I.A.T.S.E. LOCAL NO. 99

HEALTH FUND PLAN

SUMMARY PLAN DESCRIPTION

RESTATED EFFECTIVE DATE: JANUARY 1, 2004

I.A.T.S.E. LOCAL NO. 99
HEALTH FUND PLAN

INTRODUCTION

The I.A.T.S.E. Local No. 99 established and maintains the I.A.T.S.E. Local 99 Health Fund Plan (the "Plan"). Under this program, you will be able to receive certain benefits depending on the level of contributions made by participating employers. The Plan benefits are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can participate and the laws that protect your rights.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Administrative Manager for the Plan. Information about the Administrative Manager and how to contact the Plan or the Administrative Manager is contained in the Section VI, General Information. There is a Plan document on file which you may review if you desire. **In the event of a conflict between this Summary Plan Description and the Plan document, the Plan document will control.**

I. ELIGIBILITY

1. **When Can I Become a Participant in the Plan?** Before you can become a member or a "participant" in the Plan, there are certain rules that you must satisfy. First, you must meet the "eligibility requirements." After that, the next step is to actually join the Plan on the "entry date" that we have established for all workers. You will also be required to complete certain forms before you can enroll in the Plan.

2. **What Are the Eligibility Requirements for Our Plan?** You are eligible to participate in the Plan if you work for an employer who makes a contribution to the Plan on your behalf because of a written agreement negotiated between the employer and I.A.T.S.E. Local 99. Normally, any time you are employed on a job through I.A.T.S.E. Local 99, you will be credited with an employer contribution to the Plan. You can commence to participate as of the beginning of the first month after two consecutive quarters of $100 in employer contributions to the I.A.T.S.E. Local 99 Health Trust Fund (hereafter called the "Fund") on your behalf. The Administrative Manager will notify you of your eligibility to participate in the Plan and the benefit options you have as soon as reasonably possible (usually within 15 days) after the end of the first calendar quarter in which qualifying contributions were made on your behalf. At that time the Administrative Manager will provide to you the forms needed to join the Plan. You will not be allowed to participate and receive benefits until the forms have been completed and returned to the Plan office.

3. **Are There Any Workers Who Are Not Eligible?** Yes, there are certain workers who are not eligible to join the Plan. They are:

   (a) Workers for whom sufficient contributions have not been made to the Fund.

   (b) Workers who have no account balance remaining in the Fund.

4. **When is My Entry Date?** You can join the Plan when you meet the eligibility requirements, complete an application to participate and return the application and any other required

forms to the Plan office. You participate as of the first day of the calendar quarter in which you have met the eligibility requirements and have completed the necessary forms.

5. **What Must I Do to Enroll in the Plan?** Before you can join the Plan, you must complete an application to participate in the Plan. All necessary forms are available from the Administrative Manager. Remember, before you can participate and receive benefits from the Plan you must complete the application forms and return them to the Plan office.

II. OPERATION

How Does This Plan Operate? When you work under a written bargaining agreement with a signatory employer, the employer makes a contribution in your behalf to the Fund. Depending on the level of contributions made in your behalf, you qualify for benefits at one of two levels.

Level 1 benefits consist of a medical reimbursement arrangement wherein you may submit requests for reimbursement of "Qualified Health Care Expenses." "Qualified Health Care Expenses" are health care expenses that are not otherwise paid or reimbursed from any other source and that are eligible for reimbursement under Internal Revenue Code Section 105. One of the primary requirements for reimbursement under Code Section 105 is that the expense is a deductible medical expense for income tax purposes under Code Section 213(d). You will receive reimbursement for Qualified Health Care Expenses from the Plan, but only to the extent you have had qualifying contributions made by an employer to your account in the Plan. If the employer contributions in your account have been exhausted through reimbursements or payment of other benefits, your eligibility for reimbursement will cease. A portion of your account may also be used each time a reimbursement is made to cover the Plan costs of processing and paying your claim.

Level 2 benefits allow you, in some circumstances, to use the funds in your account to purchase health benefits from the I.A.T.S.E. Local 99 Welfare Plan. To be eligible for this benefit, you must have a balance in your account equal to at least two quarters' premiums for the lowest Local 99 Plan. As of January 1, 2011, the minimum amount you would have to have in your account would be $_____. This amount will change from time to time. Under the Local 99 Plan you may receive reimbursements for health care in excess of the amount of the premiums you have paid, provided the health care services you receive are covered under that plan. Unlike Level 1, you are not guaranteed under the Plan to receive health care benefits equal to the premiums paid or the amounts in your Plan account. If you feel you would qualify and wish to purchase benefits from the Plan please contact the Health Trust Office.

III. CONTRIBUTIONS

1. **How is the Plan funded?** Local 99 enters into bargaining agreements with various employers. Under the terms of these agreements when you work for an employer, the employer makes contributions in your behalf to the Fund.

