IBEW 292 Benefits

IBEW 292 TWELVE COUNTY AREA

PREMIUM PAYMENT PLAN

Effective February 1, 2010

TABLE OF CONTENTS

PREMIUM PAYMENT PLAN

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

Local Union No. 292, International Brotherhood of Electrical Workers and Minneapolis Chapter of the National Electrical Contractors Association ("NECA)" establish the IBEW 292 Twelve County Area Premium Payment Plan (the "Plan") effective January 15, 2010 (the "Effective Date"). Capitalized terms used in this Plan not defined elsewhere in this document will have the meanings given in Article II.

This Plan is designed to permit an Eligible Employee of participating Employers to pay for his or her share of Contributions under the IBEW 292 Health Care Plan (Health Plan) on a pre-tax Salary Reduction basis.

1.2 Legal Status

The Plan Sponsor intends this Plan to qualify as a "cafeteria plan" under Code § 125, the corresponding regulations, and this Plan will be interpreted to accomplish that objective.

ARTICLE II. DEFINITIONS

The following words and phrases are used in this Plan and will have the meaning assigned in this Article unless a different meaning is clearly required by the context or is defined within an Article.

2.1 Adopting Employer

"Adopting Employer" means a corporation, partnership, limited liability company, sole proprietorship or other legal entity that is a signatory to a Collective Bargaining Agreement or, with the Plan Sponsor's permission, adopts this Plan by completing and executing a participation agreement.

2.2 Bargaining Unit Employee

"Bargaining Unit Employee" means an Employee who is a member of a collective bargaining unit represented by the Union and who is an Employee of an Employer who has agreed to make Contributions to the Plan on the Employee's behalf.

2.3 Benefits

"Benefits" means the Premium Payment Benefits offered under the Plan.

2.4 Benefit Package Option

"Benefit Package Option" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

2.5 Change in Status

"Change in Status" has the meaning described in Section 6.3.

2.6 Code

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

2.7 Collective Bargaining Agreement(s)

"Collective Bargaining Agreement(s)" means any collective bargaining agreement(s) in force and effect between the Union and an Employer or the Employers of an Employer's Association which require the Employers to make contributions to the Health Plan on behalf of their Employees for work performed within the jurisdiction of the Union, together with any modifications or amendments of such collective bargaining agreements.

2.8 Contributions

"Contributions" means the amount contributed to pay for the cost of Premium Payment Benefits of an Eligible under the Plan.

2.9 Compensation

"Compensation" generally means wages or salary paid to an Eligible Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any (a) Salary Reduction election under this Plan, (b) salary reduction election under any other cafeteria plan, and (c) compensation reduction under any Code § 132(f)(4) plan but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k) or 457(b) plan or arrangement.

2.10 Dependent

"Dependent" means:

(a) An individual who qualifies as a "Dependent" under the terms and conditions of the IBEW 292 Health Care Plan.

(b) A Participant's unmarried child who would be eligible for benefits under the Health Plan as a registered student but for an absence from school may extend dependent coverage, provided the child is on a leave of absence: (i) from an accredited post-secondary educational institution, (ii) which is medically necessary, (iii) due to his or her serious illness or injury, and (iv) which caused the child to lose registered full-time student status. The child must have been registered or enrolled as a full-time student at an accredited post-secondary educational institution immediately prior to the medically necessary leave of absence. A partial reduction in schedule to part-time student status is sufficient if all other conditions are met. Dependent coverage under this paragraph may be extended only until the earlier of: (i) the first anniversary of the start of the medically necessary leave of absence, or (ii) the date on which the Plan's coverage would otherwise terminate due to any other reason. The child's treating physician must certify to the Plan, in writing, that the child is suffering from a serious illness or injury, and that the leave of absence is medically necessary.

2.11 Effective Date

"Effective Date" of this Plan is January 15, 2010.

2.12 Election Form/Salary Reduction Agreement

"Election Form/Salary Reduction Agreement" means the form provided by the Plan Administrator for allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for Premium Payment Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

2.13 Eligible Employee

"Eligible Employee" means (1) a Bargaining Unit Employee, or (2) an actively-employed Non-Bargaining Unit Employee of an Employer who has signed a contribution agreement with the Plan.

