SUMMARY PLAN DESCRIPTION

FOR THE

UTILITY WORKERS UNION OF AMERICA NATIONAL HEALTH AND WELFARE FUND

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

(For Employees of The East Ohio Gas Company d/b/a/ Dominion East Ohio Who Are Represented by Utility Workers Union of America Local Union G-555)

Effective January 1, 2007

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Health Reimbursement Arrangement Plan

The Utility Workers Union of America National Health and Welfare Fund Health Reimbursement Arrangement Plan (HRA Plan or Plan) is designed to provide reimbursement of certain health care expenses to eligible participants. The HRA Plan allows you to receive reimbursement of eligible health care expenses on a tax-free basis.

HRA Plan Highlights

- Generally, you are eligible to participate in the HRA if you are covered by a collective bargaining agreement requiring your employer to contribute to the HRA Plan on your behalf.

- Reimbursements of eligible health care expenses incurred by you, your spouse, and 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.

- Each year, employer contributions will be made to your HRA account and credited with interest. (See page 8 for more details.)

- If you terminate employment or become disabled, you may continue eligibility for HRA Plan reimbursements for at least three years. (See page 3 for more details.)

- In the event of your death, your surviving spouse and dependent children may continue to be eligible for HRA Plan reimbursements.

About This Summary

The Board of Trustees of the Utility Workers Union of America National Health and Welfare Fund (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 Plan Administrator. **In the event of any inconsistencies between this SPD and the actual provisions of the HRA Plan found in its Plan Document, 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.

Participation

Eligibility

You are eligible to participate in the HRA Plan if you are:

- An active employee of Dominion East Ohio who has not elected Medical Plan Option A,
- Represented by UWUA Local G555, and
- Covered by a collective bargaining agreement (or a participation agreement), accepted by the Board of Trustees of the UWUA National Health and Welfare Fund, requiring your employer to contribute to the Utility Workers Union of America National Health and Welfare Fund, and thereby to the Fund's HRA Plan on your behalf.

While you are an active employee, you will be eligible to:

- Have contributions made to your HRA account by your employer;
- Receive reimbursements for eligible health care expenses incurred by you and your dependents; and
- Receive reimbursements, under certain circumstances described elsewhere in this SPD, after you retire or otherwise terminate employment.

Enrollment

You will become eligible to participate in the HRA Plan on the first day of the month after becoming employed by an employer who is required to contribute to the HRA Plan on behalf of the bargaining unit in which you are a member.

Once enrolled, an HRA account will be set up for you and any employer contribution will be credited to your account. Thereafter, you may submit claims for health care expenses incurred by you, your spouse, and dependent children.

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 and/or your dependents, contact the Plan Administrator. The Plan Administrator may require additional information about you and/or your dependents.

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 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.

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

Termination of Employment

If your employment ends for any reason, including retirement, your participation in the Plan will not end immediately due to an automatic coverage continuation period, as explained below. This automatic three-year continuation period offered free of charge constitutes COBRA continuation coverage as described on pages 6 and 7 Employer contributions to your HRA Plan account will stop, but you can choose to contribute after-tax contributions to your HRA account during the period of continuation coverage.

Before Age 55: If your employment ends before reaching age 55 (retirement age), you will automatically be given a three year coverage continuation period starting on the day your employment ends. During this continuation period, you can spend down the balance in your HRA account.

Participation will end if you exhaust your account balance before the end of the three-year continuation period. Also, participation will end upon the expiration of the three-year continuation period and any remaining balance in your account will be forfeited if you do not reach age 55 or become reemployed by a contributing employer before the end of the three-year continuation period. Once participation terminates, no further reimbursements will be permitted.

If you attain age 55 after your employment ends but before your participation terminates, you will be considered to be retired by the Plan. When this happens, participation will be subject to the rules regarding inactive accounts described in the section below, *"On or After Age 55."*

If you have a Social Security Disability Award application pending with the Social Security Administration on the date that your three-year continuation period would otherwise expire, the continuation period will remain open until a decision is provided by Social Security on your application. Once a Social Security Disability Award becomes effective, you will be treated as if you retired on or after age 55 (see *"On or After Age 55"* below).

On or After Age 55: If your employment ends on or after you reach age 55, you will be considered retired and automatically be given a three-year continuation of coverage period starting on the day you retire. During this continuation period, you can spend down the balance in your account.

At the end of the three-year continuation period, your Plan participation will end and any remaining balance in your account will be forfeited if the account has been inactive during the three-year period. The account will be considered "inactive" if, during the three-year continuation period, you made no contributions to the account **and** claimed no reimbursements. Once participation ends, no further reimbursements will be permitted.

