ELECTRICAL CONSTRUCTION INDUSTRY PREFUNDING CREDIT REIMBURSEMENT PROGRAM

Summary Plan Description

2025 Edition

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PREFUNDING CREDIT REIMBURSEMENT PROGRAM

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Dear Plan Participant:

As members of the Board of Trustees of the Electrical Construction Industry Prefunding Credit Reimbursement Program (the "Plan"), we are pleased to present you with this booklet describing the Plan. Please read this booklet carefully so that you understand the Plan benefits available to you and how to receive those benefits.

This booklet constitutes a Summary Plan Description (or "SPD") and explains important aspects of the Plan, including the Plan's eligibility rules, benefits and procedures for filing a claim. We suggest that you put this booklet in a safe place for future reference. If you have any questions concerning your eligibility, Plan benefits, procedures for filing a claim or anything else related to the Plan, you may call or visit the Administration Office. The Administration Office's address and telephone number are listed in this booklet.

Sincerely,

Board of Trustees

TABLE OF CONTENTS

Page

IMPORTANT PLAN INFORMATION

The following information is provided to help you identify the Plan and the people who are involved in the Plan's operation, as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"):

Plan Name. The Plan is known as the Electrical Construction Industry Prefunding Credit Reimbursement Program.

Type of Plan. The Plan is a multiemployer group health plan maintained for the purpose of providing health premium reimbursement for Retirees who meet the eligibility requirements described in this booklet.

Board of Trustees. A Board of Trustees is responsible for the operation of the Plan. The Plan's Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Electrical Contractors Association Milwaukee Chapter, N.E.C.A., Inc. (the "Association") and the I.B.E.W. Local Union 494 ("Union") that have entered into collective bargaining agreements (or other written agreements) relating to the Plan. If you wish to contact the Board of Trustees, you may use the following address and telephone number:

Electrical Construction Industry Prefunding Credit Reimbursement Program
11001 West Plank Court, Suite 120
Wauwatosa, WI 53226
414-778-0068

The Board of Trustees is both the Plan Sponsor and Plan Administrator. As of January 1, 2025, the Trustees of the Plan are:

Employer Trustees	Union Trustees
Rick Roberts Miller Electric Company 9082 North Deerbrook Trail Brown Deer, WI 53223	John Jacobs I.B.E.W. Local Union 494 3303 South 103rd Street Milwaukee, WI 53227
Gregg Schwister Dnesco Electric, Inc. 11019 West Layton Avenue Greenfield, WI 53228	Nick Campbell I.B.E.W. Local Union 494 3303 South 103rd Street Milwaukee, WI 53227
Dajen Bohacek Electrical Contractors Association Milwaukee Chapter, N.E.C.A., Inc. 11001 West Plank Court, Suite 120 Wauwatosa, WI 53226	Steve Schobert I.B.E.W. Local Union 494 3303 South 103rd Street Milwaukee, WI 53227

The Administration Office will provide to you, upon written request, information as to whether a particular Employer is contributing to the Plan on behalf of Participants working under collective bargaining agreements (or other written agreements) and, if so, the Employer's address.

Identification Numbers. The Plan number assigned to the Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service ("IRS") is 502. The identification number assigned to the Board of Trustees by the IRS is 39-1291995.

Administration Office. The Board of Trustees has established an Administration Office through which the Plan is operated. You may contact the Administration Office at the following address and telephone number:

Electrical Construction Industry Prefunding Credit Reimbursement Program
11001 West Plank Court, Suite 120
Wauwatosa, WI 53226
414-778-0068

Personnel in the Administration Office record Employer contributions to the Plan, determine Plan eligibility, process claims for reimbursement benefits and perform other Plan administration functions.

Plan Funding. The benefits described in this booklet are financed by Employer contributions in accordance with their collective bargaining agreements (or other written agreements) which relate to the Plan. Plan Participants may examine these collective bargaining agreements and may obtain a copy of such agreements for a reasonable charge by writing to the Administration Office at the address listed above.