2.14 Employee

"Employee" means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency; (c) any employee included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this Plan; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

2.15 Employer

"Employer" means:

(a) Any person, firm, association, sole proprietorship, partnership or corporation who on the Effective Date of this Plan, entered or in the future, enters into Collective Bargaining Agreements that require Contributions be made to the Health Plan;

(b) The Employer's Association in its capacity as an Employer of employees not covered by a Collective Bargaining Agreement, provided such Employer's Association has a valid Participation Agreement in effect with the Trustees;

(c) The Union in its capacity as Employer of Employees not covered by Collective Bargaining Agreements provided the Union has in effect a valid Participation Agreement with the Trustees, and further provided that the Union does not have a voice in the selection of any Employer Trustee;

(d) Any other employer of Employees not covered by Collective Bargaining Agreements, provided such employer has in effect a valid Participation Agreement with the Trustees, and further provided that such Employer does not have a voice in the selection of any Trustee;

(e) Employers who are members of the Employer's Association, provided such employer has a valid Participation Agreement with the Trustees; and

(f) The Trustees with respect to full-time Employees of the IBEW 292 Fringe Benefit Funds.

2.16 Employer's Association

"Employer's Association" means the Minneapolis Chapter, National Electrical Contractors Association, Inc.

2.17 ERISA

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

2.18 FMLA

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

2.19 Health Plan

"Health Plan" means the IBEW 292 Health Care Plan.

2.20 Open Enrollment Period

"Open Enrollment Period" with respect to a Plan Year means the last month in the immediately preceding Plan Year, or such other period as prescribed by the Administrator.

2.21 Participant

"Participant" means a person who is an Eligible Employee and who is participating in this Plan consistent with Article III. Participants include (a) those who elect Premium Payment Benefits and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Group Health Plan (if any) with after-tax dollars outside of this Plan.

2.22 Period of Coverage

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it will mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

2.23 Plan

"Plan" means this Premium Payment Plan and as amended from time to time.

2.24 Plan Administrator

"Plan Administrator" means the Trustees.

2.25 Plan Year

"Plan Year" means the 12-month period beginning January 1 and ending December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year will be the entire short plan year.

2.26 QMCSO

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

2.27 Salary Reduction

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and paid by the Employer to the Plan Administrator under this Plan to pay for Premium Payment Benefits before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

2.28 Spouse

"Spouse" means has the meaning under the Health Plan.

2.29 Student

"Student" means an individual who, during each of five or more calendar months during the Plan Year, is a registered full-time student in an accredited secondary school, college, university, vocational or technical school or institute educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

2.30 Union

"Union" means Local No. 292 of the International Brotherhood of Electrical Workers, AFL-CIO.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is an Eligible Employee and eligible to participate in the Plan if the individual is eligible for coverage under the Health Plan. An Eligible Employee has met the eligibility requirements of the Plan and is covered by the Health Plan will automatically become a Participant to the extent of the Employee's Premiums for such coverage unless the Employee affirmatively elects not participate in the Plan during the election period stated in Section 4.1.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan at midnight of the earliest of the following dates:

(a) the termination of this Plan; or
(b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee.

Certain Employees, however, may continue eligibility for purposes of pre-taxing COBRA coverage for certain periods on the terms and subject to the restrictions in Section 6.5 for premium payment benefits. Termination of participation in this Plan will automatically revoke the Participant's election. The benefits of the Participant under the Health Plan will terminate as of the date specified in the Health Plan.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason including, but not limited to, disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination to the extent that coverage under the Group Health Plan is reinstated. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 4.1.

3.4 FMLA Leaves of Absence

If a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Participant's group health benefits will continue to be maintained on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the cost of such coverage. An Employer may require Participants to continue all group health benefits coverage while on paid leave (if Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions will be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis). In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her group health benefits during the leave.

If Participants are required to continue group health benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment will be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's group health coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the group health benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose group health benefits or health flexible spending account coverage terminated during the leave to be reinstated in such coverage upon return from a

period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

(a) *Advanced Notice and Medical Certification*. The Plan may required you to provide advanced notice and medical certification before FMLA leave is granted. Leave may be denied if the following requirements are not satisfied.

- You must provide the Plan with 30 days advance notice of your intent to take FMLA leave when it is foreseeable; and
- The Plan may require you to provide medical certification to sup-ort a request for leave due to a serious health condition.

(b) *What to do if you would like to take an FMLA leave of absence.* To take a FMLA leave of absence, you and your Employer must meet other conditions. If you would like to take a FMLA leave of absence, or if you have any questions about the FMLA, please contact the Fund Office.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 6.4(d) will apply.

