HEAT AND FROST INSULATORS

AND

ASBESTOS WORKERS

HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

For Eligible Active Maintenance Employees

and their Eligible Dependents

Revised January 1, 2023

Attention: If you are classified as a Local 5 Pre-Apprentice, Ship Yard Worker or Maintenance Worker, you are eligible for benefits under this Plan. Pre-Apprentice, Ship Yard Worker Class 2 and 3a, and Maintenance Workers 1 and 2a who work less than 3,000 hours are eligible for Trust provided single coverage only. Self-payment is available for Dependent coverage in these classifications. Maintenance Workers who work more than 3,000 hours are eligible for Trust provided Dependent coverage at no additional cost. The following classifications also have Dependent coverage at no additional cost: Ship Yard Worker Class 3b and 4, Ship Yard Worker- Craftsmanship & Lead, Ship Yard Worker- SR Craftsman Lead, and Maintenance Mechanic. Please contact the Administrative Office at (800) 433-6692 if you have any questions regarding your benefits or to find out how to add your Dependents if you want to self-pay for their coverage.

HEAT AND FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE TRUST FUND
MAINTENANCE EMPLOYEES

Administrative Office
BeneSys Administrators
1050 Lakes Drive, Suite 120 West Covina, CA 91790
Telephone (800) 433-6692

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Michael Curtin
Ernie A. Martinez (Alternate)
Craig Skeie

Union Trustees
Michael Patterson, Chairman
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Encino, CA 91436
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HEAT AND FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE TRUST FUND

To Active Maintenance Employees:

We are pleased to provide you with this new booklet that describes the Fund benefits available to eligible active Maintenance Employees and their eligible dependents. This booklet constitutes your Summary Plan Description ("SPD") and Plan Document, and includes important information to help you understand and appropriately assess your benefits. For a schedule or any additional information on your other Plan benefits under any insured plans, please refer to the appropriate HMO or Evidence of Coverage insurance booklet for the current Plan year.

Review this booklet carefully for information regarding eligibility for Fund benefits.

The life insurance, accidental death and dismemberment benefit and smoking cessation program benefits described in this booklet apply to all eligible Maintenance Employees.

Descriptions of the prepaid medical and dental plans offered by the Fund are described in separate brochures. A description of the vision plan is contained in a separate brochure available from the Administrative Office.

The nature and extent of benefits provided by the Plan and the rules governing eligibility are determined solely and exclusively by the Board of Trustees. The Board of Trustees shall also have full and sole discretion and authority to interpret the terms of the Plan and decide any factual questions related to eligibility for and the extent of benefits provided under the Plan. Such interpretations and factual findings are final and binding on the participant, their dependents and providers.

If you have any questions, please call the Administrative Office at the telephone numbers or address provided in this booklet. Under the authority granted to the Board of Trustees under the Plan, the Board of Trustees has delegated routine administrative duties under the Plan to BeneSys Administrators. The staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

Este folleto está escrito en Inglés. Si tiene alguna dificultad para entender esta descripción resumida del plan, póngase en contacto con la oficina administrativa.

IMPORTANT INFORMATION

This SPD and Plan Document provides a description of the benefits provided under this Plan. The benefits provided are governed by this SPD and Plan Document, the Trust Agreement and the contracts or service agreements from various providers.

Authorized Source of Information
Questions regarding eligibility, benefits or other matters should be submitted to the Administrative Office. The Administrator is BeneSys Administrators located at 1050 Lakes Drive, Suite 120, West Covina, CA 91790. Only the **written statements** of the Administrator and his authorized agents and legal representatives provide authorized information. Oral statements or the statements of other representatives are not authoritative sources of information.

Benefit Changes and Plan Termination
The benefits available to you under this Plan have been adopted by the Trustees based on the best information available as to the cost of benefits and the anticipated contributions under the Collective Bargaining Agreements between the Union and the Employers.

