MEDICARE HEALTH REIMBURSEMENT ACCOUNT

INTRODUCTION

FirstEnergy Corp. has established a Health Reimbursement Account (HRA) for the benefit of its retirees, their dependents as applicable, and the retirees of its participating affiliates. The purpose of the HRA is to reimburse eligible retirees for certain medical premiums and expenses. The HRA is intended to qualify as a self-insured medical reimbursement plan for the purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (the "Code") as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

The following description of the HRA has been prepared to help you gain a better understanding of the terms and conditions of the HRA, effective January 1, 2020. Each employee's benefits and rights under the HRA are governed at all times by the official contracts with the various medical plan administrators and are in no way altered or modified by the contents of this summary.

If you have questions after reviewing this material, contact Towers Watson's Via Benefits (formerly known as Extend Health and OneExchange) or the FirstEnergy Human Resources Service Center for assistance.

GENERAL INFORMATION

For the purposes of this summary, the term "Company" means the operating companies, subsidiaries and affiliates of FirstEnergy Corp. to which the Health Reimbursement Account (HRA) provided by Via Benefits ("Via Benefits") has been extended (see section entitled "Participating Employers").

ELIGIBLE EMPLOYEES AND DEPENDENTS

Eligible Employees Company retirees are eligible to participate in the HRA if they meet all requirements of an eligible retiree who is also eligible for Medicare Part A and Part B coverage through the Centers for Medicare and Medicaid Services (CMS). In addition, the eligible surviving spouse of an employee or eligible retiree may be eligible to participate. Retirees represented by a labor union at the time of their retirement, as indicated in the section entitled "Participating Unions," may participate to the extent provided by their respective collective bargaining agreement with the Company.

Eligible Dependents Your eligible dependents, which include your legal spouse as well as other Medicare eligible dependents incapable of self-support due to a physical or mental disability, may also be eligible to participate in the HRA. If you are not certain if your spouse or dependent is eligible to participate in the HRA, contact the FirstEnergy Human Resources Service Center for assistance.

Domestic Partners Domestic Partners are eligible to participate in the HRA if the retiree and domestic partner meet the Company's eligibility requirements including the Domestic Partner Declaration. This form is available through the FirstEnergy Human Resources Service Center.

A retiree who would like his or her domestic partner to participate in the HRA must meet the following criteria and submit the appropriate documentation. Domestic partner criteria require that you and your partner must be at least age 18 and have lived together 12 months in an exclusive relationship mutually responsible for each other's welfare demonstrated by three or more of the following:

- Common ownership of real property and/or a motor vehicle;
- Driver's license with common address;
- Joint bank and/or credit accounts;
- Designation as primary beneficiary for life insurance or retirement benefits, or under a partner's will;

- Assignment of durable power of attorney or health care power of attorney.

In addition, you must not be related to each other to a degree of closeness that would prohibit legal marriage in your residence state, married to anyone else or in the relationship for the sole purpose of obtaining benefits coverage.

It is fraudulent to enroll any dependent or other person not eligible for coverage or fail to notify the Company of a change in eligibility for a covered dependent. Criminal or civil penalties can result from such acts.

Qualified Medical Child Support Orders The Consolidated Omnibus Budget Reconciliation Act of 1993 requires group health plans to recognize "qualified medical child support orders" by providing benefits for participants' children in accordance with these orders. Upon receipt of an order, the Human Resources Department will follow these procedures:

1. Promptly notify the participant and each Alternate Recipient (participant's child) that the order has been received and inform them of the procedures for determining if the order is a Qualified Medical Child Support Order (QMCSO).

   A QMCSO is one that:

   - Does not require the group health plan to provide any type or form of benefit that is not already offered;
   - Either creates or recognizes the right of an Alternate Recipient to receive benefits for which a participant is entitled under the group health plan;
   - Includes the name and address of the participant and the Alternate Recipient;
   - Includes a description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined; and
   - Specifies the period for which coverage must be provided and each plan to which it applies.