ARTICLE IV. METHOD AND TIMING OF ELECTIONS

4.1 Elections When First Eligible

An Employee who is eligible to participate in this Plan and who is covered by the Health Plan will automatically become a Participant to the extent of the Employee's Premiums for such coverage unless the Employee affirmatively elects not participate in the Plan during the election period. An Employee who first becomes eligible to participate in the Plan mid-year may elect not to participate in the Plan within thirty (30) days of the date the Employee satisfied the Eligibility Requirements of the Plan (the "election period") by submitting the prescribed form to the Plan Administrator. Any Employee who is an Eligible Employee on the Effective Date will begin participating in the Plan on the Effective Date. Any Employee who becomes an Eligible Employee subsequent to the Effective Date will begin participating in the Plan on the first day of the pay period immediately following the date the Employee satisfies the conditions for eligibility. An Eligible Employee who affirmatively elects not to participate in the Plan when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 6.4.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator will provide an Election Form/Salary Reduction Agreement to each Employer for distribution to each Eligible Employee who has elected not to participate in the Plan. The Election Form/Salary Reduction Agreement will enable the Eligible Employee to elect to participate in the Plan and to authorize the necessary Salary Reductions to pay for the Premium Payment Benefits. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or

before the last day of the Open Enrollment Period, and it will become effective on the first day of the next Plan Year. The Election Form/Salary Reduction Agreement will remain in effect until the Participant submits an affirmative election not participate during a subsequent Open Enrollment Period.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

An Eligible Employee who elects not to participate in the Plan will have elected to receive his/her full Compensation in cash.

A Participant who elects not participate in the Plan or fails to return a completed Election Form/Salary Reduction Agreement to the Plan Administrator within the time period described in Sections 4.1 and 4.2 may not elect to receive Benefits under the Plan until the earlier of (a) the next Open Enrollment Period; or (b) an event occurs that would justify a mid-year election change, as described under Section 6.4 or 6.5.

4.4 Irrevocability of Elections

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates unless an exception applies as described in Article VI.

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

Under this Premium Payment Plan a Participant's pays the Participant's share of the Contributions for coverage under the Health Plan on a pre-tax Salary Reduction basis (Premium Payment Benefits), or, if the Participant affirmatively elects not to participate in this Plan, to receive his/her full Compensation for any Plan Year in cash and to pay for his or her share of the Contributions for such coverage with after-tax deductions outside of this Plan. The applicable contribution rates for the current plan year are stated on Exhibit A to this Plan.

Pursuant to Section 1.125-1(h) of the proposed regulations, if the coverage includes coverage of a Dependent (other than the Participant's spouse) who is not also a "dependent" under Section 152 of the Code, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof (a "non-tax Dependent"), and if the Participant has elected, or is deemed to have elected, to pay his/her share of the cost of such coverage through the Plan, then the entire cost of such coverage, including the cost of the non-tax Dependent's coverage, will be paid pre-tax through the Plan. The value of the non-tax Dependent's coverage will be imputed as income to the Participant as the coverage is provided. This provision applies regardless of whether the cost of coverage is paid by salary reduction or allocation of available employer contributions. The preceding notwithstanding, if the cost of the coverage for a non-tax Dependent is paid with after-tax dollars, there will be no imputation of income.

5.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount of the Participant's share of the cost for coverage under the Health Plan established under the Collective Bargaining Agreement or a participation agreement.

5.3 The Benefits Provided Under the IBEW 292 Health Care Plan

The medical benefits will be provided by the Health Plan, not this Plan. The types and amounts of benefits, the requirements for participating in the Health Plan, and the other terms and conditions of coverage and benefits of the Health Plan are contained in the Health Plan document and no changes can be made with respect to such Health Plan under this Plan (such as mid-year changes in election) if such changes are not permitted under the Health Plan. All claims to receive benefits under the Health Plan will be subject to and governed by the terms and conditions of the Health Plan and the corresponding rules, regulations, policies, and procedures as may be amended from time to time.

An Eligible Employee's election with respect to Benefits under this Plan is irrevocable for the duration of the Period of Coverage to which it relates unless an exception as described in Article VI applies.