The Trustees have the right in their sole and absolute discretion to change or eliminate any or all of the benefits under the Plan, to interpret the terms of the Plan, to determine or change the eligibility rules, maximum benefits, deductible, self-payment rates, any/or all terms of the Plan and to resolve any ambiguities in the Plan. Notice of any change(s) will be provided to you within sixty (60) days prior to the effective date of the change, when required by law.

The Trustees in their sole and absolute discretion may terminate any or all of the benefits provided or require a self-payment for such benefits. The Union and the Employers may also terminate the Trust through collective bargaining. If the Trust is terminated, all benefits will cease after the assets of the Trust have been disbursed.

FEDERAL REQUIREMENTS FOR BENEFITS

Newborns' and Mothers' Health Protection Act

Special Rights Upon Childbirth
Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans may not, under federal law, require that the provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

Special Rights Concerning Mastectomy Coverage
Under Federal law, group health plans that provide coverage for mastectomies (yours does) are also required to provide coverage for reconstructive surgery and prostheses following mastectomies. Specifically, the law mandates that a participant or eligible beneficiary who is receiving benefits for a covered mastectomy and who elects breast reconstruction in connection with a mastectomy, will also receive coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and is subject to the same annual deductible, coinsurance and/or co-payment provisions otherwise applicable under the Plan. If you have questions concerning your coverage, please call the Administrative Office at (800) 433-6692.

COBRA QUICK REFERENCE

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your eligible Dependents (Qualified Beneficiaries) may continue health care coverage past the date coverage would normally end under certain circumstances (Qualifying Events). You and your eligible Dependents will be required to pay the full cost of the coverage plus two percent for administration in order for it to be continued.

A "Qualified Beneficiary" as defined under COBRA means any individual who on the day before a Qualifying Event was covered under this Plan by virtue of being, on that day, either the Employee, the spouse of an Employee, or a dependent child of an Employee. A child born to or placed for adoption with an Employee during a period of COBRA Continuation Coverage shall be a Qualified Beneficiary entitled to his or her own COBRA rights.

Circumstances under which health care coverage can be continued and the duration of Continuation Coverage are outlined in the following chart:

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
Reduction in employee's hours	Employee, spouse and dependent children	18 months after date of qualifying event
Termination of employee's employment except for gross misconduct	Employee, spouse and dependent children	18 months after date of qualifying event
Death of Employee covered under the Plan. Refer to special extensions of coverage for spouses and dependents on page 8.	Spouse and dependent children	36 months after date of qualifying event
Divorce or legal separation of an eligible employee	Spouse and dependent children	36 months after date of qualifying event
Dependent child's loss of that status under Plan	Affected dependent child	36 months after date of qualifying event
Covered employee's entitlement to Medicare: (1) prior to an initial qualifying event (2) second qualifying event	Spouse and dependent children	(1) Later of 18 months from the qualifying event or 36 months from the date of the employee's Medicare entitlement (2) 36 months after date of initial qualifying event

Refer to pages 9-12 for a complete description of COBRA Continuation of Coverage Provisions.

Quick Reference - Important Contacts

Information Needed	Who to Contact
Eligibility Information Request for Claim Forms **Claims Information**: Life Insurance and AD&D, Smoking Cessation Program Benefits	Administrative Office (BeneSys Administrators) (800) 433-6692 1050 Lakes Drive, Suite 120 West Covina, CA 91790 www.hfawbenefits.org
Smoking Cessation Helpline	(800) 662-8887 (English) (800) 456-6386 (Spanish) (800) QUIT NOW (800-784-8669)
Vision Care Benefit Information and Forms	Vision Service Plan Phone: (800) 877-7195 333 Quality Drive Rancho Cordova, California 95670 Fax Out of Network claims to: (916) 851-5152 Internet Website: www.vsp.com
Kaiser Foundation Health Plan	Phone: (800) 464-4000 Internet Website: www.healthy.kaiserpermanente.org
DeltaCare USA	Phone: (800) 422-4234 Internet Website: www.deltadentalins.com/deltacare
United of Omaha	Phone: (800) 775-8805 Internet Website: www.mutualofomaha.com
WorkCare	Phone: (800) 455-6155