Trust Fund. The Board of Trustees holds all Employer contributions and other assets of the Plan in trust. Self-funded benefits and administrative expenses are paid from the Trust. At the present time, all Plan benefits are provided on a self-funded basis.

Type of Plan Administration. The Board of Trustees is the Plan Administrator. The Administration Office performs Plan administrative functions on behalf of the Board of Trustees, such as determining Plan eligibility and recording Employer contributions to the Plan. In addition, the Board of Trustees may contractually retain certain organizations to provide administrative services for the Plan.

At the present time, the Administration Office processes Plan benefits. You should send Plan benefit claims and appeals to:

Electrical Construction Industry Prefunding Credit Reimbursement Program
Board of Trustees
11001 West Plank Court, Suite 120
Wauwatosa, WI 53226
414-778-0068

Legal Process. The Administration Office is the Plan's agent for service of legal process. Accordingly, if a legal dispute arises involving the Plan, any legal documents should be served upon:

Administrative Manager
Electrical Construction Industry Prefunding Credit Reimbursement Program
11001 West Plank Court, Suite 120
Wauwatosa, WI 53226
414-778-0068

Such documents may also be served upon any of the Plan's Trustees.

Plan Year. The records of the Plan are kept separately for each Plan Year. The Plan Year begins on June 1 and ends May 31.

Additional Plan Documents. If you wish to inspect or receive copies of additional documents relating to this Plan, you should write to the Administration Office at the address listed in this booklet. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.

No Agent May Interpret the Plan. The Board of Trustees is the only party authorized to interpret and answer questions regarding the Plan and the benefits described in this booklet. An Employer, the Union, the Association and the individual Trustees are not authorized to interpret this Plan, nor can any such person act as the agent of the Board of Trustees.

If you have any questions about this Plan, your questions should be directed to the Board of Trustees through its Administration Office, at the address or telephone number listed in this booklet.

Legal Documents Control. This SPD booklet describes the benefits provided by the Plan in general terms and does not provide all the rules under which the Plan operates. If there is any inconsistency between this booklet and the legal documents governing the operation of the Plan, such as the Plan's Rules and Regulations, the legal documents will control.

Determination by Board of Trustees Binding. The Board of Trustees or, where Trustee responsibility has been delegated to others, such delegates have complete authority to apply and interpret this booklet and the Plan's Rules and Regulations and to determine the level of proof which will be required to establish eligibility for Plan benefits or coverage for incurred expenses.

All questions or controversies of whatsoever character, arising in any manner or between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of this booklet and the Plan's Rules and Regulations, or as to any writing, decision, instrument or accounting in connection with the operation of the Plan, or otherwise, must be submitted to the Board of Trustees or, where responsibility has been delegated to others by the Board of Trustees, to such delegatees for a decision. The Board of Trustees (or their delegatees, as applicable) have discretionary authority to determine if a person is entitled to benefits under the Plan. The decision of the Board of Trustees or their delegatees will be binding upon all persons dealing with the Plan or claiming any benefits under the Plan, except to the extent that such a decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matter.

No Guarantee. None of the benefits provided under this Plan are guaranteed by the Board of Trustees, any participating Employer, the Association, the Union or any other individual or entity. The Plan's benefits may be provided only from the amounts collected and available for such purposes. The Trustees reserve the right, in their sole discretion, and without notice to Employees, Employers, the Union, the Association and others affected to interpret, amend, or modify all or part of the Plan and to take any action the Board of Trustees deems desirable to preserve the financial stability of the Plan.

This is considered a retiree-only plan because only Retirees are eligible to receive Plan benefits. If you are a Retiree receiving benefits from the Plan or will become an eligible Retiree in the future, please understand that the Board of Trustees has the right to terminate the program of benefits at any time. The Board of Trustees also has the right at any time to modify the benefits provided to Retirees.