5.4 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for the Participant's Benefits is an amount equal to: (1) the annual Contributions for such Benefits divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon under the Collective Bargaining Agreement or Participation Agreement; or (3) an amount the Plan Administrator determines is appropriate (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election as permitted under Section 6.4, the Salary Reductions per pay period for the affected Benefits will equal: (1) the new reimbursement limit elected pursuant to Section 6.4, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an the Plan Administrator determines appropriate (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are paid by the Employer to the Plan Administrator to pay for the Participant's share of the Contributions for the Benefits and, are considered Employer contributions for the purposes of this Plan and the Code.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for Benefits under this Plan as of the date that any such coverage terminates, the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) *After-Tax Contributions for Premium Payment Benefits.* For those Participants who elect to pay their share of the cost of coverage under the Health Plan with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.5 Medical Benefits; COBRA and USERRA

To the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), will be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage will be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either: (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage will be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

ARTICLE VI. IRREVOCABILITY OF ELECTIONS; EXCEPTIONS

6.1 Irrevocability of Elections

Except as described in this Article, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. Unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan; or
- Salary Reduction amounts.

6.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 4.2, declined to be a Participant) may make a new election within 90 days of the occurrence of an event described in Section 6.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period. A Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Group Health Plan will automatically result in a corresponding election change, whether or not requested by the Participant within the period to make an election change.

(b) *Effective Date of New Election.* Elections made pursuant to this Section will be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes will be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

6.3 Change in Status Defined

A Participant may make a new election upon the occurrence of events as described in Section 6.4, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or corresponding regulations, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

6.4 Exceptions to Irrevocability Rule for All Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) *Open Enrollment Period.* A Participant may change an election during the Open Enrollment Period consistent with Section 4.2.

(b) *Termination of Employment.* A Participant's election will terminate under the Plan upon termination of employment consistent with Sections 3.2 and 3.3, as applicable.

(c*) Leaves of Absence.* A Participant may change an election under the Plan upon FMLA leave consistent with Section 3.4 and upon non-FMLA leave consistent with Section 3.5.

(d) *Change in Status.* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage. Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a requested change is because of and corresponds with a Change in Status based on prevailing IRS guidance. In addition to satisfying the general consistency requirement, a requested election change must satisfy the following specific consistency requirements, before a Participant may alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances will fail to correspond with that Change in Status. The Participant may increase his or her election to

pay for such coverage, however, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan consistent with Section 3.2). (This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage because of divorce, annulment, or legal separation).

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent becomes eligible for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) *HIPAA Special Enrollment Rights.* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or
- a new Dependent is acquired because of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents because of the acquisition of a new Spouse or Dependent child will be considered to be consistent with the special enrollment right. An election change because of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days). For purposes of this Section, the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no

longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders.* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid.* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) *Change in Cost.* For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee for the health plan coverage significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant consistent with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost; and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant consistent with prevailing IRS guidance.

(4) *Change in Coverage.* The definition of "similar coverage" under Section 6.4(h) applies also to this Section.

(5) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion and on a uniform and consistent basis will decide whether a curtailment is "significant" and whether a Loss of Coverage has occurred consistent with prevailing IRS guidance.

(i) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage. Coverage under a plan is "significantly curtailed" only if there is an overall reduction in coverage provided under the plan that constitutes reduced coverage generally.

(ii) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(iii) *Definition of Loss of Coverage.* For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of participating physicians;
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(6) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option consistent with prevailing IRS guidance.

(7) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to)

the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(8) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is because of and corresponds with a change made under the other employer plan, consistent with prevailing IRS guidance.

6.5 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits under this Plan than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE VII. RECORDKEEPING AND ADMINISTRATION

7.1 Plan Administrator

The administration of this Plan will be under the supervision of the Plan Administrator. The Plan Administrator has the principal duty to ensure that this Plan is operated consistent with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

7.2 Powers of the Plan Administrator

The Plan Administrator will have such duties and powers as it considers necessary or appropriate to discharge its duties. It will have the exclusive right to interpret the Plan and to decide all matters under the Plan, and all determinations of the Plan Administrator with respect to any matter under the Plan will be conclusive and binding on all persons. Without limiting the generality of the previous sentence, the Plan Administrator will have the following discretionary authority:

(a) To construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

7.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

7.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Trustees, may employ the services of such persons as it may determine necessary or desirable in connection with the operation of the Plan.

7.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator will not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

7.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties will be paid by the Employer.

7.7 Bonding

The Plan Administrator will be bonded to the extent required by ERISA.

7.8 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator will, to the extent that it determines administratively possible and otherwise permissible under Code § 125 or the corresponding regulations, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

7.9 General Plan Information

Name of Plan: IBEW 292 Twelve County Area Premium Payment Plan

Plan Sponsor: This Plan is sponsored and administered by a joint labor-management Board of Trustees. The Board is divided equally between Trustees selected by the Union and by Trustees appointed by Contributing Employers.