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SCHEDULE OF BENEFITS

EMPLOYEE ONLY BENEFITS

LIFE INSURANCE – PROVIDED BY UNITED OF OMAHA $2,000
DEATH BENEFIT (Self-funded) $3,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS –
PROVIDED BY MUTUAL OF OMAHA

Loss of Life $20,000

Loss of:
- Two or more: hands, feet, sight of eye or loss of speech or hearing $20,000
- One hand, one foot, speech or hearing, or sight in one eye $10,000
- Thumb and index finger of the same hand $5,000

TRAVEL ASSISTANCE – PROVIDED BY MUTUAL OF OMAHA
Emergency evacuation, repatriation, return of remains and other advisory services provided to all eligible members. Spouses and dependent children are also eligible. Trips up to 90 days and 100 miles or more from home are covered up to $100,000 per person per event. Refer to separate Certificate of Coverage provided by Mutual of Omaha for specific benefit provisions or contact the Administrative Office.

EMPLOYEE AND DEPENDENT BENEFITS - PROVIDED BY THE FUND

Smoking Cessation Program
Treatment and resources that are designed to help you quit smoking is provided by the Plan. Counseling provided at no charge. For more details about the benefits provided under this program contact the Administrative Office.

Insured Medical and Dental Plans
If you are eligible to select one of the insured medical or dental plans for you and/or your eligible dependents, you will receive a separate schedule of benefits describing the benefits you and your eligible dependents will be provided under the Plan.

You must file your claims for benefits over which the Plan has discretion within twelve (12) months from the date the services or supplies were rendered.

ELIGIBILITY RULES

The eligibility rules described in this SPD and Plan Document apply to all the benefits provided through the Fund to active maintenance employees and their eligible dependents, and may be changed from time to time at the sole and absolute discretion of the Trustees.

Initial Eligibility

To establish eligibility for all benefits under the Plan, with the exception of the medical examination benefit, you must work for contributing employers at least 320 hours during a consecutive three month period. Your coverage will begin on the first day of the second month that follows the month you accumulate the required 320 hours.

Example:

- If you work a total of at least 320 hours during January, February and March, you become eligible on May 1.
- If you work a total of at least 320 hours during January and February, you become eligible on April 1.
- If you work a total of at least 320 hours during January, you become eligible on March 1.

Continuing Eligibility

To maintain your eligibility you must work for contributing employers at least 120 hours per month. Coverage will be provided for the second month following the month during which the 120 hours were worked.

Example:

If you work 120 hours during January you receive coverage for March.

Month of Hours Worked	Hours Reported to Trust Fund Office	Eligible for Coverage as of 1st of the Month
January	February	March 1

Hour Bank

If you work more than 120 hours during any month, the excess hours will be credited to your Hour Bank, up to a maximum of 30 hours per month. In no event will the number of hours in your Hour Bank exceed 240.

If you work less than 120 hours for a contributing employer during any month, the number of hours needed to total 120 will be subtracted from your Hour Bank. If the hours worked plus the hours remaining in your hour bank total less than 120 hours, you will be given the option of self-paying the difference between those hours and the 120 hour requirement for that month of coverage. The self-payment required for continued coverage will be equal to the rate as determined by the trustees, in their sole discretion, and which may be changed from time to time. Self-payment of hours needed for coverage will allow you to continue coverage, but will not allow you to re-instate coverage once eligibility is lost.

Hours in an employee's Hour Bank will be suspended during such time as the employee, whether or not actively employed, becomes eligible to participate in any other Health and Welfare Fund, or during such

time as the employee becomes actively employed in the insulation or asbestos abatement industry by an employer that is not contributing to this Trust Fund. This suspension may not exceed 12 consecutive months, at which time any residual hours shall be terminated.

Additionally, if an employee has a continuous 12 month period without any Employer contributions, all hours in the Hour Bank shall be forfeited.

