UTILITY WORKERS' UNION OF AMERICA NATIONAL HEALTH AND WELFARE FUND

RETIREE HEALTH REIMBURSEMENT ARRANGEMENT PLAN

SUMMARY PLAN DESCRIPTION

Utility Lines Construction Services, LLC
Represented by UWUA AFL-CIO

January 1, 2023

TO ALL RETIREE PARTICIPANTS:

We are pleased to offer you coverage under the Utility Workers' Union of America National Health and Welfare Fund (Fund) Retiree Health Reimbursement Arrangement (HRA) Plan (Plan). This Summary Plan Description (SPD) booklet is intended to be an easy to understand description of your Retiree HRA Plan benefits.

Under the Plan, you and your eligible family members can be reimbursed for health care expenses that are not otherwise covered such as deductibles and coinsurance amounts. These expenses must be incurred upon or after retirement or termination of employment from Utility Line Construction Services, LLC (ULCS).

Please keep in mind that this SPD booklet is only a summary of your benefits as set forth in the Plan Document. If there is a conflict in the wording of this booklet and the Plan Document, the Plan Document will govern.

Please read this SPD carefully and keep it in a safe place. The Fund Office is available to answer your questions and offer assistance during regular office hours.

Sincerely,

Board of Trustees
Utility Workers' Union of America National Health and Welfare Fund

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SECTION 1: INTRODUCTION

The Utility Workers' Union of America National Health and Welfare Fund (Fund) Retiree Health Reimbursement Arrangement Plan (Plan) is designed to provide reimbursement of certain health care expenses to eligible Participants. Reimbursement is permitted for eligible health care expenses incurred upon or after retirement or termination of employment from Utility Lines Construction Services (ULCS).

RETIREE HRA PLAN HIGHLIGHTS

- Generally, you are eligible to participate in the HRA if you are covered by a collective bargaining agreement requiring ULCS, your employer, to contribute to the HRA plan on your behalf while you are an active employee and you have terminated your employment or retired.

- Retiree HRA reimbursements of eligible health care expenses incurred by you, your Spouse, and/or your Dependents are tax-free.

- Any balance remaining in your HRA account at the end of the year can be carried over into the next year.

- Employer contributions are/were made to your HRA account and credited with interest while you are/were an active employee (or prior to your retirement or termination of employment).

- In the event of your death, your surviving Spouse and/or Dependents *may* continue to be eligible for HRA Plan reimbursements.

- The Affordable Care Act (ACA) requires that you be able to permanently "opt-out" of the Fund's HRA at least once each year. You may opt-out of this Plan at any time. Opting-out will allow you to buy health insurance on the ACA exchanges and be eligible for an income-based premium subsidy. You may opt-in under certain circumstances.

ABOUT THIS SUMMARY

The Board of Trustees (Trustees) of the Fund has established the HRA Plan with the intention that it qualify as a medical reimbursement plan within the

meaning of Sections 105 and 106 of the Internal Revenue Code of 1986 (Code). This summary plan description (SPD) describes the benefits, terms, and conditions of the HRA Plan as it applies to you when you are eligible for participation in the Plan.

This SPD is a summary of the HRA plan and is not meant to interpret, extend, or change the HRA Plan document in any way. We encourage you to read the SPD carefully so that you understand the HRA Plan's operation and its benefits to you. However, the provisions of the HRA Plan can be determined more precisely by consulting the Plan document, which is available from the Fund Office. **In the event of any inconsistencies between this SPD and the actual provisions of the HRA Plan, the terms of the Plan document will govern.** The Board of Trustees reserves the right to amend, modify, or terminate the HRA Plan at any time.

SECTION 2: PARTICIPATION

ELIGIBILITY TO ENROLL

You will become a "Participant" when you are eligible to participate in the Retiree HRA Plan on the first day of the month after termination of employment or retirement from an employer who is required to contribute to the Plan on behalf of the bargaining unit in which you are a member.

As an active employee, a Retiree HRA account will be set up for you and any employer contributions will be credited to your account. **Upon retirement or termination of employment on or after age 55, you will be eligible to submit reimbursement claims for health care expenses incurred by you, your Spouse, and/or your Dependents**.