2. **How Much is Contributed on My Behalf to the Fund?** The amount of contributions to the Fund made on your behalf depends on the agreement with the employer, the type of work that you do and the amount of work you do.

3. **What Happens to Contributions Made to the Plan?** The amounts contributed to the Fund are credited to an account on your behalf. The Health Trust Office will send you a statement telling you how much has been contributed in your behalf. Your account may be used to reimburse you for Qualified Health Care Expenses as they arise during the Plan Year. Only expenses that arise after you commence participation in the Plan are eligible for reimbursement. There is a quarterly fee charge. As of January 1, 2010, that charge is $20,

which is deducted from accounts not used to purchase health coverage from the Plan. This charge may increase from time to time. If you qualify for Level 1 benefits, as explained above, you may use the amounts in your account to purchase health care benefits from the Plan.

IV. BENEFIT PAYMENTS

1. **When Will I Receive Benefit Payments?** You will be eligible to receive benefits after the first calendar quarter in which qualifying contributions are made on your behalf. You must submit information to the Plan about the health services you have used that is acceptable to the Plan in order to receive a reimbursement payment. This is explained in greater detail in Section VII, Claims Procedures.

2. **What Benefits Will I Receive?** There are two types of benefits under the Plan, reimbursement of medical expenses and payment of health insurance premiums for the Plan. Participants with a fund balance that equals or exceeds the cost of two quarters' premiums will be given the choice either to receive medical expense reimbursements up to their plan account balance or to exercise an election to participate in the Insured Plan.

   Participants who either do not have a sufficient balance to purchase coverage under the Insured Plan or who elect not to do so are eligible for reimbursement of certain medical expenses up to their account balance in the reimbursement Plan. During the course of the Plan Year, you may submit requests for reimbursement of medical expenses you have incurred. Expenses are considered "incurred" when the service is performed, not when it is paid for. The Health Trust Office will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Only expenses incurred after you participate in the Plan are eligible for reimbursement. Further, medical expenses that are reimbursable are generally only those medical expenses that are deductible under Section 213 of the Internal Revenue Code and that are not reimbursable from another source.

   If your claim for Qualified Health Care Expenses exceeds the amount in your account, the Plan will continue to provide reimbursement payments to you as additional employer contributions are made to your account until the claim is satisfied. However, if no additional employer contributions are made to your account for more than 12 months after your account is exhausted, any balance on your claim will no longer be paid from the Plan.

3. **What Happens If I Do Not Continue Employment?** If you do not continue employment during the Plan Year or if you do not submit claims for reimbursement of Qualified Health Care Expenses for an extended period, your right to benefits will be determined in the following manner:

   - To the extent you have an account balance, you will continue to receive reimbursement for medical expenses or payment of insurance premiums from the balance remaining in your account at the time you no longer continue employment.

   - If you have an account balance, but you have not submitted any claims for Qualified Health Care Expenses for 36 continuous months, your account will be forfeited to cover Plan expenses. A forfeiture will occur, if at the close of that year (the third year), you have not submitted any claims for Qualified Health Care Expenses for that year either. The amount forfeited will be the balance in your account as of the last day of the third oldest plan year prior to the current plan year.

If you are receiving health insurance from the Plan when you discontinue employment, under federal law, you, your spouse, and your dependents may be entitled to continuation of health care coverage called COBRA Continuation Coverage. The administrator of the Plan will inform you of these rights if you terminate employment and as a consequence lose health care coverage provided under the Plan. Generally, health plan continuation must be made available for a period not to exceed 18 months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Plan Administrator for more details regarding this extended coverage. However, in certain circumstances this continuation coverage may be terminated as provided by federal law, for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan, whether as an employee or otherwise (provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary), termination of our health plan, or you (or the person entitled to continued coverage) become entitled to Medicare benefits. However, if you become entitled to Medicare benefits, your dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

(a) If you would otherwise lose your Plan health insurance coverage under this Plan because of a termination of employment or reduction in hours, you may continue the Plan health insurance coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances.

(b) Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) termination of your employment (for reasons other than gross misconduct) or a reduction in your hours of employment; (3) your divorce or legal separation; or (4) you become eligible for Medicare.

(c) Your dependent children may choose continuation coverage for themselves if they lose group health coverage with the Plan for any of the following reasons: (1) death of a parent; (2) termination of your employment (for reasons other than gross misconduct) or a reduction in your hours of employment; (3) your divorce or legal separation; (4) you become eligible for Medicare; or (5) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the administrator of the Plan in the event of divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within 60 days of the event. It is our responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, or Medicare eligibility.

V. PLAN ACCOUNTING

Periodic Statements. The Administrator will provide you with a statement of your account periodically. You will receive a statement at least once during each Plan Year that shows your

account balance. It is important to read these statements carefully so you understand the balance remaining to reimburse for health benefits.