Eligible Dependents

If you are a Pre-Apprentice, Ship Yard Worker Class 2 and 3a, or a Maintenance Worker 1 and 2a who has worked less than 3,000 hours for a Contributing employer, you may elect coverage for your eligible dependents. However, a self-payment is required for this coverage. The amount of self-payment reflects the rate as established by the Trustees, in their sole discretion, which may be changed from time to time. If you are a Maintenance Worker who has worked more than 3,000 hours for a Contributing employer, dependent coverage is automatically provided at no cost to you. All other classifications under the Maintenance Workers SPD are eligible for Trust provided dependent coverage immediately upon eligibility without self-payment.

For all benefits, except life insurance benefits, your eligible dependents are your legal spouse, registered domestic partner, and your children who are:

- natural children under 26 years of age;
- any child required to be recognized under a Qualified Medical Child Support Order.

Your children also include the following individuals under 26 years of age:

- legally adopted children from the time the child is placed in your custody;
- children for whom adoption proceedings have been started;
- stepchildren; and
- children for whom you have been appointed legal guardian.

For life insurance; your eligible dependents are your legal spouse and your unmarried children who are:

- under 21 years of age; or
- between 21 and 23 years of age, if they are full-time students in an educational institution and dependent upon you for financial support.

Any spouse, registered domestic partner or child who is eligible under the Plan as an active participant will not also be considered eligible as a dependent. A child will not be considered a dependent of more than one eligible active participant.

An eligible child who reaches 26 years old and is subject to termination under the terms of the Plan, will continue to be covered till the end of the month in which the child reaches 26 years old.

Unless your registered domestic partner is considered a tax dependent, federal law requires that taxes must be paid on the value of the imputed income of the registered domestic partner's health benefits. Generally, in order for your registered domestic partner to be qualified as a tax dependent, your registered domestic partner: 1) must not be a qualifying child of any taxpayer, 2) must be a citizen, national, or legal resident of the U.S. or a resident of a contiguous country, 3) must be a member of the employee's household for the full tax year, and 4) must receive more than half of their support from the employee.

The Trust does not provide tax or legal advice, and you should consult your tax advisor or attorney. If your registered domestic partner is considered your tax dependent, you can submit a written, notarized certification that states that your registered domestic partner is your tax dependent for federal tax purposes and meets the criteria listed above.

If your registered domestic partner is not your dependent for federal tax purposes, you will be billed monthly for all applicable federal taxes based on the imputed income value of your registered domestic partner's benefits as determined by the Trust. If full payment of the taxes is not received by the end of the month in which it is billed, your registered domestic partner's benefits may be terminated. The administrator will file federal taxes with the IRS quarterly and will issue a Form W-2 annually. If you have any questions, please contact that Administrative Office at (800) 433-6692.

Unless your registered domestic partner is considered a tax dependent, federal law requires that taxes must be paid on the value of the imputed income of the registered domestic partner's health benefits. Generally, in order for your registered domestic partner to be qualified as a tax dependent, your registered domestic partner: 1) must not be a qualifying child of any taxpayer, 2) must be a citizen, national, or legal resident of the U.S. or a resident of a contiguous country, 3) must be a member of the employee's household for the full tax year, and 4) must receive more than half of their support from the employee.

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Qualified Medical Child Support Orders

The Plan will enroll children of an Eligible Employee, as directed by a Qualified Medical Child Support Order (QMCSO). A Qualified Medical Child Support Order is any judgment, decree or order issued by a court or by an administrative agency under applicable state law that has the force of state law which:

- Provides the child of an Eligible Employee with coverage under a health benefits plan, or
- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Eligible Employee or Retired Participant parent does not enroll the child, then the non-Employee or non-Participant parent or State agency may enroll the child.

To be Qualified, a Medical Child Support Order must clearly specify:

- The name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order,
- A description of the type of coverage to be provided by the Plan to each such child,
- The period to which the Order applies, and
- The name of each Plan to which the Order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Plan under a Medical Child Support Order to reimburse expenses claimed by a child shall be made to the child or his custodial parent or legal guardian if so required by the Medical Child Support Order.