2. Review the Order to determine if it qualifies as a QMCSO. If necessary, the Order will be forwarded to the Company's Legal Department for review. The participant and any Alternate Recipient will be notified of the determination.

3. If the Order is determined to be a QMCSO, inform the Alternate Recipient that a representative (custodial parent or guardian) may be designated to receive any required notices. Also, the Order would specify to whom the Plan would make any payments or reimbursements.

4. Provide the Alternate Recipient or representative a copy of this summary plan description. Also, a supply of claim forms will be provided.

Enrollment and Date of Coverage You and your eligible dependents are eligible to participate in the HRA on the first day of the month in which you become Medicare eligible. Participants who enrolled in a plan for the 2012 plan year with Aon Hewitt Navigators ("AHNs"), and wish to remain with AHNs as their broker, will remain eligible to participate in the HRA. Participants who become Medicare eligible and enroll into a plan on or after September 1, 2012, or who were enrolled in a plan with AHNs but decided to change plans and enroll in a different plan with Via Benefits, will be eligible to participate in the HRA. You and your eligible dependents must also meet with the following requirements:

- You and/or your dependent have obtained an individual health insurance policy through AHN, or through Via Benefits (or any of its affiliates) on or after September 1, 2012, or if FirstEnergy provides satisfactory evidence to Via Benefits that you or your dependent has coverage permissible to be reimbursed from the HRA;
- You and/or your dependent have completed any enrollment forms or procedures required by FirstEnergy and Via Benefits or AHNs to be eligible to receive reimbursement from the HRA.

Annual Enrollment Open enrollment is announced and conducted in the fall each year as part of the Medicare Open Enrollment period. Via Benefits will provide information to you regarding the enrollment period. It is your annual opportunity to change your election for coverage. Changes in coverage made during the annual enrollment period are effective the following January 1. Separate enrollment elections may need to be made for both medical and prescription drug coverage.

Health Reimbursement Account (HRA) Funding FirstEnergy will fund the HRA for each eligible retiree and dependent, in an amount it determines appropriate, on January 1 of the year in which the retiree and dependent remain eligible to receive funds. Any balances in the account from a previous year will remain in the account for use in subsequent years. In situations where coverage is provided for more than one eligible participant, HRAs will be set up as a joint account for use by all eligible dependents.

Eligible Expenses Eligible expenses to be reimbursed by the HRA include the following:

- Premiums for eligible dependents for medical, prescription drug, dental, and vision coverage, which were obtained with the assistance of AHNs or Via Benefits;
- Medicare Part D premiums are eligible for reimbursement from the HRA;
- Out-of-pocket medical, prescription drug, dental and vision expenses, starting 1/1/2015.

How to receive reimbursement from the HRA To receive reimbursement from your HRA, you may need to complete a reimbursement form and mail or fax it to the Claims Submission Agent with Via Benefits.

You must complete a reimbursement/recurring reimbursement form and mail or fax it to Via Benefits along with a copy of your insurance premium bill. The written statement from the service provider must contain the following: (a) the name of the participant, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from Via Benefits. Your claim is deemed filed when it is received by the Claims Submission Agent, Via Benefits.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

If you enrolled in a plan with the assistance of Via Benefits, you may not need to submit the forms mentioned above. Ask your Via Benefits Advisor if your plan qualifies for automatic reimbursement.

Participation Ends Eligible retirees and dependents will cease being a participant for the HRA on the earlier of:

- The date you cease to be an eligible retiree or dependent for any reason;
- The date you are hired or rehired by the Company as an active employee;
- The date you cease to be eligible for Medicare;
- Your date of death;
- The effective date of any amendment terminating your eligibility; or
- The date the HRA is terminated.

You may not obtain reimbursement of any eligible premiums incurred after the respective date that your or your dependent's eligibility ceases. You have 180 days after your eligibility ceases to request reimbursement of eligible premiums you incurred before your eligibility ceased.