IMPORTANT INFORMATION ABOUT YOUR PLAN COVERAGE

The following information is provided to help you understand some important aspects of your Plan coverage:

Eligibility Requirements. To become eligible for the Plan's benefits described in this booklet, you must first satisfy the Plan's eligibility requirements.

Definitions. Certain words in this booklet are capitalized, such as "Employee" and "Retiree." Definitions for these capitalized words can be found either in this booklet's Definitions section or in the same section in which the word is used.

Time Limit for Submitting Claims. Claims for Plan benefits must be submitted within certain time limits. More information on how and when to file a claim for Plan benefits is provided in this booklet.

Covered Benefits. The Plan only provides reimbursement of premiums you pay for retiree Health Coverage. The Plan does not cover other health care related services. You should carefully review this booklet's description of covered Plan benefits.

If you have any questions about Plan coverage after you review this booklet, you should contact the Administration Office at the address or telephone number listed in this booklet.

Notification. It is important that you contact the Administration Office in writing at the address listed in this booklet whenever:

(a) you change your address;

(b) you enter any branch of the U.S. Armed Forces; or

(c) you return to employment.

ELIGIBILITY RULES FOR EARNING CREDIT TOWARDS PREMIUM REIMBURSEMENT BENEFITS

Initial Employee Eligibility. You are generally eligible to participate in the Plan and earn credit towards premium reimbursement benefits if your Employer is required to make contributions to the Plan on your behalf. You will be credited only with hours that your Employer reports to the Plan and for which it contributes to the Plan.

Also, if you were covered by the Inside Wiremen provisions of a collective bargaining agreement and were eligible for premium reimbursement benefits as of December 31, 2011, you remained eligible for these benefits on and after January 1, 2012, even if you had not yet begun receiving benefits.

Sound and Communication Employees, 494 Office Staff, JATC Office Staff and NECA Employees (as set forth in the "Definitions" section of this booklet) will be eligible for premium reimbursement benefits if 375 hours of contributions are made to the Plan on their behalf in any Plan Year beginning on or after June 1, 2022.

Continuation of Plan Eligibility. You will remain eligible to earn credit towards the premium reimbursement benefit as long as contributions are made to the Plan on your behalf.

Termination of Plan Eligibility. You will stop earning credit towards the premium reimbursement benefit on the first day of the calendar month following the month in which you are no longer employed by an Employer in a position for which contributions must be made to the Plan on your behalf.

If the Plan terminates, Plan coverage for you and your spouse will automatically terminate.

The Plan will not be responsible for reimbursement of any premium expenses you or your spouse incur after Plan eligibility ends, unless specifically stated otherwise.

Employees in the Armed Forces. If you enter full-time active duty with the U.S. Armed Forces, you will continue to earn credit towards the premium reimbursement benefit as usual if the service is for less than 31 days. If your period of service is greater than 30 days, you will cease earning credit as of the date you enter full-time military, naval or air service unless, upon discharge from uniformed service, you return to active employment with an Employer within the period during which reinstatement rights are guaranteed by law.

If you have any questions regarding how active duty in the U.S. Armed Forces may affect your Plan coverage, you should contact the Administration Office at the address or telephone number listed in this booklet.

PRE-FUNDING RETIREE REIMBURSEMENT PROGRAM

Upon your retirement from employment with your Employer, you may be eligible to receive reimbursement of a portion of the expenses you incur for retiree coverage through the Decatur Plan or towards the health plan coverage of your choosing as indicated below.

Eligibility. To be eligible for the reimbursement benefits, you must meet the following requirements:

(a) You were (i) covered by a collective bargaining agreement as an Inside Wireman, or you were an Employee of IBEW Local Union No. 494 and were covered by a collective bargaining agreement applicable to Inside Wiremen, or (ii) you were a Sound and Communication Employee, 494 Office Staff, JATC Office Staff or NECA Employee (as further defined on page 22 of this booklet).