Normally, you will be enrolled based on information provided by your employer. If you think you are not enrolled or that the Plan has incorrect information about you, your eligible family members, contact the Fund Office. The Fund Office requires additional information about you, your Spouse and/or your Dependents. You must provide a marriage certificate, birth certificate, if applicable. Additional documentation is required in the event of a divorce.

SPOUSE ELIGIBILITY

A "Spouse" is a person to whom you are legally married.

DEPENDENT ELIGIBILITY

A "Dependent" for the purposes of this HRA Plan means any person who is your tax dependent as defined in Code Section 152. This also includes children of divorced parents where either you or your ex-Spouse have custody of the children for more than one-half of the calendar year and you work together with your ex-Spouse to provide more than one-half of the child's support for the calendar year.

Domestic partners who meet the definition of a Code Section 152 tax dependent are eligible to participate in the Plan. You must provide additional information to demonstrate tax dependent status. Contact the Fund Office for details.

Expenses incurred by a minor child who is the subject of a Qualified Medical Child Support Order (QMCSO) or a National Medical Child Support Order may be reimbursed under the Plan even if the child does not otherwise meet the definition of a "Dependent" as described above.

A "Dependent," for the purposes of this Plan, also means any child of a Participant who has not attained age twenty-seven (27) before the end of the Participant's taxable year, regardless of financial dependency upon the Participant, residency with the Participant, student status, marital status, or employment.

ELIGIBILITY FOR REIMBURSEMENT

You are eligible for HRA reimbursements if:

- you are a ULCS retired employee who is age 55 or older and ULCS was required to make contributions to the Fund on your behalf pursuant to a collective bargaining agreement or participation agreement; or
- you are a ULCS terminated employee and reach age 55 before your HRA is forfeited pursuant to the terms of the Plan.

***Note**: You will also be considered retired on the date a Social Security*

Disability Award becomes effective before you reach age 55.

As a retiree or terminated Participant, reimbursements are for eligible health care expenses incurred by you, your Spouse and/or your Dependents.

DEATH AFTER YOU RETIRE OR TERMINATE

In the event of your death your surviving Spouse will be permitted to keep your HRA account open indefinitely in three-year intervals, provided he or she keeps the account "active" by receiving at least one reimbursement during the three-year continuation period. If your surviving Spouse does not receive any reimbursements from the account, the account will be considered inactive.

An inactive account means any remaining account balance will be forfeited and your surviving Spouse's participation in the HRA Plan will be terminated. However, a surviving Spouse can extend the three-year continuation period for another three years if he or she requests the extension before the initial three-year continuation period expires.

In the event of your death, your surviving Dependents will be permitted to utilize your Plan account as described above. Dependents may be reimbursed until they no longer qualify as Dependents under the terms of the Plan.

If there is neither a surviving Spouse nor a surviving Dependent(s), your HRA account will be forfeited.

Note: If your death occurs prior to your retirement or termination of employment with ULCS -- *i.e.*, you are an active employee -- your surviving Spouse and/or Dependent(s) will be permitted to utilize your Plan account as described above.

REEMPLOYMENT AFTER PARTICIPATION

Upon reemployment with a contributing employer after you terminate or retire on or after age 55 or terminate employment and are rehired in less than three years (if before attaining age 55), your HRA balance will continue to accrue new contributions which can be used when you terminate employment with the new contributing employer. That is, your HRA account balance at the time of your reemployment plus any new contributions remitted due to your

reemployment can be used to pay for eligible medical expenses when you terminate employment again. You are ineligible to use your HRA while actively employed by a contributing employer.

SECTION 3: FEDERAL MANDATED NOTICES

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

Under MHPAEA, group health plans generally may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans to ensure that financial requirements (such as coinsurance, copayments and/or deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Your health plan may not, under Federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the mother's or the newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, no pre-authorization from your health plan or the group health insurance insurer is needed for a stay of up to forty-eight (48) hours (or ninety-six (96) hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The medical options provide benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This Federal law states that group health plans provide medical and surgical benefits for mastectomy and must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the medical plans will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance

- Prostheses and treatment of physical complications of mastectomy, including lymphedema.

Benefits will be provided as they would for any other surgical expense.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Omnibus Budget Reconciliation Act of 1993 requires that group health plans, like the Plan, recognize and comply with "Qualified Medical Child Support Orders." Below are the Plan's procedures for processing medical child support orders that are claimed to be Qualified Medical Child Support Orders.