Remaining HRA funds at the end of the Year If you do not use all the amounts credited to your HRA during a plan year, those amounts will carry over to subsequent plan years. These funds are available each January 1 for reimbursement of eligible premiums.

Account balance upon death If the retiree or eligible dependent passes away, the funds remain in the account for the survivor. The eligibility ends and no further funds will be added to the account for the deceased. The survivor may continue to use all the funds in the account for eligible premiums. Any claims for the deceased participant must be submitted within 180 days of the date of death.

Taxes The HRA is not considered taxable income to the retiree or eligible dependents. However, the Company cannot guarantee the tax treatment of any given participant as individual circumstances may vary. If you are not sure if the HRA funds are taxable to you, consult your tax advisor.

Overpayments If it is determined that you or your eligible dependent has received an overpayment or a payment was made in error, you or your eligible dependent will be required to refund the overpayment or erroneous reimbursement to the HRA. If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or to withhold such funds from any amounts due to you from the Company.

BENEFIT CLAIMS AND APPEALS PROCEDURES The following is an outline of the procedures for the processing of a claim and summarizes the appeal of any claims determination made by the Plan Administrator or its Designee relative to the entitlement of a participant, beneficiary or other claimant to benefits offered under the Plan. The procedures defined in this document are intended to comply with the Employee Retirement Security Act of 1974 ("ERISA") and the regulations issued by the Department of Labor related to ERISA as amended effective January 1, 2002.

The Plan Administrator is FirstEnergy Service Company. It is not intended that the Plan Administrator will assume the responsibility for the initial claims determination or for the appeals process for any carrier or other benefit service provider to whom that responsibility has been given under agreement with FirstEnergy Service Company and/or its subsidiaries or affiliates. Any carrier or benefit service provider who has agreed to act as a fiduciary for the purpose of initial claims determination or for the appeals process shall be hereinafter referred to as "Designee".

Claims Process A Claim as referred to in this document is a request for a Plan benefit. Claims for benefits must be in writing, signed by the participant, beneficiary, other claimant or their authorized representative, and submitted on the appropriate form and in a manner acceptable to the Plan Administrator or its Designee. A claim for a benefit includes any claim for reimbursement.

If the Designee denies any part, or all, of the initial claim for benefits, the claimant will be notified in writing, stating the reason for the denial and the Plan provisions on which the denial is based. The claimant shall be entitled to receive, upon written request, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits. The denial will provide a description of any additional information or material necessary for the claimant to perfect the claim and an explanation as to why the additional information or material is required. The denial will further provide an explanation of the claims appeal procedure and the time limits for filing an appeal. Such notice of denial or any other notice as referred to in this procedure shall be deemed duly given when addressed to the claimant and mailed by first class mail to the address last appearing in the records of the Plan Administrator or Designee.

The claimant shall have 180 days from the date of the initial benefit determination to file an appeal. The appeal must be in writing, unless the claim involves urgent care or the Designee otherwise permits verbal appeals. The claimant will have the opportunity to submit written comments, documents or other information in support of the claim as part of the appeal. The appeal must be submitted to the Designee that made the initial claims determination, at the address, fax or phone number provided on the initial claim denial. If the Designee permits a verbal appeal, or the appeal involves urgent care, all necessary information shall be transmitted to the Designee by telephone, facsimile, or other available similarly expeditious method.

Appeals Process The Designee will review and make its decision on the appeal. The claimant shall be provided two levels of appeal. The claimant shall have 60 days to file a second appeal once they have been notified of the decision on the first level of appeal. This second level of appeal shall be sent to the same address as the first appeal.

Since two levels of appeal are provided, the Designee shall provide the claimant notice of the Plan's determination on review, with respect to any one of such two appeals, not later than 30 days after receipt by the Plan of the claimant's request for review of the adverse determination or the Plan's first determination on review.