VI. GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information that you may need to know about the Plan.

1. **General Plan Information.**

I.A.T.S.E. Local No. 99 Health Fund Plan is the name of the Plan.
I.A.T.S.E. Local No. 99 sponsors the Plan and has assigned Plan Number 501 to the Plan.

The provisions of the Plan became effective on January 1, 1999, which is called the Effective Date of the Plan. The Plan has been amended and restated effective January 1, 2004. This amended Summary Plan Description incorporates all Plan amendments made to the Plan as of January 1, 2004.

Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year begins on January 1st and ends on December 31st.

2. **Sponsor Information.** The Sponsor's name, address, and identification number are:

I.A.T.S.E. Local No. 99
526 West 800 South
Salt Lake City, Utah 84101
EIN: 87-6128478

3. **Plan Administrator Information.** The name, address and business telephone number of your Plan's Administrator are:

Trustees, I.A.T.S.E Local No. 99 Health Trust Fund
Attention: Dan Hutten, Administrative Manager, or
Robert Chase, Benefits Coordinator
230 West 200 South Ste 2102
Salt Lake City, Utah 84101
Telephone: (801) 363-0815
EIN: 87-6205567

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. **Service of Legal Process.** The name and address of the Plan's agent for service of legal process is:

Dan Hutten
230 West 200 South, Ste 2102
Salt Lake City, Utah 84101

5. **Type of Administration.** The Plan is self-administered.

6. **Management of Plan Assets.** All benefits under the Plan are funded by contributions made to the I.A.T.S.E. Local 99 Health Trust Fund (the "Fund"). The Trustees of the Fund are the fiduciaries responsible under ERISA for the management of all monies contributed to the Fund.

VII. CLAIMS PROCEDURES

1. **Claims Process.** In order to obtain reimbursement for Qualified Health Care Expenses:

   (a) You must submit a properly completed claim form to the Health Trust Office, along with written evidence from an independent third party stating the Qualified Health Care Expense has been incurred. In addition to such other information as the Administrative Manager may find necessary, the claim form must include at a minimum -

      (1) the amount of the expense,

      (2) the date(s) of service, and

      (3) the name of the service provider.

   (b) You must also submit with the other required documents a signed statement in the form determined by the Administrative Manager, certifying that the expenses for which reimbursement is sought are expenses that you believe in good faith are Qualified Health Care Expenses.

   The Administrative Manager reserves the right to verify all claimed expenses before reimbursement. The Administrative Manager may refuse to reimburse any amounts that are not Qualified Health Care Expenses. All claims for reimbursement during a Plan Year must be submitted not later than 120 days following the end of the Plan Year in which the expense was incurred. Any claims submitted after that time will not be considered. The minimum claim that will be paid from the Plan is $20, unless the claim is submitted after you cease employment and only a smaller amount remains in your account.

   Initial claims for reimbursement of Qualified Health Care Expenses will be determined as soon as reasonably possible, which normally will be no later than: (1) 72 hours after the claim is submitted if it is an urgent care claim (24 hours for requests to extend previously granted benefits for a course of treatment) or sooner based upon medical circumstances; (2) 15 days after the claim is submitted for a determination of a pre-service claim (or sooner based upon medical circumstances); (3) 30 days after the claim is submitted, if the decision is on a post-service claim. (4) One 15-day extension by the Plan for reasons beyond Plan control may apply for pre-service and post-service claims.

2. **Claims Review and Appeals Process.** All claims for reimbursement of Qualified Health Care Expenses are reviewed and approved by the Administrative Manager, unless a separate claims administrator has been appointed. Information about a claim may be provided in writing or via fax (or in the case of certain urgent care claims, orally), as approved by the Administrative Manager. All benefits payable under the Plan are secondary. That is, they are payable only if not paid by any other plan or insurer or government program or agency that might pay you health benefits. Benefits under this Plan are also secondary to Medicare and Medicaid benefits.

   If your claim for Qualified Health Care Expenses is denied in whole or in part, the Administrative Manager is required to follow the Plan's review process to insure that any dispute

about the claim is settled promptly and fairly. All decisions involving claims for Qualified Health Care Expenses must be made in accordance with Plan terms. The review procedure includes the following steps:

(a) When a claim is denied, you or your authorized representative will receive a written verification of the denial, explaining the reason for the denial. The denial will include references to any Plan provisions, guidelines or the like that were relied on in denying the claim, or it will advise you how to obtain copies, free of charge, of the provisions or guidelines. If a claim denial involves a determination as to "medical necessity," "experimental treatment," or the like, the denial will include an explanation of the clinical judgment applied to the determination or will advise you how to get such an explanation free of charge. Upon your request, it will identify the name of any medical professionals consulted as part of the claims process. The denial will also indicate if there is any additional material or information needed to make the claim acceptable and the reasons why the information is necessary. In the case of an urgent care claim (as defined below) the Plan has 24 hours to request the missing information and you have 48 hours to provide it. In the case of a pre-service or post-service claim (as defined below), the Plan has 5 days or 30 days, respectively, to request the missing information and you have 45 days to provide it.