No Participant's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a Dependent on the parent's Federal income tax return or does not reside with the parent.

When a Qualified Medical Child Support Order is Received
The Trustees have adopted a Qualified Medical Child Support Order Procedure, which is available upon request to the Administrative Office. If the Trust receives a proposed or final order, the Administrative Office will notify the Participant and each child named in the order. The order will then be reviewed to determine if it meets the definition of a "Qualified Medical Child Support Order." Within a reasonable time, the Participant and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party(ies) filing the order will be given an opportunity to correct the order or appeal the decision through the *Appeal Procedure* explained in this SPD/Plan Document.

If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire Qualified Medical Child Support Order must be received prior to enrollment, and Participants must pre-pay any required contributions for the child(ren). Child(ren) enrolled pursuant to a Qualified Medical Child Support Order will be subject to all provisions applicable to Dependent coverage under the Plan.

When Coverage Becomes Effective

Your dependent's coverage will become effective on the later of the following dates, provided you make the self-payment, if required:

- the date your coverage becomes effective;
- the date you acquire the dependent; or
- the first day of any calendar month following dependent enrollment in coverage. Dependents can be added up to 6 months after your initial eligibility.

The amount of the self-payment and method of payment is determined by the Board of Trustees and is subject to change from time to time at the sole and absolute discretion of the Trustees. Payments must be received by the Administrative Office no later than the 20th day of the month prior to the month for which dependent coverage is desired to begin.

Example:

- If you would like dependent coverage for June, payment must be received by May 20.

Special Enrollment Rights

If you are eligible for coverage under the Plan and you failed to enroll or elected not to enroll your dependents because of other health insurance or group health plan coverage including coverage under a Medicaid plan or State Children's Health Insurance Plan ("SCHIP") you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 6 months after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you or your dependents become eligible for the state premium assistance subsidy from Medicaid or SCHIP, you or your dependent may have special enrollment rights but you must request enrollment within 6 months after the date your eligibility for the subsidy is determined. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment for your dependent within 6 months after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact:

BeneSys, Inc.
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(800) 433-6692

When Your Coverage Terminates

Your coverage and coverage for your dependents will terminate on the earliest of the following:

- the last day of the month following the month in which the hours worked for contributing employers plus the hours in your Hour Bank do not total at least 120 hours;
- the first day of the month for which a self-payment, if required, is not received by the Administrative Office (refer to page 8 for a description of the Fund's self-pay provisions);
- the date your full-time military service exceeds 31 days;
- the date the benefit programs are terminated by the Board of Trustees;
- you are an owner operator and your Company is delinquent in payments of its contributions; or
- the date you continue working for a contributing Employer or Other Employer and you have received notice in writing to discontinue working for the Employer because of a contribution delinquency.

See "Special Extension" provisions for extended coverage options.

Reinstatement of Coverage

If you lose your eligibility because the hours you worked for contributing employers plus the hours in your Hour Bank do not total at least 120 hours, you will be reinstated as an active participant on the first day of the second month following the completion of a month in which you work 120 hours. You must work these 120 hours within 12 months of the date you lost eligibility. If more than 12 months has elapsed since you lost eligibility, you must satisfy the initial eligibility requirements detailed on page 2.

Continued Coverage While in Uniformed Service

If an Eligible Employee performs service in the Uniformed Services of the United States, federal law provides certain rights to continued coverage under this Plan. An Eligible Employee may choose to continue coverage for up to a maximum of 24 months from the date that service commences.
The terms “Uniformed Services of the United States” and/or “Uniformed Services” means the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If an Employee (and his or her eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Services, and the Employee’s absence is due to a Uniformed Services leave of **31 days or less**, coverage will be continued at no cost to the Employee. The Employee will be credited with hours necessary to keep coverage in effect as if the Employee had worked in covered employment with a Contributing Employer during the period of service.