If you have an inactive account, you can avoid losing participation in the Plan and forfeiting your account balance if you request an extension before the expiration of the initial continuation period. You may request as many three-year extensions as you wish. Contact the Plan Administrator to request an extension. Your participation will terminate and your account balance will be forfeited if your account is inactive for three calendar years and you do not request an extension prior to the termination of your participation. The Plan will notify you at

your last provided or known address that your account is in danger of forfeiture in sufficient time to allow you to request an extension.

As long as contributions are made into the account or reimbursements are claimed from the account during the three-year continuation period, your participation will continue past the expiration of the initial continuation period and you will not experience a loss of participation or forfeiture until your account is exhausted, or if sooner, it has been inactive for three calendar years and you do not request an extension prior to termination of your participation.

> ***Example:*** Sam retired on December 31, 2007 with a balance in his HRA account. He was automatically granted a three-year continuation period starting January 1, 2008 and ending December 31, 2010. During this three-year continuation period, Sam received several reimbursements but made no contributions to further fund the account. The last reimbursement made from his account was September 30, 2009. On December 31, 2010, Sam has a balance remaining in his account. His participation will not end on December 31, 2010 because his account has not been inactive for three calendar years. If Sam makes no further claims for reimbursements and no further contributions are made to his account, his account will become inactive and be forfeited as of December 31, 2013. To avoid forfeiture, he must request in writing to the Plan an extension of the continuation period prior to December 31, 2013. The extension and the account will terminate on the later of December 31, 2016 or three calendar years following the last reimbursement or contribution. Prior to forfeiture, Sam can request additional three year extensions. Sam's participation will end earlier than the dates noted above if his account balance is exhausted and no further contributions are made to his account.

Cessation of Employer Contributions

In the event your employer stops making contributions to the Plan before you retire, you will be treated as an active participant for the purpose of using your account balance until you terminate employment, and then be subject to the rules in the "Termination of Employment" section.

Death

In the event of your death, employer contributions will end, but your surviving spouse and dependents will automatically be entitled to the three-year continuation period. This automatic three-year period of continuation constitutes COBRA continuation coverage offered free of charge to your surviving spouse and dependents. During a continuation period, your spouse and/or dependents may, but are not required to, make after-tax contributions to the HRA account. Please see the COBRA continuation of coverage provisions found on pages 6 and 7.

Upon your death, your surviving spouse will be entitled to reimbursements from your HRA account until the account reaches a zero balance or the three-year continuation period ends, whichever is earlier. In addition, your dependents may be reimbursed until they no longer qualify as dependents under the terms of the Plan (or until the balance in the account reaches zero or the three-year continuation period ends).

If your death occurs *after* you retire, 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 making at least one monthly after-tax contribution **or** receiving at least one reimbursement during the three-year continuation period. If your surviving spouse does not make any contributions to the HRA account **or** 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.

If there are no surviving dependents, your HRA account will be forfeited.

Family and Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during a 12-month period due to (1) the birth of a child or placement of a child with you for adoption, (2) the care of a seriously ill spouse, child, or parent, or (3) your own serious illness.

During your leave, you will maintain your HRA Plan coverage if you properly notify your employer and your employer continues to contribute on your behalf. You are eligible for a leave under FMLA if you:

- Have worked for a contributing employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within a 75-mile area.

The Fund will maintain your prior eligibility until the end of the leave, provided your employer properly grants the leave under the FMLA and makes the required notification and payment to the Fund.

You may be required to provide:

- 30-day advance notice of the leave if possible; and
- Medical evidence (e.g., doctor's report) supporting the need for a leave.

FMLA leave will end on the earlier of your return to work or within 12 weeks. If you do not return to work within 12 weeks of the date your leave began, you may qualify for continuation coverage (see page 6).

Military Leave

If you serve in the United States military service (active or inactive duty) for less than 31 days, your HRA Plan coverage will continue if your employer contributes on your behalf as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If your military service lasts 31 days or longer, you may continue coverage for up to three years under USERRA in accordance with the Plan's COBRA continuation of coverage rules.

COBRA Continuation Coverage

If you or your dependents experience one of the following "qualifying events" and lose eligibility for HRA Plan coverage because of the qualifying event, you (and/or your dependents) are automatically entitled to three 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).

The "qualifying events" include:

- Termination of employment before your retirement (for reasons other than gross misconduct);
- Retirement;
- Reduction in your hours of employment to fewer than the number required for your participation in the Plan;
- Entitlement to Medicare (eligibility for and enrollment in Part A and/or Part B);
- 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 years, even if there are multiple qualifying events within the three-year period. For example, if you retire and then get divorced, the divorce will not create another three-year period or otherwise extend the original three-year continuation period.