(b) If you were covered by a collective bargaining agreement as an Inside Wireman or were an Employee of IBEW Local Union No. 494 and were covered by a collective bargaining agreement applicable to Inside Wiremen, you must retire from employment with an Employer after May 31, 2003.

(c) If you were a Sound and Communication Employee, 494 Office Staff, JATC Office Staff or a NECA Employee, you must retire from employment with an Employer after May 31, 2023.

(d) For Inside Wiremen, your Employer must have contributed to the Plan's retiree prefunding program on your behalf before January 1, 2012 or

contributed to the Plan on your behalf for periods of employment on or after January 1, 2012.

(e) For Sound and Communication Employees, 494 Office Staff, JATC Office Staff and NECA Employees, your Employer must have contributed to the Plan on your behalf for periods of employment on or after June 1, 2022.

(f) You have been credited with at least 7,500 hours under the Plan in the 10 years prior to your retirement.

(g) You have earned at least 10 Service Credits.

(h) You have attained age 55 or, if you have not attained age 55, you are eligible for a disability pension from the Electrical Construction Industry Pension Plan.

Prohibited Employment. In order to be eligible to receive reimbursement benefits, you cannot be employed in "prohibited employment." For purposes of this section, "prohibited employment" means you work for 40 hours or more in a month in employment or self-employment:

- in the same industry in which you were employed and eligible for benefits under the Plan when your Retiree coverage started or would have started if you had not remained in or returned to work;
- in the same "trade or craft" in which you were employed at any time while covered by the Plan or are supervising activities related to the "trade or craft"; and
- in the State of Wisconsin.

Prohibited employment does not include work as an instructor in an apprenticeship program recognized by the Trustees where contributions are not made to the Plan on behalf of the Participant, or work as an electrical inspector for a government authority where contributions are not made to the Plan on behalf of the Participant.

Amount of the Reimbursement. To determine the amount of your reimbursement benefit, your Service Credits are multiplied by the applicable Retiree Credit established by the Board of Trustees from time to time. The result is your monthly reimbursement amount. As of January 1, 2025, the Retiree Credit is $15 per year of Service Credit (not to exceed 30 years).

The monthly reimbursement amount cannot exceed the monthly premium for Health Coverage you purchase. Any excess reimbursement amount calculated but not used in a given month cannot be carried over for use in subsequent months.

Service Credit. You earn Service Credit for a Plan Year based on hours worked for which contributions are made to the Plan on your behalf by your Employer. You do not earn any Service Credit for hours you worked but for which a contribution was not made to the Plan.

Service Credit for a Plan Year is credited in accordance with the following table:

Hours Credited During a Plan Year	Service Credits
1,500 or more hours	1.0 credit
1,125 – 1,499 hours	.75 credit
750 – 1,124 hours	.50 credit
375 – 749 hours	.25 credit
0 – 374 hours	No credit

For inside wiremen, Service Credit for periods prior to June 1, 1987 shall be verified based on the records of the Electrical Construction Industry Pension Plan. Service Credit will be granted for periods of military service to the extent necessary to comply with Federal Law. Your Service Credits are fixed at the time of your initial retirement, regardless of whether you are later reemployed, except that if you retire on a disability pension under the Electrical Construction Industry Pension Plan and subsequently recover from your disability so that your disability pension ceases and then return to employment with a participating Employer for which contributions are made to this Plan on your behalf, you will be eligible to earn additional Service Credit for periods of employment after your disability pension ceased. ***The maximum number of Service Credits you can earn to calculate your monthly reimbursement amount is 30.***

Retiree Credit. The Retiree Credit is the credit established by the Board of Trustees from time to time. The Retiree Credit applicable to you is based on your age at retirement, calculated to the nearest whole age. The Retiree Credit is determined at the time of your initial retirement, regardless of whether you are later reemployed. If you retire from employment with your Employer on or after age 62, you are eligible for the full Retiree Credit established by the Board of Trustees. If you retire from employment with your Employer on or after age 55 and before age 62 with at least 10 Service Credits, you are eligible for a reduced Retiree Credit based on the following chart:

Age	Reduction Percentage
62	0
61	1%
60	2%
59	5%
58	8%
57	11%
56	14%
55	17%

Also, if you retire from employment with your Employer due to a disability and, at the time of your retirement, you receive a disability pension from the Electrical Construction Industry Pension Plan, you are eligible for the full Retiree Credit established by the Board of Trustees.