In making its decision, the Designee will have full power and authority to interpret the Plan, to resolve ambiguities, inconsistencies and omissions, to determine any question of fact, to determine the right to benefits of, and the amount of benefits, if any, payable to the claimant in accordance with the provisions of the Plan. The Designee will not defer to the original determination but will independently review the initial claim for benefits and consider all comments, documents and other information submitted as part of the appeal in making its decision. In addition, neither the person who made the adverse determination nor that person's subordinate will participate in the decision on the appeal.

If the Designee's decision is to uphold the denial of benefits, the notification will include the reason for the denial and the Plan provisions on which the denial is based. The claimant shall be entitled to receive, upon written request, reasonable access to and copies of all documents, records and other information on which the decision was based. The decision will further provide a notice of the participant's right to appeal the decision of the Appeals Committee or Designee in accordance with ERISA and the time limits for filing an appeal.

The claimant must exhaust the above appeals process prior to any action at law, in equity, pursuant to arbitration or otherwise. The participant shall have 180 days from the date of the decision of the Appeals Committee or Designee to file an appeal action under ERISA. No legal action may be commenced against the Plan, the Plan Administrator, the Appeals Committee, or the Designee more than 180 days after the decision has been made with respect to all or any portion of the claim for benefits.

Legal Claims Any civil suit brought against the Plan, its Administrator, Sponsor or any other Plan fiduciary may only be submitted and filed in the United States District Court for the Northern District of Ohio.

CLAIMS AND APPEALS OTHER THAN FOR BENEFITS A separate claims procedure shall apply to claims regarding eligibility or participation by any eligible employee or eligible retired employee, eligibility for a dependent to be entitled to coverage or benefits, and to claims other than claims for benefits.

Any participant who wishes to file a claim for any benefit relating to the terms of eligibility or participation under the Plan, including but not limited to eligibility to participate in any benefit program or coverage option, the dependent status of an individual, eligibility to make a mid-year change in a coverage election, eligibility to pay premiums on a pre-tax or after-tax basis, the amount of any premium, or for benefits other than benefits, shall file such claim with the Administrator.

The address for filing a claim with the Administrator is:

FirstEnergy Health Reimbursement Account Plan
Attention: Plan Administrator
76 South Main Street, 7th floor
Akron, Ohio 43308

Initial Claim Decision for Claims Relating to Eligibility and Participation The Administrator shall process each properly filed claim within a reasonable time but not later than 90 days after its receipt of an application for benefits. This period may be extended by an additional 90 days if the Administrator provides the claimant with written notice of the extension within the initial 90-day period. The extension notice shall explain the reason for the extension and the date by which the Administrator expects a decision will be made. If the extension is necessary because additional information is needed to decide the claim, the extension notice shall describe the required information. The claimant should provide the required information as soon as possible.

The Administrator shall notify the claimant in writing, delivered in person or mailed by first-class mail to his or her last known address, if any part of a claim has been denied. The notice of a denial of any claim shall include: (i) the specific reasons for the denial; (ii) a reference to specific provisions of the plan document upon which the denial is based; (iii) a description of any internal rule, guidelines, protocol or similar criterion relied on in making the denial (or a statement that such internal criterion will be provided free of charge upon request); (iv) a description of any additional material or information deemed necessary by the Administrator for the claimant to perfect his or her claim and an explanation of why such material or information is necessary; and (v) an explanation of the claims review procedure under the plan.

If the notice described above is not furnished and if the claim has not been granted within the time specified above, the claim shall be deemed denied and shall be subject to review as set forth below.

Appeals of Denied Claims Relating to Eligibility and Participation If a claim is denied, in whole or in part, the claimant may request that the Appeals Committee review his or her claim. A claimant shall

have 60 days in which to request a review. Such request shall be in writing and delivered to the Appeals Committee. The address for the Appeals Committee is:

FirstEnergy Corp. Employee Benefit Claims and Appeals Committee
76 South Main Street, 7th floor
Akron, Ohio 43308

If no such review is requested, the decision of the Administrator shall be considered final and binding.