If an Eligible Employee (and his or her eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Services of the United States, and the Employee’s absence is due to a Uniformed Services leave of 31 days or more, the Employee or eligible dependent(s) may elect to continue coverage

by: (1) using available hours in their hour bank account, or (2) self-payment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). An Employee electing to continue coverage need not use his/her hour bank and may always pay the required premium and preserve the hour bank account, but if he/she chooses to use his/her hour bank to pay USERRA premiums, the portion of the hour bank that is used will not be re-credited to the employee upon reinstatement.

A premium for continuation coverage under USERRA will be in an amount established by the Trust. Such premium shall be payable in monthly installments. The maximum length of USERRA Continuation Coverage is the lesser of:

- 24 months beginning on the day that the Uniformed Services leave commences; or
- a period ending on the day after the Eligible employee fails to return to employment within the time allowed by USERRA.

If non-service related health care expenses are incurred by the Employee or Dependents during a period of Uniformed Services leave, and those expenses are submitted to the Plan and benefits are paid by the Plan, the employee will be deemed to have chosen continued coverage for the month(s) beginning when the Employee entered Uniformed Service leave through the last month in which those health care expenses were incurred. In this case, available hours will be deducted from the Employee's hour bank account to provide eligibility to the extent possible.

Reinstatement of Eligibility Following Uniformed Service

If an Employee was eligible for benefits on the date of entry into the Uniformed Services and upon completion of service the Employee notifies the Employer of his or her intent to return to employment as specified in USERRA, the employee's eligibility will pick up as it was the day before the Employee entered into Uniformed Services.

The Plan pays no benefits for conditions incurred or aggravated during performance of duties in the Uniformed Services.

If there is any conflict between these provisions and USERRA, the minimum requirements of USERRA shall govern.

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) provides that in certain situations an Eligible Employee is entitled to take up to 12 weeks of unpaid leave during any 12-month period, and that in such situations the Contributing Employer is required to continue coverage for the Employee. **Determination as to whether a leave of absence is an FMLA leave shall be made by the Contributing Employer, and is subject to review by the Board of Trustees.** If requested, an employee must submit proof acceptable to the Trust that the leave is in accordance with FMLA provisions.

If an Employee becomes eligible for both: (a) FMLA coverage due to the Employee's own disability, and (b) this Plan's 12-month *Special Extension for Total Disability*, continuation of eligibility will run concurrently until the FMLA leave is exhausted, then the available balance of *Special Extension for Total Disability* will be applied. Continuation of eligibility under the FMLA is concurrent with all other continuation options except for COBRA. An employee is eligible to elect COBRA Continuation Coverage as of the day FMLA coverage ceases.

Continuation of coverage under FMLA ends on the earliest of:

- The day the Employee returns to work;
- The day the Employee notifies his or her employer that he or she is not returning to work;
- The day coverage under the Plan would otherwise end (i.e., Plan maximum has been paid); or
- The day after coverage has been continued under FMLA for 12 weeks.

Employees should contact their Employer to find out more about Family and Medical Leave and the terms on which an Employee may be entitled to it.

If there is any conflict between these provisions and FMLA, the minimum FMLA provisions shall govern.

Employers shall contribute 160 hours per month at the current Employee contribution rate for Employees who are on FMLA leave.

When Your Dependent's Coverage Terminates

Your dependent's coverage will terminate on the earliest of the following dates:

- the date your eligibility terminates;
- the date the dependent no longer qualifies as a dependent, as defined on page 3;
- the date the dependent enters full time service in the armed forces; or
- the date the benefit programs are terminated by the Board of Trustees.

In certain circumstances your dependent's coverage may be continued. Refer to "Special Extensions" below.