Participant Continuation Coverage Before Retirement: During the continuation period, you can spend down the balance in your HRA account.

Participation will end if you exhaust your account balance before the end of the three-year continuation period. In addition, your Plan participation will end and any remaining account balance will be forfeited if you do not retire or become reemployed by a contributing employer before the end of the three-year continuation period. If you experience a reduction in hours that causes employer contributions to cease, please see the section "Cessation of Employer Contributions" on page 4.

Participant Continuation Coverage On or After Retirement: If you retire on or after reaching age 55, you can spend down the balance in your account during the continuation period. At the end of the three-year continuation period, your Plan participation will end and any remaining balance in your account will be forfeited if the account has been inactive during the three-year period. ***Note****: You will also be considered retired on the date a Social Security Disability Award becomes effective before you reach age 55.*

The account will be considered "inactive" if, during the three-year continuation period, you made no contributions to the account **and** claimed no reimbursements. As long as contributions are made into the account or reimbursements are claimed from the account during the three-year

continuation period, your participation will continue past the expiration of the initial continuation period and you will not experience a loss of participation or forfeiture until your account is exhausted or if sooner, it has been inactive for three calendar years and you do not request an extension prior to termination of your participation.

If you have an inactive account, you can avoid losing Plan participation and forfeiture of your account balance if you request an extension of the continuation period before the expiration of three calendar years without account activity. You may request as many extensions as you wish. Contact the Plan Administrator to request an extension.

Dependent Continuation Coverage: In the event of divorce or legal separation, the loss of dependent status, or the participant's death, surviving spouses and 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, please see page 4 for special rules that apply to surviving spouses.

If a dependent loses Plan coverage due to divorce or legal separation or due to the loss of dependent status, the dependent has the option of establishing and contributing to his or her own HRA account in an amount equal to that of the participant. A separate account must be funded through the payment of monthly, after-tax contributions for the three-year continuation period, made on a monthly basis in the manner described below.

Funding of HRA Account During Continuation Period: During a continuation period, neither you nor your dependents are required to contribute to your HRA account. However, if you wish to increase the amount in your HRA account during a continuation period, you must pay a monthly premium. The monthly premium will be equal to 102% of the monthly contribution required by your employer. Failure to timely pay a premium will terminate your ability to make further contributions.

Funding Your HRA Account

When you become a participant, an HRA account will be established in your name. Eligible health care expenses incurred by you and your covered dependents 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.

Employee Contributions

Participants are not permitted to contribute to the Plan. In general, this means no pre-tax, salary reduction contributions under a cafeteria plan (e.g., flex credits) or after-tax contributions will be accepted by the Plan. However, you may elect to make after-tax contributions during a period of continuation coverage (See page 7 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.

Set forth below is an explanation about how income and losses are allocated to your HRA account.

Income: Each Plan Year, employer contributions will be credited to your account within 30 days of receipt by the Fund.

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

Losses: Eligible health care expenses incurred by you and your covered 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: The balance in your account will be determined on December 31 of each Plan Year. Your balance will be computed by looking at:

1. the balance in your account on January 1; plus

2. the amount of employer contributions and net income credited to your account during the Plan Year; minus

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

Example: During 2007, Jessica's HRA account was credited with $1,800 in employer contributions and debited $393 in reimbursements and administrative expenses. On December 31, 2006, she had an account balance of $567. As of December 31, 2007, Jessica's account balance is $1,974 ($567 + $1,800 - $393).

You are eligible to participate in the HRA Plan if you are:

- An active employee of Dominion East Ohio who has not elected Medical Plan Option A,
- Represented by UWUA Local G555, and
- Covered by a collective bargaining agreement (or a participation agreement), accepted by the Board of Trustees of the UWUA National Health and Welfare Fund, requiring your employer to contribute to the Utility Workers Union of America National Health and Welfare Fund, and thereby to the Fund's HRA Plan on your behalf.

Forfeitures: Amounts remaining in your account after participation has ended 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 for your group.

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.

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*)*; and

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

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

- Be incurred by you 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 of the Internal Revenue Code are eligible. Some Section 213 medical expenses are excluded from coverage (see "Excludable Expenses" below.) If you have any questions as to whether an expense is reimbursable, call the Plan Administrator.

Coordination of Benefits

If you have a health care flexible spending account, 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 health care flexible spending account, you can submit such expenses to this Plan for reimbursement.

Excludable Expenses

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs:

- Long-term care services.

- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary 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. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

- The salary or expense of a nurse to care for a healthy newborn at home.

- Funeral and burial expenses.

- Household and domestic help (even though recommended by a qualified physician due to a participant's or dependent's inability to perform physical housework).

- Massage therapy.

- Home or automobile improvements.

- Custodial care.

- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.

- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).

- Bottled water.

- Diaper service or diapers.

- Cosmetics, toiletries, toothpaste, etc.

- Vitamins and food supplements, even if prescribed by a physician.

- Uniforms or special clothing, such as maternity clothing.

- Automobile insurance premiums.

- Transportation expenses of any sort, including transportation expenses to receive medical care.

- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

- Any item that does not constitute "medical care" as defined under Internal Revenue Code § 213.

- Premiums 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.

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. In addition, any expenses submitted for reimbursement after your participation terminates will not be eligible for reimbursement.

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 Plan Administrator within 12 months of the date the expense was incurred. After 12 months, the expense will no longer be eligible for reimbursement.

You can only make one claim submission per calendar quarter although the submission may be for reimbursement of multiple medical expenses. Also, incurred expenses must total at least $50 before they can be submitted for reimbursement. You may include multiple eligible health care expenses to be included in a claim in order to reach the $50 minimum. The greater the number of submissions, the higher the administrative fee will be, so including multiple expenses in one submission can help control administrative costs for your group.

Substantiation: In order to be reimbursed, you must use a claim form furnished by the Plan Administrator 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 flexible spending account medical plan, 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 flexible spending account medical plan has been exhausted.

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

UWUA National Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

Telephone:	(443) 573-3634
Toll-Free Telephone:	(800) 920-8116
Facsimile:	(410) 444-0035

You may also write or call the UWUA National Health and Welfare Fund to request a claim form.

Claims Decisions: Within 30 days of the date you submitted your claim to the Plan Administrator, 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 30-day deadline. If additional information is needed before your claim can be processed, you will be notified within the 30-day period. You will then have up to 45 days to provide the requested information. The Plan will notify you of its

decision within 15 days following the earlier of: (i) the date the information is received; or (ii) the expiration of the 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 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.

You, or your authorized representative, have the right to appeal a denial of your claim and have your claim reviewed again by the Board of Trustees. An appeal must be filed with the Plan no later than 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:

UWUA National Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

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. The Trustees will not consider or defer to the initial decision in making their determination about the appeal.

A determination will be made and you will be notified of the appeal decision within 60 days of the date the Plan received your request for appeal.

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 the Employee Retirement Income Security Act of 1974 (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.

If you are not satisfied with the appeal decision after the Plan's appeals process has been exhausted, you have the right to file a civil action against the Plan in accordance with Section 502(a) of ERISA.

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.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan'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 Plan 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, please contact the Plan's Privacy Official through the Plan Administrator's Office.

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 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.

To contact the Board of Trustees, you may use the address and phone numbers below:

UWUA National Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

Telephone:	(443) 573-3634
Toll Free Telephone:	(800) 920-8116
Facsimile:	(410) 444-0035

Union Trustees

Donald Wightman
UWUA National Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

Robert Mitchell
UWUA National Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

Employer Trustees

Michael McNally
1 Westinghouse Plaza, Building D
Hyde Park, MA 02136

John Higgins
87 Ellisville Road
Plymouth, MA 02360

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 has delegated administrative responsibilities to Benefits Administration Corporation, an independent third party administrator.

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. The collective bargaining agreements determine the amount of contributions and employees on whose behalf an employer is required to contribute. Participants and dependents may obtain, upon written request to the Plan Administrator, 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 Plan Administrator. You may also review these agreements, at no charge, at the Plan Administrator's Office, at the principal office of each participating Union, and at employer worksites at which 50 participants customarily work.

Plan Name

The name of the Plan is the Utility Workers Union of America National Health and Welfare Fund 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 53-0183102.

Plan Year

The Plan Year begins on January 1 and ends on December 31. However, the Plan's initial Plan Year will begin on April 1, 2006 and end on December 31, 2006.

Agent for Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the address of the Plan Administrator. However, such documents may also be served upon any individual Trustee.

Plan Type

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

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 Plan Administrator's 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 Plan Administrator, 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 Plan Administrator may make a reasonable charge for the copies); and

- Receive a summary of the Plan's annual financial report, which the Plan Administrator 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 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.

In addition, you may request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your 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 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 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 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 Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA at:

National Office:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
Telephone: (866) 444-3272

Washington Regional Office:

Employee Benefits Security Administration
Washington District Office
1335 East-West Highway, Suite 200
Silver Spring, MD 20910
Telephone: (301) 713-2000

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

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