Receipt of Order

The Fund Office shall promptly notify the Participant and each alternate recipient (i.e., a person to receive benefits according to the Order) of the Order's receipt and the Plan's procedures for determining whether a medical child support order is a Qualified Medical Child Support Order. The Fund Office shall forward a copy of the order to Fund Counsel.

Determination of Qualification

Within a reasonable period after receipt of such Order, the Fund Office, with the assistance of the Fund Counsel, shall determine whether such order is a Qualified Medical Child Support order and notify the Participant and each alternate recipient of such determination.

The procedures to determine whether medical child support orders are QMCSOs shall follow the criteria established by Section 609 of the ERISA, as amended and any applicable regulation and administration actions by agencies charged to enforce Section 609. Those criteria include:

- Inclusion of the order in a judgment order or decree made pursuant to state domestic relations law or, is made pursuant to state domestic relations law, or pursuant to a law relating to medical child support described in 42 U.S.C. 1396g-1 issued by a court of competent jurisdiction or administrative process that has the force or effect of law in the state issuing the order.

- Creation, assignment or recognition of the right of an alternate recipient to receive Fund benefits to which a Participant or a beneficiary is entitled.

- Whether the alternate recipient is a child of the Participant or a child adopted by or placed for adoption with a Participant.

- Inclusion of the name and last known mailing address of the affected Participant and the name and last known mailing address of the alternate recipient.

- Inclusion of a description of the type of coverage to be provided by the Fund or the manner in which such coverage is to be determined.

- Identification of the period for which the order applies.

- Identification of the Fund as the Plan to which the order applies.

- Certification that the order does not require the Fund to provide benefits or a form of benefits other than one provided by the Plan, provided that

the Fund shall satisfy requirements of applicable laws relating to medical child support described in 42 U.S.C. 1908.

Effect of National Medical Support Notices
The Plan shall recognize as Qualified Medical Child Support Orders "National Medical Support Notices" that comply with the provisions of applicable final regulations effective March 27, 2001.

Status of Alternate Recipients
Alternate recipients shall be deemed Plan Participants for purposes of applicable reporting and disclosure requirements and shall be treated as Plan beneficiaries for all other purposes.

Direct Payments

Payments for benefits or claims for reimbursements made by alternate recipients under qualified domestic child support orders shall be made to the alternate recipients or their legal guardians as applicable.

Notification Issues
The Fund Office shall notify an alternate recipient or the alternate recipient's legal guardian of its determination concerning a medical child support order which is claimed to be a Qualified Medical Child Support Order within a reasonable time after receipt. Alternate recipients shall be entitled to designate a representative for the receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order. The custodial parents or guardians of minor alternate recipients shall be considered their designated representatives absent an express written request of other representatives.

SECTION 4: COBRA CONTINUATION COVERAGE

If your family members experience one of the following "qualifying events" and lose eligibility for Plan coverage because of the qualifying event, your Spouse and/or your Dependents are automatically entitled to three (3) years of continuation coverage free of charge. The automatic continuation coverage provided under the Plan constitutes coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Note: Domestic partners are not eligible for continuation coverage.

The "qualifying events" include:

- Death of the Participant;
- Divorce or legal separation; or
- Loss of Dependent status.

The three-year continuation period starts on the date of the qualifying event. In no case will a qualifying event create a continuation period of more than three (3) years, even if there are multiple qualifying events within the three-year period.

Spouse and/or Dependent Continuation Coverage
In the event of divorce or legal separation, the loss of Dependent status, or the Participant's death, Spouse and/or Dependents will automatically receive a three-year continuation period. A Dependent may continue to submit eligible health care expenses to the Plan for reimbursement during the continuation period. In no event will any of these qualifying events entitle a Dependent to more than a single three-year continuation period. However, see page 4 for special rules that apply to surviving Spouses.

SECTION 5: FUNDING YOUR HRA ACCOUNT

When you become a Participant, an HRA account will be established in your name, eligible health care expenses incurred upon or after your retirement or termination of employment, (by you and your covered family members) may be reimbursed from the balance in your account at the time a claim is submitted. This section of the SPD booklet describes how your account is funded and how it is administered.

Employer Contributions
The HRA Plan is funded exclusively through contributions made by your employer in accordance with the collective bargaining agreement or participation agreement applicable to you. These contributions were made while you were an active employee (pre-retirement/termination).