Special Extensions of Coverage

Disabled Active Maintenance Employees

If you lose eligibility because you become totally disabled on or after June 1, 2019, coverage for you and your eligible dependents may be continued for up to 12 months provided you file an application with the Administrative Office on a form provided by the Administrative Office, including additional documentation from a licensed Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) within your network certifying your disability. For example, if you are a Kaiser member, the disability certification must come from a MD or DO in your Kaiser network. This Special Extension includes coverage for life insurance and accidental death and dismemberment benefits, in addition to medical, prescription, dental and vision benefits.

If you lose eligibility because you are totally disabled, coverage for you and your eligible dependents may be continued for up to 12 months provided you file an application with the Administrative Office. This includes life insurance and accidental death and dismemberment benefits, in addition to medical, dental and vision benefits. Dependent coverage may be continued by making a self-payment, if required.

TOTALLY DISABLED shall mean, that as a result of injury or illness, you are unable to perform your regular duties as a Heat and Frost Maintenance Worker.

If you exhaust this extension, you and your dependents may continue coverage in accordance with the Fund's COBRA provisions described on pages 9 through 12. Once a participant reaches the maximum number of months allowed, he or she will not be entitled to another disability extension until regaining eligibility as a result of working in a covered classification and being eligible for 12 consecutive months.

Mentally and Physically Handicapped Children

If your dependent child is unmarried and incapable of self-sustaining employment because of a physical or mental handicap on the date his eligibility would otherwise terminate because of age, his coverage will be continued if proof of incapacity is submitted to the Administrative Office.

Self-Pay Provisions

Active Maintenance Employees With Less Than 120 Hours or Who Have Exhausted Their 12 Month Disability Extension

If you lose eligibility because the hours you work for a contributing employer plus the hours in your Hour

Bank total less than 120 or because you exhaust your 12 month disability extension, you may continue your coverage, including life insurance and accidental death and dismemberment benefits, for up to nine months by making self-payments. This self-payment privilege terminates if during the nine months you: (1) return to active employment, (2) become eligible to participate in another health and welfare plan, or (3) become actively employed in the insulation industry by an employer that is not contributing to the Trust Fund. Payments must be received by the Administrative Office no later than the 20th day of the month prior to the month for which coverage is desired.

Example:

- If you want to self-pay for coverage during June, payment must be received by May 20.

The amount of the self-payment and method of payment shall be determined by the Board of Trustees in its sole and absolute discretion and is subject to change from time to time.

If you exhaust this nine (9) month self-payment option and you lost eligibility due to insufficient hours, you may be entitled to an additional continuation of coverage. Please contact the Administrative Office for further information.

Please note that your self-payment coverage applies to any COBRA coverage to which you and your eligible dependents may be entitled.

Surviving Dependents of Deceased Active Maintenance Employees
If your surviving eligible dependents exhaust their 24 month coverage extension, your surviving spouse may continue their coverage by making self-payments. Payments must be received by the Administrative Office no later than the 20th day of the month prior to the month for which coverage is desired. The amount of the self-payment and method of payment shall be determined by the Board of Trustees in its sole discretion and is subject to change from time to time.

Self-pay coverage for your surviving dependents may be continued, but will terminate upon the happening of the earliest of:

- the first day of the month for which the required self-payment is not received by the Administrative Office;
- the date your contributing employer stops making contributions to the Fund;
- the date your surviving spouse remarries;
- the date your surviving spouse is eligible for similar medical coverage under another group plan;
- the date the benefit programs are terminated by the Board of Trustees; or
- the last day of the month following the date of your death.

If your dependent’s coverage terminates because the participant's spouse remarries, or the 24 month extension expires without an election by the surviving spouse to continue coverage by self-payments, your surviving eligible dependents may continue coverage by self-payments until a total period of 36 months has elapsed from the death of the participant, or until the dependent’s eligibility for coverage by self-payments expires, whichever occurs first.

COBRA Continuation Coverage

For All Maintenance Employees and Dependents
You and your dependents have the right to continue coverage under the Plan for a period of time defined

by Federal law if eligibility terminates due to certain events. The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1995 (“COBRA”). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end under the Plan. It is important to note that when you become eligible for COBRA continuation coverage, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. It is your responsibility to determine if COBRA continuation coverage is right for you. The events that trigger COBRA continuation coverage rights are called "qualifying events." This continuation coverage may require self-payment of premiums and does not include life insurance or accidental death and dismemberment benefits. You may select "core" coverage, which provides medical benefits only, or "core plus", which includes medical and dental and vision benefits.