A request for review must specify the claimant's reason(s) for requesting that the denial be reversed. The claimant may submit additional written comments, documents, records, and other information relating to and in support of his or her claim; all information submitted shall be reviewed whether or not it was available for the initial review. A claimant may request reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits. If a review is requested, a full and fair review of the decision will be made by a person different than, and who is not a subordinate of, the original decision maker.

The Appeals Committee shall render its final decision within a reasonable period of time but not later than 60 days from its receipt of a request for review. This period may be extended up to an additional 60 days, if the Appeals Committee determines that special circumstances exist (such as the need for a hearing) which require an extension of time for processing the review. The Appeals Committee shall provide the claimant with written notice of the extension within the initial 60-day period. The extension notice will explain the reason for the extension and the date by which the Appeals Committee expects a decision will be made. If the extension is necessary because additional information is needed, the extension notice will describe the required information. The claimant should provide the required information as soon as possible.

If after review the claim continues to be denied, the Appeals Committee shall provide the claimant with a notice of the denial of his or her appeal which shall contain the following information: (i) the specific reasons for the denial of the appeal; (ii) a reference to the specific provisions of the plan document on which the denial was based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits; (iv) a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the denial (or a statement that such information would be provided free of charge upon request); and (v) a statement describing his or her right to bring a civil suit under Federal law no later than 180 days after receipt of the denial and a statement concerning any other voluntary alternative dispute resolution options that may be available.

Legal Claims Any civil suit brought against the Plan, its Administrator, Sponsor or any other Plan fiduciary may only be submitted and filed in the United States District Court for the Northern District of Ohio.

HIPAA PRIVACY NOTICE The Plan will only disclose Protected Health Information (PHI) to the Employer in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan agrees not to use or further disclose PHI other than as permitted in its privacy notice or as required by law.

The Plan will train any employees who have access to PHI regarding the requirements of HIPAA. The Plan ensures that any of its business agents that receive PHI from the Plan agree to the same restrictions and conditions. PHI will not be used or disclosed for employment-related actions or in connection with any other benefit or employee benefit plan.

Access to and use of PHI by Human Resources personnel shall be restricted to plan administration functions performed for the Plan. Such access or use shall be permitted only to the extent necessary to perform the duties of the Plan.

Seeking assistance from Human Resources The Plan will attempt to limit PHI received from participants or beneficiaries by encouraging participants and beneficiaries to directly contact the provider who administers benefits payable by the applicable health and welfare plan. However, in the event that the Company receives PHI, the following procedures will be in effect to protect the privacy of that information.

The Company will designate specific Human Resources representatives to have access to PHI at each Company location. To the extent possible, only the designated Human Resources representative and members of the Benefits section of the Human Resources Department will have access to PHI. Under HIPAA regulations, designated Human Resources representatives or members of the Benefits section of Human Resources will not be permitted to disclose PHI to a health care provider unless authorized in writing by the participant/beneficiary or his or her authorized personal representative.

LEGISLATIVE CHANGES

The FirstEnergy Health Reimbursement Account Plan is compliant with the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Questions regarding which changes apply to the plan should be directed to the plan administrator: FirstEnergy Health Reimbursement Account Plan, 76 South Main Street, Akron, OH 44308, Attn: Plan Administrator.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

OTHER FACTS AND INFORMATION

Benefit Rights This summary describes the current level of benefits for retirees and eligible dependents. The decision to offer funding for benefits are based on management decision or with respect to some bargaining unit employees, upon the agreements reached between the Company and the unions. Retirement health care benefits and/or the funding for those benefits are not vested. Company contributions for medical benefits and the contributions required for coverage including retiree health care benefits and may be amended or terminated at any time by the Chief Executive Officer of FirstEnergy Corp. or his or her appointed designee. The Company has determined that it will not provide any funding for most HRA accounts after December 31, 2014.