Employee Contributions
Participants are not permitted to contribute to the Plan. However, you may

elect to make after-tax contributions during a period of continuation coverage Contact the Fund Office for more information.

Funding
All reimbursements payable from the Plan will be paid from the general assets of the Fund. Your account is a bookkeeping record to track on paper any contributions and investment gains credited to your account and losses debited to the account such as reimbursements, investment losses, and administrative expenses.

Below is an explanation about how income and losses are allocated to your HRA account.

Income
Each Plan Year, employer contributions were credited to your account within thirty (30) days of receipt by the Fund.

In addition, investment income earned during the Plan Year, less administrative charges assessed by the Trustees, will continue to be credited to your account during the Plan Year.

Losses
Eligible health care expenses incurred by you, your Spouse and/or your Dependents that are payable to you as reimbursements will be recorded as a loss, or debited, to your account. Losses on investments will also be debited to the account as well as administrative charges.

Account Balance after Retirement or Termination
The balance in your account will be determined on December 31 of each Plan Year. Your balance will be computed by looking at:

- the balance in your account on January 1; plus

- investment income, if any, credited to your account during the Plan Year; minus

- the benefit payments, administrative expenses, and investment losses (if any) debited to your account during the Plan Year.

Example: During 2020, Jessica's HRA account was credited with $100 in earnings and debited $393 in reimbursements and administrative expenses. On December 31, 2019, she had an account balance of $1,567. As of December 31, 2020, Jessica's account balance is $1,274 ($1,567 + $100 - $393).

Forfeitures
Amounts remaining in your account after your death, provided there is no surviving Spouse or Dependent, will be forfeited (see pages 3 and 4 for more detailed information about when participation terminates). Forfeitures will be used by the Board of Trustees to reduce Plan administrative expenses.

Any benefit payments that are unclaimed (e.g., unclaimed benefit checks) within the 12-month period after the close of the Plan Year in which the claim expense was incurred will be forfeited.

SECTION 6: LIMITED PURPOSE HRA

A Limited Purpose HRA is available to Eligible Employees who have an employer-provided Health Savings Account (HSA) and a High Deductible Health Plan (HDHP). The HDHP must satisfy the definition of IRC §223(c)(2) which requires the HDHP to satisfy the minimum deductible criteria and not exceed the maximum limitations (out-of-pocket expenses) permitted by applicable Department of Labor rules and regulations.

For purposes of this section, an Eligible Employee is an individual who:

- is covered under a HDHP on the first day of any month;
- has no other coverage except what is permitted by IRS regulations;
- is not enrolled in Medicare;
- cannot be claimed as a Dependent on someone else's tax return for the year; and
- has an accumulated balance in a Fund-sponsored HRA available for use.

To be eligible to use your Limited Purpose HRA, you cannot have "Other Health Coverage" which includes any coverage that is not an HDHP, except

you and your Spouse (if covered by family coverage) may have:

- Insurance that provides only benefits for the following:
    - Liabilities incurred under workers' compensation;
    - A specific disease or illness; or
    - A fixed amount per day (or other period) of hospitalization.
- Coverage (whether through insurance or otherwise) for:
    - Accidents;
    - Disabilities;
    - Dental Care;
    - Vision Care; and/or
    - Long Term Care.

Your Limited Purpose HRA shall only reimburse benefits listed as described below. Participation in the Limited Purpose HRA is automatic provided the HDHP is affordable and provides minimum value. The employer must notify the Fund that the Eligible Employee is a participant in the employer's HSA and HDHP. This participation becomes effective as of the first day of the coverage period in which you meet the requirements to be an Eligible Employee per this section.

You may only be reimbursed from your Limited Purpose HRA for the following medical expenses: Non-premium expenses incurred as part of Other Health Coverage, as defined above with the exception of expenses related to long-term care services. The Fund will determine in accordance with IRS guidelines, which benefits are payable from your Limited Purpose HRA.

If your employer-provided HSA is funded through a salary reduction agreement under a cafeteria plan during the coverage period, your employer shall ensure that your salary reductions are used only to fund your HSA and no employee salary reductions will be contributed (directly or indirectly) to the Fund HRA.