Enrollment. In order to receive the reimbursement benefits, you must notify the Plan Administrator in writing of your desire to begin receiving benefits by completing an application form. An election to receive reimbursement benefits becomes effective:

- The month following the month in which your coverage under the Decatur Plan terminates if the election is made ***on or before*** the last day of the month in which your coverage under the Decatur Plan terminates.

Example: Coverage under the Decatur Plan terminates July 31, election to receive reimbursement benefits is received by the Plan Administrator on July 15, then benefits under this Plan become effective August 1.

OR

- The month following the month in which your application is received if the election to receive reimbursement benefits is made after your coverage under the Decatur Plan terminates.

  Example: Coverage under the Decatur Plan terminates July 31, election to receive reimbursement benefits is received by the Plan Administrator on the following September 10, then benefits under this Plan become effective October 1.

Your election to receive the subsidy under this Plan is irrevocable, provided, however, in the event you return to employment with an Employer and regain your eligibility under the Decatur Plan, then you may again elect to receive the reimbursement benefit effective as of the dates outlined above when active coverage under the Decatur Plan subsequently terminates.

Use of Reimbursement Benefit. You may use the reimbursement benefit for Health Coverage for yourself and your eligible dependents. The reimbursement benefit can only be used for reimbursement of premiums or contributions to a health plan as part of Health Coverage, and cannot be used to directly pay uninsured medical or other expenses. The reimbursement benefit cannot be used to purchase stand-alone (individual) dental or vision insurance.

Impact on Eligibility for ACA Subsidy. Your eligibility for premium reimbursement benefits under the Plan may affect you if you choose to purchase health coverage through your state's health care exchange (also known as a "marketplace exchange") pursuant to the Affordable Care Act ("ACA"). As outlined above, the Plan will reimburse you for premiums you pay for retiree Health Coverage through the Decatur Plan or another health plan. Alternatively, you can choose to purchase coverage under an ACA marketplace exchange (the state exchanges established pursuant to ACA that offer health insurance to individuals). Under ACA, pre-Medicare retirees may be eligible for income-based government premium subsidies to apply towards the premium they pay for coverage under the ACA marketplace exchange. However, the ACA premium subsidy is not available to pre-Medicare retirees who have other health coverage available to them. The ACA considers the benefits you receive under this Plan to be "other health coverage" for this purpose. Therefore, you will not be eligible for an ACA premium subsidy as long as you are eligible for benefits under this Plan. If you would prefer to obtain coverage through an ACA marketplace exchange and seek a government premium subsidy under the ACA program, you would need to opt out of this Plan. A Retiree may opt out of the Plan and the benefits provided hereunder at any time by notifying the Plan in writing. A Retiree who opts out can subsequently opt back in to the Plan effective as of any January 1 following the date the Retiree submits his written request to the Plan to opt in. However, if a Retiree later opts out of the Plan a second time, that second opt out is irrevocable, and he cannot subsequently opt in to the Plan. By enrolling in the ACA marketplace exchange with an ACA premium subsidy, a Retiree will be deemed to have opted out of coverage hereunder. Please contact the Plan Office if you are interested in opting out of benefits from this Plan.