Source Of Benefits The complete terms of the Plan are set forth in this summary plan description and as administered under the terms of the Administrative Services Agreement by a third party Administrator. The extent of the funding for each individual is determined at all times by the Company. The administrator determines the benefits for which an individual qualifies under the Plan. All payments are based upon that determination.

VEBA The Company has established trusts to pre-fund a portion of its post-retirement medical liability for current and some future retirees. These trusts are called a Voluntary Employee Benefit Associations (VEBAs) and will be operated to receive favorable tax treatment under Section 501(c)(9) of the Code. The VEBAs are as follows:

- Ohio Edison Company Postretirement Health Benefits Trust for Management and Non-represented Employees.
- Ohio Edison Company Postretirement Health Benefits Trust for Represented Employees.
- Trust Agreement for GPU Companies Health Care Plan for Non-bargaining Retirees.
- Trust Agreement for GPU Companies Health Care Plan for Employees Represented by IBEW System U-3.
- Trust Agreement for GPU Companies Health Care Plan for Employees Represented by IBEW Local 777.
- Trust Agreement for GPU Companies Health Care Plan for Employees Represented by IBEW Local 459 and UWUA Local 180.
- Trust Agreement for GPU Companies Health Care Plan for Non-bargaining Employees.
- Trust Agreement for Allegheny Power System Benefit Fund– Medical (APEF1707502, APEF1707432, APEF1707422, and APEF1710422) for all non-bargaining and pre-1/1/1993 retirees except for Local 102.
- Trust Agreement for Monongahela Power Company – Medical (APRF1745692) for all pre-1/1/1993 retirees for Local 2357 and 162.
- Trust Agreement for Potomac Edison Company – Medical (APRF1745702) for pre-1/1/1993 retirees of Local 307, 771 and 331.
- Trust Agreement for West Penn Power Company – Medical (APRF1745742) for all pre-1/1/1993 retirees of Local 102.

Trust assets are used to pay health benefits for active and retired employees, and the administrative costs of the trust and Plan. The amount of funding, timing of contributions, details of administration, and funding policy will be determined by the Plan Sponsor.

The creation, administration, and funding of these trusts does not preclude the Plan Sponsor from amending, modifying, or terminating the health care benefits at any time. Post-retirement medical benefits are not vested.

Participant's Rights As a participant in the Plan you are entitled to:

- Examine, without charge, at the Plan Administrator's office and plant or regional human resources offices, a copy of the Plan, the latest annual report and the Plan description;

- Obtain copies of Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies;

- Receive a summary of the Plan's annual financial report; and

- Expect that the people who operate your Plan, called "fiduciaries" of the Plan, will do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one — 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 Plan benefit or exercising your rights under ERISA. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials and do not receive them for 30 days, you may file suit in a federal court. If you have a claim for benefits which is denied or ignored, in whole or in part, 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 for asserting your rights, you may

seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you are successful, the court may order the person you have sued to pay court costs and legal fees; if you lose, the court may order you to pay these costs and fees.

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, you should contact the nearest area office of the Employee Benefits Administration 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, D.C. 20210.

Plan is Not an Employment Contract The Plan shall not be deemed to constitute a contract between the participating employer and any employee. Nothing herein contained shall be deemed to give any employee any right to be retained in the employ of the participating employer nor to interfere with the right of the participating employer to discharge any employee at any time and to treat the employee without regard to the effect which such treatment might have upon the employee as a participant in the Plan.

Right to Amend Plan The Plan may be amended or terminated by the Chief Executive Officer of FirstEnergy Corp. or his or her appointed designee at any time or, for employees represented by a labor union, in accordance with the applicable collective bargaining agreements.

