construed to be, a waiver of any subsequent breach of the same or any other term of this Agreement. The failure of either Party to enforce at any time or for any period one or more terms of this Agreement will not constitute a waiver of any such terms or the right of that Party to enforce each and every term of this Agreement.

e. Governing Law. This Agreement will be construed under and governed by all applicable Federal law and, to the extent not preempted by Federal law, the laws of the State of Minnesota without reference to its conflict of law provisions. A forum within the State of Minnesota will determine any dispute arising under this Agreement and will exercise in personam jurisdiction over the Parties. The Parties waive any claim or defense that such forum is not convenient or proper. Process may be served in any manner authorized by Minnesota law.

f. Severability. If any term of this Agreement is held illegal, invalid, or unenforceable under present or future law, that term will be fully severable, and this Agreement will be construed and enforced as if that term had never comprised a part of this Agreement.

g. Counterparts. This Agreement may be executed simultaneously in multiple counterparts, which taken together will constitute one instrument that may be sufficiently evidenced by any one counterpart. An electronic copy of an executed counterpart of this Agreement will be effective as an original executed counterpart of this Agreement.

h. Termination. This Agreement may be terminated on thirty (30) days notice of the intention to terminate furnished by either Party to the other, or as otherwise provided in this Agreement and the Trustees' rules and regulations. This Agreement will continue in full force and effect until terminated.

Remainder of page intentionally left blank.

i. Notices. Any and all notices required to be given under this Agreement must be in writing and will be considered to have been duly given if sent by first class mail to the following addresses:

Plan:
IBEW Local 292 Benefits Office
Attn: Jody Roe-Hardie
6900 Wedgwood Road North, Suite 425
Maple Grove, MN 55311-3552

Employer:

Name: _____

Address: _____

_____

The names and addresses provided above may be changed at any time by either Party upon written notice to the other Party (the Employer may use the attached Information Update Form to change its address). Notices will be deemed given upon actual receipt of first class mail.

j. The Effective Date of this Agreement is _____.

IBEW 292 HEALTH CARE PLAN

_____
Chairman

_____
Secretary

Employer

_____
By

_____
Its

IBEW 292 HEALTH CARE PLAN

APPLICATION

FOR COVERAGE OF NON-BARGAINING EMPLOYEES

Instructions: You must complete the entire Application to enroll employees in the Plan. The Application must be signed and the original sent to the Benefits Office at:

IBEW Local 292 Fringe Benefit Funds
Attn: Jody Roe-Hardie
6900 Wedgwood Road N, Suite 425
Maple Grove, MN 55311
(763) 493-8830
(800) 368-9045

If you have any questions regarding this Application, you may write or call the Benefits Office.

PART I: Employer Data

Employer: _____

Address: _____

_____

Phone No.: _____

Fax No.: _____

HR Contact: _____

HR Email: _____

Tax ID: _____

PART II: Employee Data

Instructions: Identify all employees of the Employer in the worksheet below (other than those for whom the Employer is required to contribute to the Plan under a collective bargaining agreement). Employees include current employees and former employees who currently are enrolled for continuation (COBRA) coverage in the employer's health care plan. **Use additional sheets if necessary.**

Mark whether each employee has elected coverage. Select only one category. **For each employee who has not elected coverage, include a waiver of coverage form signed by the employee.** If the Plan does not receive a waiver of coverage form for each employee who has not elected coverage, coverage for all the Employer's non-bargaining employees may be delayed until the Plan receives a properly completed Application.

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Coverage: ☐ Yes ☐ No

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Coverage: ☐ Yes ☐ No

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Coverage: ☐ Yes ☐ No

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Coverage: ☐ Yes ☐ No

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Coverage: ☐ Yes ☐ No

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Coverage: ☐ Yes ☐ No

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Coverage: ☐ Yes ☐ No

PART III: Employer Certification

I hereby certify that the above information is true, complete and correct and to the best of my knowledge and is offered in support of the Employer's request for participation in the Plan by specified categories of employees.

_____

Employer

_____

By

_____

Its

IBEW 292 HEALTH CARE PLAN
NON-BARGAINING PARTICIPATION
NOTICE OF PREMIUMS

Effective **[July 1, 2015]**, the monthly premium under a Participation Agreement with the IBEW 292 Health Care Plan is as follows.

Contribution

$1202.50

Contact the Benefits Office at (763) 493-8830 or (800) 368-9045 if you have questions.

IBEW 292 HEALTH CARE PLAN

WAIVER OF COVERAGE FORM

Instructions: Complete this entire form and return it to your employer. Contact the Benefits Office at (763) 493-8830 or (800) 368-9045 if you have questions.

Employee: _____

Address: _____

_____

Phone: _____

Email: _____

S.S.N.: _____

Check one:

☐

- **I am not currently covered** by the IBEW 292 HEALTH CARE PLAN (Plan) under my employer's participation agreement with the Plan.
- I elect to waive coverage (for myself and my dependents, if any).

☐

- **I am currently covered** by the Plan under my employer's participation agreement with the Plan.
- I elect to cease receiving coverage (for myself and my dependents, if any) as of the last day of:_____ **(insert the last month for which you want coverage)**.

By submitting this waiver to your employer, you elect to waive coverage by the IBEW 292 HEALTH CARE PLAN under your employer's participation agreement with the Plan. You (and your dependents, if any) will not be eligible for coverage by the PLAN until you revoke this waiver. To revoke this waiver, you must notify the Plan in writing (on a form acceptable to the Plan).

Signature _____

Date _____

IBEW 292 HEALTH CARE PLAN

INFORMATION UPDATE FORM

Instructions: Complete this entire form and return it to Benefits Office at IBEW Local 292 Fringe Benefit Funds, 6900 Wedgwood Road N, Suite 425, Maple Grove, MN 55311. Contact the Benefits Office (763) 493-8830 or (800) 368-9045 if you have questions.

Employer Information

Employer: _____

Address: _____

_____

Phone: _____ Fax: _____

HR Contact: _____ HR Email: _____

Employee Information (Do not complete this section if you are updating employer contact information).

Employee Name: _____

Address: _____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____

Reason for Update (check one):

☐ New employee.

☐ Employee termination.

☐ Change in employer contact information.

IBEW 292 HEALTH CARE PLAN

EMPLOYEE INFORMATION UPDATE FORM

Instructions: Complete this entire form and return it to your employer. Contact the Benefits Office at (763) 493-8830 or (800) 368-9045 if you have questions.

Employee: _____

Address: _____

_____

Phone: _____

Email: _____

S.S.N.: _____

- Previously, I waived coverage (for myself and my dependents, if any) by the IBEW 292 HEALTH CARE PLAN (Plan) under my employer's participation agreement with the Plan.
- As of the date below, I revoke my waiver of coverage (for myself and my dependents, if any).
- I understand that revoking my waiver of coverage does not guarantee that I (and my dependents, if any) will receive coverage under the Plan, and that all terms of coverage are determined by my employer's participation agreement with the Plan.

Signature _____

Date _____