Application for Reimbursement Benefit. You must pay the applicable cost of Health Coverage to the entity providing coverage, and the Plan will reimburse you for the monthly

amount paid towards that coverage, up to the monthly reimbursement amount described above. In order to receive the reimbursement benefit, you must submit a claim form to the Plan and include any required documentation, such as a copy of the invoice from the health plan or insurer. Claims for reimbursement must be submitted by the end of the calendar year following the calendar year in which the premium expense was incurred. Claims submitted after this deadline will not be eligible for reimbursement. ***For example***, expenses incurred for premiums paid in 2024 must be submitted to the Plan for reimbursement no later than December 31, 2025.

Loss of Eligibility. Your eligibility for the retiree reimbursement benefits terminates if any of the following occurs:

(a) You have a lapse in Health Coverage that exceeds 30 days;

(b) You return to employment with an Employer and regain eligibility under a health plan based on hours worked and contributions made on your behalf; or

(c) You die.

If you die while receiving the monthly reimbursement benefit, your surviving spouse will be eligible to continue receiving the reimbursement benefit following your death for his or her life (or until he or she has a 30-day lapse in Health Coverage).

Reduction or Elimination of Retiree Reimbursement Benefit. The Trustees reserve the right to modify or rescind the benefits provided under the Plan as long as any such change is not inconsistent with the collective bargaining agreements providing for contributions to the Plan.

CLAIMS AND APPEAL PROCEDURE

The Board of Trustees has adopted procedures for processing claims and claims appeals. You may designate in writing an authorized representative to act on your behalf in filing a claim, providing requested information or pursuing an appeal of an adverse claims decision. Please contact the Administration Office at the address or telephone number listed in this booklet if you would like more information on designating an authorized representative.

The Plan's claims and appeals procedures are as follows:

Initial Decision on Benefit Claim - Time Limits. The Plan will inform the Participant of the decision on an application for reimbursement benefits within 30 days of the date the claim is filed, regardless of whether all necessary information was included with the claim. Within that 30-day period, the Participant will receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the end of the initial 30-day benefit determination period, by which the Participant can expect to receive a decision.

If, during the review, additional information is required, the Participant will be so notified within the required time period for notice of a decision detailed above. The Participant will have at least 45 days to provide such information. Following the provision of the required information, or the expiration of the time period for providing such information, the Plan will issue a written notice of the decision.

Content of Denial Notice. If the Participant's claim is partially or wholly denied, the Participant will receive a notice from the Plan:

(a) stating the specific reason(s) for the denial and providing specific reference to the pertinent Plan provision(s) on which the denial is based;

(b) describing and explaining any additional material or information required of the Participant in order to make the claim valid;

(c) explaining the Plan's appeal procedure and the Participant's right to appeal the initial decision;

(d) explaining that the initial decision will be a final decision unless the decision is appealed as described below.

(e) detailing the Participant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on an appeal; and

(f) notifying the Participant that, if a specific rule or guideline was relied upon, a copy of such rule or guidelines is available free of charge upon request.

Appeal Procedure. If a Participant does not agree with the action taken on his or her claim, the Participant has the right to appeal to the Board of Trustees, or a Committee designated by the Board of Trustees, for a further review. The procedure for appealing claims is as follows:

(a) After a Participant receives a notice denying a claim for benefit payment that the Participant believes is incorrect, the Participant should notify the Administration Office in writing of the wish to have the claim reviewed by the Board of Trustees or Committee designated by the Board of Trustees. Such notice of appeal must be filed within 180 days from receipt of written notice of denial.

(b) The request for review should include all information regarding the claim as well as the reason(s) the Participant believes the original decision was incorrect. Copies of any documents relevant to the claim will be provided to the Participant at no cost, upon request.

(c) The review by the Board of Trustees or Committee designated by the Board of Trustees will consider all comments, documents, records and other information submitted by the Participant, regardless of whether the information was submitted or considered in the initial claim review. If the decision requires medical judgment, the Board of Trustees or designated Committee will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

(d) The Board of Trustees or designated Committee will meet quarterly to render a determination on appeals of claims received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting will be decided at the next following quarterly meeting.