Administration The Plan Administrator has the authority to control and manage the operation and administration of the Plan with benefits provided in accordance with the provisions of the group policy issued by the insurance company. Inquiries should be made to the Plan Administrator:

FirstEnergy Service Company
76 South Main Street, 7th floor
Akron, OH 43308
1-800-543-4654

Plan Sponsor FirstEnergy Corp. is the Plan Sponsor for the Plan

General inquiries about the Plan may also be directed to the administrators that have contracted with FirstEnergy Service Company to process claims. Any questions about benefit coverage, or the processing of a claim should be directed to Member Services for the administrator you have elected for coverage at the address or telephone number below.

Via Benefits
10975 South Sterling View Drive
Suite A-1 South
Jordan, UT 84905
855-535-7156
.my.viabenefits.com/firstenergy

Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims	Via Benefits P.O. Box 3039 Omaha, NE 68103-3039

Submission Agent. Forms should not be mailed to the Plan Sponsor.	Fax: (402) 231-4310

Type of Plan
The Plan is a welfare benefit plan.

Plan Number
501

Agent for Service of Legal Process
CT Corporation System
400 Easton Commons Way
Suite 125
Columbus, OH 43219

Fiscal Year
The last day of the Plan's fiscal year is December 31.

PARTICIPATING EMPLOYERS AND IDENTIFICATION NUMBERS

FirstEnergy Service Company
EIN 34-1968288

Ohio Edison Company
EIN 34-0437786

Pennsylvania Power Company
EIN 25-0718810

The Cleveland Electric Illuminating Company
EIN 34-0150020

The Toledo Edison Company
EIN 34-4375005

Jersey Central Power & Light Company
EIN 21-0485010

Metropolitan Edison Company
EIN 23-0870160

Pennsylvania Electric Company
EIN 25-0718085

American Transmission Systems, Incorporated
EIN 34-1882848

The Potomac Edison Company
EIN 13-5323955

Monongahela Power Company
EIN 13-5229392

West Penn Power Company
EIN 13-5480882

Additions or deletions to the list of Participating Employers may be made at any time at the sole discretion of the Program Sponsor. An up-to-date listing of Participating Employers may be obtained from the Plan Administrator.

PARTICIPATING UNIONS

Participating Unions in accordance with the labor agreement between The Toledo Edison Company and:

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 245

Participating Unions in accordance with the labor agreement between Metropolitan Edison Company and:

International Brotherhood of Electrical Workers A.F.L.-C.I.O
Local Union No. 777

Participating Unions in accordance with the labor agreement between Ohio Edison Company and:

International Brotherhood of Electrical Workers A.F.L.-C.I.O
Local Union No. 1194

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union Nos. 118/126

Participating Unions in accordance with the labor agreement between Jersey Central Power and Light Company and:

International Brotherhood of Electrical Workers A.F.L.-C.I.O
Local Union No. 1289

Participating Unions in accordance with the labor agreement between The Toledo Edison Company, FirstEnergy Service Companyand:

Office & Professional Employees International Union, A.F.L.-C.I.O.
Local Union No. 19

Participating Unions in accordance with the labor agreement between Pennsylvania Power Company and:

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union No. 140

Participating Unions in accordance with the labor agreement between Pennsylvania Electric Company and:

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union No. 180

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 459

Participating Unions in accordance with the labor agreement between The Cleveland Electric Illuminating Companyand:

Utility Workers Union of America, A.F.L.-C.I.O.
Local Union No. 270

Participating Unions in accordance with the labor agreement between Monongahela Power Company and:

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 2357

Participating Unions in accordance with the labor agreement between Allegheny Energy Service Corporation on behalf of Allegheny Energy Supply, LLC and the Potomac Edison Company and West Penn Power Company doing business as Allegheny Energy:

International Brotherhood of Electrical Workers, A.F.L.-C.I.O
Local Union No. 50

Participating Unions in accordance with the labor agreement between Metropolitan Edison Company and:

International Brotherhood of Electrical Workers, A.F.L.-C.I.O.
Local Union No. 777S – Reading Call Center

Participating Unions in accordance with the labor agreements between Monongahela Power Company:

Utility Workers Union of America, A.F.L.-C.I.O
Local Union No. 304