You cannot request reimbursement of the same medical expense from more than one plan or arrangement if you have an HSA, a health FSA and/or an HRA. This Plan requires you to exhaust your health FSA first before using

your HRA. Your Limited Purpose HRA must be used as described in this section.

Once your HRA is deemed a Limited Purpose HRA, during any portion of any coverage period, your HRA will remain a Limited Purpose HRA for the remainder of that coverage period.

All other provisions of this HRA plan apply to the Limited Purpose HRA unless specifically exempted.

SECTION 7: HRA BENEFITS

The Plan reimburses you for "eligible health care expenses," as described below.

ELIGIBLE HEALTH CARE EXPENSES

To be considered an "eligible health care expense" that qualifies for reimbursement, an expense must:

- be incurred while you are eligible for reimbursement. (***Note****: An* eligible health care expense is considered to be "incurred" on the date the medical care or service is provided rather than on the date it is billed*)*;

- be substantiated by filing a claim and providing evidence that an eligible health care expense was incurred;

- not be reimbursable from any other health plan or insurance; and

- be incurred by you, your Spouse and/or your Dependents for medical care, as defined in Code Sections 105 and 213(d).

Medical Care Expenses
In general, medical care expenses include, but are not limited to, amounts for such things as hospitalization, doctors and dentists bills, and prescription drugs. Such expenses also include amounts you pay for deductibles, copays, coinsurance, as well as premiums for group health plan coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment

with pre-tax dollars), COBRA continuation coverage, and Medicare Parts B, C, and D coverage. However, not all medical care expenses will be considered "eligible health care expenses" that qualify for reimbursement under the Plan. Generally, only medical care expenses within the meaning of Section 213(d) of the Internal Revenue Code are eligible. If you have any questions as to whether an expense is reimbursable, call the Fund Office.

Coordination of Benefits with HRA and Healthcare Flexible Spending Account (HFSA)

The Plan may only pay eligible medical expenses not previously reimbursed or for which you will not seek reimbursement from any other accident or health plan, cafeteria plan, or health insurance. If you have a HFSA, you must *first* submit any claim for reimbursement of eligible health care expenses to the flexible spending account before expenses will be reimbursed under this Plan. If any portion of your eligible health care expenses is not reimbursed after submission to your HFSA, you can submit such expenses to this Plan for reimbursement.

Excludable Expenses

Certain expenses are not reimbursable. Please see Appendix B, for a listing of reimbursable expenses and exclusions.

Carryover of Account Balance

Any unused amounts in your account at the end of a Plan Year will be carried over into the next Plan Year. If you do not incur enough expenses in a Plan Year to use up your account balance, you will not lose the unused amount credited to your account. Remember, any eligible health care expenses incurred in a previous Plan Year or in the current Plan Year can be reimbursed from the current balance in your account, even if all or part of the balance was carried over from the previous Plan Year.

Any benefit payments that are unclaimed (*e.g.*, uncashed benefit checks) within the 12-month period following the close of the Plan Year in which the health care expense was incurred will be forfeited.

SECTION 8: REIMBURSEMENT PROCEDURES

The following procedures must be followed in order to receive a reimbursement:

FILING A CLAIM FOR REIMBURSEMENT

Claims Submission
A request for reimbursement of an eligible health care expense is considered to be a claim. A claim for reimbursement of an eligible health expense must be submitted to the Fund Office within twelve (12) months of the date the expense was incurred. After twelve (12) months, the expense will no longer be eligible for reimbursement. You may include multiple medical expenses, if you wish. Contact the Fund Office to request a claim form.

Substantiation
In order to be reimbursed, you must use a claim form furnished by the Fund Office and provide receipts, bills, invoices or other statements from the medical provider.

If an expense has already been paid or reimbursed by another health plan or insurance, it will not be eligible for reimbursement from this Plan. To the extent there is any remaining, unpaid portion of an eligible health care expense that was submitted to another health plan or insurer, you may submit it to this Plan for reimbursement. ***Note***: If you participate in your employer's HFSA, you must first exhaust your annual benefits under it before this Plan will pay benefits. The claims form will require you to certify that the balance in your employer's HFSA has been exhausted.