If special circumstances require a delay in the decision, the decision will be rendered no later than the third quarterly meeting following receipt of the appeal, and the Plan will notify the Participant of the reasons for the delay prior to any extension. The Plan will notify the Participant of the decision within five days of the date the decision is made.

(e) The Participant will receive the Board of Trustees' (or designated Committee's) decision in writing. The decision will include:

(i) the reasons for the decision;

(ii) reference to specific Plan provisions on which the decision is based;

(iii) notice if the determination is based on a medical necessity determination or experimental treatment or similar exclusion, and notice that an explanation of the scientific judgment supporting the determination is available free of charge upon request;

(iv) notice of the Participant's right to file suit against the Plan under ERISA section 502(a); and

(v) notice if a specific rule or guidance was relied upon, and notice that a copy of such rule or guidance is available without charge upon request.

Other Information. In the event a claim appeal has been denied, no lawsuit or other action against the Plan or the Board of Trustees may be filed after 180 days from the date the Participant has been given written notice of the decision on the appeal. If this time limitation is less than that required by applicable law, the limitation will be extended to agree with the minimum period permitted by applicable law.

The Board of Trustees has sole authority to make the final determination regarding any application for benefits and to interpret the Plan and any administrative rules adopted by the Board of Trustees. The Board of Trustees' (or designated Committee's) decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees or designated Committee is challenged in court, such decision is to be upheld unless it is determined to be arbitrary and capricious.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Electrical Construction Industry Prefunding Credit Reimbursement Program (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);

2. your privacy rights with respect to your PHI;

3. the Plan's duties with respect to your PHI;

4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and

5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1.
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general

administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

(1) For treatment, payment and health care operations.

(2) Enrollment information can be provided to the Trustees.

(3) Summary health information can be provided to the Trustees for the purposes designated above.

(4) When required by law.

(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(7) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other

activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2
Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the

Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf

before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;

2. a court order of appointment of the person as the conservator or guardian of the individual; or

3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3
The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted on the Plan's website, www.eciplans.com, you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;

2. uses or disclosures made to the individual;

3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;

4. uses or disclosures that are required by law; and

5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4
Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: 11001 West Plank Court, Suite 120, Wauwatosa, Wisconsin 53226.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

STATEMENT OF ERISA RIGHTS

As a Participant in the Electrical Construction Industry Prefunding Credit Reimbursement Program (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 shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Administration Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against from 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 the Plan, you should contact the Administration 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 Administration Office, you should contact the nearest office of the Employee Benefits

Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Decatur Plan. The NECA-IBEW Welfare Trust Fund, located in Decatur, Illinois.

Employee. An individual who is covered by the Inside Wireman provisions of a collective bargaining agreement, and, effective June 1, 2022:

(a) an individual covered by the Sound and Communication provisions of a collective bargaining agreement ("Sound and Communication Employees"); or

(b) an employee of IBEW Local Union 494 covered by the OPEIU collective bargaining agreement ("494 Office Staff"); or

(c) office employees of the Milwaukee Electrical Joint Apprenticeship and Training Committee ("JATC Office Staff"); or

(d) employees of the Milwaukee Chapter of the National Electrical Contractors Association ("NECA Employees")

who are eligible to participate in the Plan for purposes of earning credit towards a retiree reimbursement benefit based on the requirements outlined herein.

Employer. An employer that qualifies as an employer under the Plan's trust agreement.

Health Coverage. Any plan or program providing benefits or services for or by reason of medical or health treatment or healing under the following arrangements: franchise, blanket, or group insurance; labor-management trusteed plans, union welfare plans, employer organization health plans or employee benefit organization health plans; self-funded health and welfare plans sponsored by employers; Medicare; coverage offered through an ACA marketplace exchange; and individually underwritten policies of health insurance.

Participant. An Employee or Retiree or spouse of a Retiree.

Retiree. A former Employee of an Employer who is eligible to receive a retiree reimbursement benefit under the Plan.