Type of Administration: The Trustees administer the Plan with the help of a salaried administrator. The salaried administrator and other personnel of the Fund office are employees of the Fund. The address of the Plan Administrator is the same as the address for the Fund Office.

The Plan is maintained under a Collective Bargaining Agreement between Local No. 292 of the International Brotherhood of Electrical Workers, AFL-CIO, and the Minneapolis Chapter of the National Electrical Contractors Association. A copy of the Collective Bargaining Agreement may be obtained by Eligible Individuals and beneficiaries upon written request to the Fund Office. A copy is also available for examination by Plan Eligible Individuals and beneficiaries at the Fund Office.

Contact Person: Jody Roe-Hardie

Plan Administrator's Address: Fringe Benefit Funds, 5100 Gamble Drive, Suite 430, St. Louis Park, MN 55416

Plan Administrator's Phone/Fax Number(s): P) 952-591-7733; F) 952-591-7728

Plan Number: 502

Plan Year: January 1 – December 31, except the initial plan year which is February 1, 2010 through December 31, 2010.

Agent for Service of Process: Jody Roe-Hardie, Fringe Benefit Funds, 5100 Gamble Drive, Suite 430, St. Louis Park, MN 55416

Source of Contributions and Plan Participation: The Plan receives employee salary reduction contributions from Employers who have entered into Collective Bargaining Agreements with any local union affiliated with the Union and are required to contribute to the Plan. The amounts of those contributions are calculated according to a formula in the relevant Collective Bargaining Agreement which specifies a particular dollar amount to be contributed for each hour of covered employment. The Plan also receives contributions from employers who have participation agreements with the Trustees to provide coverage for their Employees who are not Bargaining Unit Members. In those cases, the Trustees will determine an employer's rate of contribution when approving the participation agreement. Contributions are made monthly to the Plan and enable employees working under participation agreements to participate in the Plan.

Employees are entitled to participate in this Plan if they work under one of these Collective Bargaining Agreements or participation agreements and if their Employers make the required contributions to the Plan on their behalf.

Accumulation of Assets and Payments of Benefits:

Employer contributions and Employee Contributions are received and held in trust by the Trustees pending the payment of premiums for coverage under the Health Plan, and administrative expenses.

All benefits paid from this Plan are self-insured. An insurance carrier is not responsible for financing or administration (including payment of claims) of the Plan. Benefits payable by the Plan are limited to the Plan assets available for paying benefits.

ARTICLE VIII. GENERAL PROVISIONS

8.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Participants.

8.2 No Contract of Employment

Nothing contained in this Plan is intended to be or will be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are employed at the will of the Employer.

8.3 Non-Alienation of Benefits.

Benefits payable under this Plan will not be subject to anticipation, alienation, sale, transfer execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, for any other relative of the Participant, prior to actually being received by the person entitles to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan will be void. The Adopting Employer, Plan Administrator and/or Claims Administrator will not in any manner be made liable for, or subject to, the debts, contract, liabilities, engagement or torts of any person entitles to benefits under the Plan.

8.4 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period. Nonetheless, the Trustees may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Trustees or by any person or persons authorized by the Trustees to take such action, and any such amendment or termination will automatically apply to the Adopting Employers that are participating in this Plan.

8.5 Governing Law

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

8.6 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all corresponding regulations. This Plan will be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the applicable provisions of the Code and/or ERISA, the provisions of the Code and ERISA will be controlling, and any conflicting part, clause, or provision of this Plan will be superseded to the extent of the conflict.

8.7 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It will be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

8.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan will not be alienable by the Participant by assignment or any other method and will not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

8.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

8.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan is in any construction interpreted as being in conflict with the provisions of this Plan in this document, the provisions of this Plan will be controlling.

8.11 Severability

If a court of competent jurisdiction determines that any provision of this Plan is invalid, the remainder of the Plan will be given effect to the maximum extent possible.

8.12 Family and Medical Leave Act of 1993 ("FMLA").

This Plan will be operated and maintained in a manner consistent with FMLA, to the extent applicable.

8.13 Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

Notwithstanding any provision of this Plan to the contrary, this Plan will be operated and maintained in a manner consistent with USERRA.

8.14 Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

This Plan will be operated and maintained in a manner consistent with HIPAA, to the extent the Plan is subject to such law.

8.15 Qualified Medical Child Support Order

The Health Plan will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

EXHIBIT A