Where to File a Claim
To file a claim for reimbursement, send your claims form to:

TIC International, Inc.
6525 Centurion Drive
Lansing, MI 48917-9275
Telephone: (517) 321-7502
Toll-Free: (800) 920-8116
Facsimile: (517) 321-7508

SECTION 9: CLAIMS AND APPEALS

CLAIMS PROCESS

Claims Decisions
Within thirty (30) days of the date you submitted your claim to the Fund

Office, you will either be reimbursed or provided with a notification that all or a part of your claim has been denied. If additional time is needed, due to matters beyond the control of the Plan, you will be informed of the extension within this thirty (30) day deadline.

If additional information is needed before your claim can be processed, you will be notified within the thirty (30) day period. You will then have up to forty-five (45) days to provide the requested information. The Plan will notify you of its decision within fifteen (15) days following the earlier of: (i) the date the information is received; or (ii) the expiration of the forty-five (45) day period for providing requested information.

Denied Claims

If your claim is denied in whole or in part, the Plan will notify you within thirty (30) days of the date the claim was submitted. The denial notice will provide:

- The specific reason(s) for the decision;
- Any references to provision(s) in the Plan on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim;
- A statement that a copy of any rule, guideline, or protocol relied upon by the Plan in denying your claim is available for your review; and
- A statement that a copy of any scientific or clinical judgment used by the Plan in denying your claim is available for your review.

INTERNAL APPEALS PROCESS

How to Appeal

You, or your authorized representative, have the right to appeal a denial of

your claim and have your claim reviewed by the Board of Trustees. An appeal must be filed with the Fund no later than one hundred eighty (180) days after the date the claim was initially denied.

Your appeal must be in writing and explain the reasons you disagree with the decision on your claim. When filing an appeal, you may:

- submit additional materials, including comments, statements, or documents in support of your appeal;

- request a review of all relevant information pertaining to your claim (free of charge);

- request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and

- request a copy of any explanation of the scientific or clinical judgment (if any) on which the denial was based.

Where to File an Appeal

Send your written appeal to:

TIC International, Inc.
UWUA HRA Appeals
6525 Centurion Drive
Lansing, MI 48917-9275

Appeals Decisions

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made by the Board of Trustees at the next Board of Trustees meeting. The Trustees will not consider or defer to the initial decision in making their determination about the appeal.

A determination will be made at the next Board of Trustees meeting and you will be notified of the appeal decision as soon as administratively feasible after the meeting.

If the Trustees' deny your appeal, you will receive a notice providing:

- the specific reason(s) for the decision;

- the reference(s) to Plan provision(s) on which the decision was based;

- a statement that you have a right to bring a civil action under Section 502(a) of ERISA; and

- a statement that you have the right to look at and/or copy (free of charge) any rule, guideline, protocol, or similar criteria, any scientific or clinical judgment, and any documents, records, or other information relevant to your claim.

SECTION 10: PRIVACY POLICY

The Plan is required to protect the confidentiality of your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. This includes HIPAA privacy rules found at 45 CFR Parts 160 and 164 and the HIPAA security rules found at 45 CFR Parts 160 and 164 as well as the Security Breach Notification procedures.

You may find a complete description of your rights under HIPAA in the Fund's Privacy Notice that describes the Fund's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- receive confidential communications of your protected health information, as applicable;

- see and copy your health information;

- receive an accounting of certain disclosures of your health information;

- amend your health information under certain circumstances; and

- file a complaint with the Fund or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice or have any questions or feel your rights have been violated, please contact the Fund's Privacy Official at the UWUA Fund, 6525 Centurion Drive, Lansing, Michigan 48917-9275, or (517) 321-7502, (800) 920-8116, by fax (517) 321-7508 or by email privacyofficer@tici.com.

SECTION 11: ADMINISTRATIVE INFORMATION

PLAN SPONSOR

The Plan is sponsored by the Board of Trustees of the Utility Workers' Union of America National Health and Welfare Fund (the Fund). The Board of Trustees consists of employer and Union representatives selected by employers and unions that have entered into collective bargaining agreements that relate to this Plan.

The Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan Participants and beneficiaries in accordance with the requirements of ERISA.

The Board of Trustees' contact information is located in Appendix A.

DISCRETION AND AUTHORITY OF BOARD OF TRUSTEES

The Board of Trustees has full discretion and authority to interpret the terms of all documents establishing this Plan, including but not limited to, the rules of eligibility. Benefits are only provided if the Trustees (or their delegate) decide, in their discretion, that the individual is entitled to them under the Plan's terms. You will receive written notice of any Plan amendments.