(b) Any documents created or received by the Plan during claims review or the appeals process are available to you at your request, free of charge. In the event of appeal, you are entitled to review all documents, records and other information relevant to your claim, even if those documents were not relied on by the Administrative Manager.

(c) The time limits for processing claims varies, depending upon the kind of claim submitted. Different time frames shall apply to initial and appeal decisions and to decisions on "urgent care" claims, "pre-service" claims and "post-service" claims. There are limits regarding changes due to "concurrent care decisions." An "urgent care" claim is a claim for medical care when delaying processing could seriously jeopardize life, health or the ability to regain maximum function or could result in severe pain that cannot adequately be managed without the care subject to the claim. If a physician determines that your medical condition meets these criteria, your claim will be treated as an urgent care claim. A "pre-service" claim is a request for approval of a benefit that the Plan wholly or partly conditions on approval prior to receipt of the service. A "post-service" claim is a request for the approval of a benefit that the Plan does not condition upon receipt of prior approval. "Concurrent care decisions" are decisions concerning the continuation or extension of approved benefits or services provided over time.

(d) Time periods begin when the claim is filed, even if all information is incomplete. If the period is extended because of missing information, the time period for a decision is "tolled" (extended) when the notice of extension is sent.

3. **Claim Denials.**

(a) If your claim is denied, you have up to 180 days to appeal the decision. The Plan will typically respond to an appeal request by no later than the following times: 72 hours for urgent care claims, 30 days for pre-service claims, and 60 days for post-service claims.

(b) The review on appeal will be made by Trustees who were not involved in the initial claim denial. The review on appeal will be an original review. That is, the appeal

review will not give any weight to the initial denial, and will take into account all information you have submitted whether or not it was considered in the initial denial. In deciding an appeal based wholly or partly on medical judgment (including decisions about whether a particular medical procedure or service is experimental, investigational or not medically necessary or appropriate), the Trustees normally will consult with a qualified health care professional who was not consulted in connection with the initial adverse decision. The Trustees have complete authority and discretion to determine the standard of proof required in any case and to apply and interpret the Plan document. The decision of the Trustees is final and binding.

(c) You are not required to file more than two appeals as a condition to filing a civil suit for benefits. One of these appeals may be an arbitration, however, any arbitration will be non-binding.

4. **Non-Medical Claims.** Claims under the Plan that are not claims for reimbursement of Qualified Health Care Expenses (such as claims involving coverage determination or eligibility) must be presented to the Health Trust Office. Notice of the disposition of a claim will be furnished no later than 90 days after the claim is submitted. In the event the claim is denied, the reasons for the denial will be set forth, along with references to appropriate provisions of the Plan. An explanation as to how the claim may be appealed will also be provided, as well as an explanation of the Plan's claim review procedure. The appeal, together with a written statement of the reasons why the appeal should be allowed, must be filed with the Health Trust Office no later than 60 days after receipt of the written denial. The Trustees will conduct the review of the appeal. The Trustees have complete authority and discretion to determine the standard of proof required in any case and to apply and interpret the Plan document. The decisions of the Trustees is final and binding.

The Trustees, in their sole discretion, may order a hearing and accept written and oral evidence and arguments in support of the appeal. During the appeal review period or at the hearing (upon five business days prior written notice to the Trustees) you or your representative will have an opportunity to review all documents in the possession of the Plan that are pertinent to the claim. A final decision on the claim will normally be made by the Trustees within 60 days of receipt of the appeal. However, the time for decision may be extended another 60 days under special circumstances or if a hearing is held. The Trustees' decision will be written and will include specific reasons for the Trustees' decision and specific references to pertinent Plan provisions.

5. **Limitations of Legal Actions on Claims.** No civil action with respect to a claim for benefits may be commenced, whether through litigation, arbitration or otherwise, prior to the completion of the claims and claims appeals process. Also, all civil actions are barred if not commenced before two years from the date of delivery of the final decision of the Trustees with respect to any claim.

VIII. ADDITIONAL PLAN INFORMATION

1. **Your Rights Under ERISA.** Plan participants, eligible workers and all other employees of the Employer are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that participants, eligible workers and all other employees are entitled to:

- examine without charge at the Administrator's office all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and

- obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may charge a reasonable fee for the copies.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials 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 request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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.

IX. SUMMARY

Our Plan is intended to help you provide heath care benefits to you and your family. The Plan is the result of our continuing efforts to find ways to help you get the most for the time you work. If you have any questions, please contact the Administrator.