The Board of Trustees also decides any factual question related to eligibility for and amount of benefits. The decision of the Board of Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion.

Your coverage by this Plan does not constitute a guarantee of your continued employment or participation in this Plan and you are not vested in the benefits described in this SPD. The Trustees reserve the right to amend, modify, or terminate the Plan or any of its benefits at any time.

PLAN ADMINISTRATOR

The Board of Trustees, as Plan Administrator, has delegated administrative responsibilities to TIC International Corporation, an independent third-party administrator called the "Fund Office".

PLAN FUNDING

The Plan is funded exclusively through employer contributions and benefits are paid from the general assets of the Fund.

PARTIES TO THE COLLECTIVE BARGAINING AGREEMENT

The Plan is maintained pursuant to collective bargaining agreements and participation agreements. The collective bargaining agreements/participation agreements determine the amount of contributions and employees on whose behalf an employer is required to contribute. Participants, Spouses and Dependents may obtain, upon written request to the Fund Office, information as to the address of a particular employer and whether an employer is required to pay contributions to the Fund.

You may obtain a copy of the collective bargaining agreement under which you are covered, at a reasonable charge, upon written request to the Fund Office. You may also review these agreements, at no charge, at the Fund Office, at the principal office of each participating Union, and at employer worksites at which fifty (50) Participants customarily work.

PLAN NAME

The name of the Plan is the Utility Workers' Union of America National Health and Welfare Fund Retiree Health Reimbursement Arrangement Plan.

PLAN NUMBER

The Plan Number is 501.

PLAN SPONSOR EIN

The employer identification number of the Fund, which is the Plan Sponsor, is 20-0027580.

PLAN YEAR

The Plan Year begins on January 1 and ends on December 31.

AGENT FOR SERVICE OF LEGAL PROCESS

Lauren Crummel
Watkins, Pawlick, Calati & Prifti, P.C.
1423 E. Twelve Mile Rd
Madison Heights, Michigan 48071

PLAN TYPE

The Plan is considered a welfare benefit plan, providing reimbursement for medical care expenses under the terms of Internal Revenue Code Sections 105, 106 and 213(d).

SECTION 12: ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

As a Plan Participant, you have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);

- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Fund Office may make a reasonable charge for the copies); and

- Receive a summary of the Plan's annual financial report, which the Fund Office is required by law to provide to each Participant.

CONTINUE GROUP HEALTH PLAN COVERAGE

Also, you have the right to:

- Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan because of a qualifying event. (You, your Spouse or your Dependents may have to pay for such coverage; review this Summary Plan Description and any documents governing the Plan on the rules governing your COBRA continuation coverage rights.); and

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have Creditable

Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you:

- Lose coverage under the Plan;
- Become entitled to elect COBRA continuation coverage; or
- Lose COBRA continuation coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Fund Office to provide the materials and pay you up to one hundred ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Office.

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. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in

federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the EBSA or

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website of the EBSA at www.dol.gov/ebsa.

APPENDIX A – BOARD OF TRUSTEES

UTILITY WORKERS' UNION OF AMERICA NATIONAL HEALTH AND WELFARE FUND

EMPLOYER TRUSTEES	UNION TRUSTEES
Lee Ellis, Secretary 400 Renaissance Center, Suite 2600 Detroit, MI 48243	Patrick M. Dillon, Chairman 3534 Twin Spruce Drive Kalamazoo, MI 49004
Nathan Fisher NPL Construction 19820 North 7th Avenue, Suite 120 Phoenix, AZ 85027	Michael A. Coleman Utility Workers' Union of America AFL-CIO 1300 L Street, NW, Suite 1200 Washington, DC 20005
Tina Hayes Utility Lines Construction Services, LLC 12500 E. 10 Mile Road Warren, MI 48089	Shawn Garvey 16 Grand Avenue Lynbrook, NY 11563-1014
Nicholl Salamone American Water 1 Water Street Camden, NJ 08102	Debbie Syck P.O. Box 873 Bridgeport, WV 26330
	Michael Sallach 3607 Riverview Street Lower Burrell, PA 15068

APPENDIX B - HRA ELIGIBLE AND NON-ELIGIBLE HEALTH CARE EXPENSES

The following list identifies some of the common medical, dental and health related expenses that the **Internal Revenue Service** (IRS) considers to be deductible expenses. These expenses are eligible for reimbursement through your Retiree HRA Plan provided that you have not been reimbursed for them through any other benefit plan(s). **You must be eligible on the date of purchase/service.**

*EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES (*REIMBURSEMENT FOR CO-PAYMENTS)*

Abortion, Legal	Insurance Premiums (paid with after-tax dollars)
Acupuncture	Laboratory Fees
Alcoholism & Drug Addiction Treatments	Lead based paint removal – to prevent lead poisoning
Ambulance Services	Legal Fees – to allow treatment for mental illness
Annual Physical Examination	Lip Reading Lessons
Artificial Limbs & Teeth	Lodging for medical care
Bandages	Long Term Care
Body Scan	Meals
Birth Control Pills	Medical Information Plan
Braces	Medicare B & D
Braille books & magazines	Nurses Expenses & Board
Breast Pump & Supplies	Nursing Care
Capital Expenses – Special equipment installed in home or improvements made, if main purpose is medical care	Prepaid Insurance Premiums
Car – special medical equipment within	Operations & related treatments
Contact Lenses – including saline solution & enzyme cleaner	Orthopedic Shoes
Crutches	Over the Counter Drugs
Dental Treatment	Oxygen Equipment
Diagnostic Devices/Services	Prescribed drugs & medicine
Disabled Dependent Care Expenses	Rental of Medical Equipment

Electrolysis or Hair Removal (medically necessary)	Skilled Nursing Home – (if for medical reasons)
Eye Examination	Smoking Cessation Programs
Eyeglasses	Special Schooling for Physically or Mentally Handicapped
Eye Surgery	Sterilization
Fees for Health Club (prescribed by physician)	Telephone – for the deaf
Fees for Doctors & Hospitals **	Television Equipment – for the deaf
Fertility Enhancement	Therapy – for medical treatment
Guide Dog (and other service animals) & upkeep	Travel Costs – to obtain medical care & prescriptions (must be submitted via paper claim)
Hair Transplant (medically necessary)	Vasectomy
Health Institute – prescribed by a physician	Vitamins – that require a prescription for purchase
Hearing Aids & batteries	Weight Loss Program – physician approved
Hospital Services	Wheel Chair
HMO Health Maintenance Organization – co-pays	Wigs – to cover baldness due to medical reasons
Insulin	X-Rays

** Anesthesiologist
Chiropractor
Christian Science Practitioner
Clinic Charges
Dentist
Dermatologist
General Practitioner
Gynecologist
Internist
Midwife
Neurologist
Obstetrician
Ophthalmologist
Optometrist
Osteopath, licensed
Physical Therapist
Podiatrist
Practical Nurse
Psychiatrist
Psychoanalyst (medical care only)
Psychologist (medical care only)
Sex Therapist
Surgeon

Note: In 2020, the IRS added COVID personal protection equipment (PPE such as hand sanitizer, masks, etc.), menstrual products and over-the-counter drugs (without a prescription) to the list of eligible medical care expenses.

You can find additional information about which medical expenses are reimbursable and those costs and services that are excluded in IRS Publication 502. It contains specific examples and the information is updated annually.

EXAMPLES OF NON-ELIGIBLE HEALTH CARE EXPENSES

Babysitting, Childcare for a normal, healthy baby	Household and Domestic Help (even if prescribed by a doctor due to an Employee's or Dependent's inability to perform physical housework)
Controlled Substances – i.e. marijuana	Illegal Operations & Treatments
Cosmetic Services/Procedures (unless necessary to restore normal functioning or to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease)	Insurance Premiums (paid with pre-tax dollars; active individual policies)
Dancing or Swimming Lessons (even if they are recommended by a doctor)	Maternity Clothes
Diaper Service	Medicines & Drugs from other countries
Electrolysis, Hair Removal, Hair Transplant	Non-prescription Drugs & Medicines
Flexible Spending Account (FSA, MSA, HSA, HRA)	Nutritional Supplements
Funeral or Burial Expenses	Personal Use Items
Future Medical Care	Teeth Whitening
Health Club Dues even if the program is necessary to alleviate a specific medical condition such as obesity	Veterinary Fees
Health Coverage Tax Credit	Weight Loss Program

Any item that does not constitute "medical care" as defined under IRC §213 is a non-reimbursable health care expense.