You may continue your coverage if one of the following qualifying events occurs:

- your employment terminates for any reason except gross misconduct; or
- you lose eligibility because the hours you work for a contributing employer plus the hours in your Hour Bank total less than 120.

Your spouse may continue coverage if one of the following qualifying events occurs:

- you die;
- you and your spouse divorce or become legally separated;
- you become entitled to Medicare benefits (Part A, Part B, or both);
- your employment terminates for any reason except gross misconduct; or
- you lose eligibility because the hours you work for a contributing employer plus the hours in your Hour Bank total less than 120.

Your dependent child may continue coverage if one of the following qualifying events occurs:

- your dependent child ceases to be a Dependent as defined on page 3. A child eligible to be continued under the Plan's special extension for mentally and physically handicapped children (page 8) will be considered to have dependent status;
- you die;
- you and your spouse divorce or become legally separated;
- if you become entitled to Medicare benefits (Part A, Part B, or both);
- your employment terminates for any reason except gross misconduct; or
- you lose eligibility because the hours you work for a contributing employer plus the hours in your Hour Bank total less than 120.

New dependents acquired while you are covered under COBRA can be added by notifying the Administration Office within 60 days of acquiring the new dependent.

Continuation Period
Coverage may continue, on a self-pay basis, as follows:

- Coverage for you and/or your dependent(s) may be continued for up to 18 months if coverage terminated due to your termination of employment (other than for gross misconduct), or reduced work hours, and coverage begins as of the date of the qualifying event. This includes any non-COBRA self-pay coverage.

- If the Social Security Administration determines that you or any of your covered dependents were disabled during the first 60 days of COBRA Continuation Coverage and you inform the Heat & Frost Insulators and Asbestos Workers Health and Welfare Fund before the end of the 18 month continuation period, coverage may be extended for an additional 11 months, for a total of 29 months. Proof of disability must be provided to the Plan Administrator within 60 days of the date the Social Security Administration makes the determination. This extended period of Continuation Coverage applies to the person who has been determined to be disabled by the Social Security Administration (and/or any other family members if family coverage is elected).

- Coverage for your dependents may be continued for an additional 18 months for a total continuation period of up to 36 months upon the happening of a second Qualifying Event. This extension is available if coverage terminated due to your death, divorce, or legal separation, or your dependent child's ceasing to satisfy the Plan's definition of an eligible dependent and proper notice is received by the Administrative Office as described below.

If your dependent's coverage is continued after termination of your employment or reduction in hours and, during the initial Continuation Period, a second Qualifying Event occurs which entitles the dependent to Continuation Coverage, your dependent may elect to continue coverage up to a combined maximum of 36 months. Dependent will include the employee's newborn and adopted children added after the qualifying event, provided the dependent is enrolled within 60 days after the birth or placement for adoption. A child born or placed for adoption while you are on COBRA coverage will have all the same COBRA rights as your Dependents who were covered by the Plan before the qualifying event that resulted in your loss of coverage.

Please note, once the Administrative Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of your qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their children.

Premium Payments
You and your eligible dependents are responsible for all premium payments for their Continuation Coverage. As allowed by federal law, the premium payment will be equal to the cost of the coverage selected plus 2% for administration. The COBRA rates are changed once each year on April 1st.

No Coverage During Election Period
A Qualified Beneficiary will not be covered under the Plan(s) during the 60-day election period and 45-day period allowed to pay for COBRA coverage. However, if a COBRA coverage election is made in accordance with the current COBRA laws and all applicable premiums are paid in a timely manner, then coverage through the Fund for the benefits selected will be retroactive to the original loss of coverage date in accordance with federal law. If a medical, dental or vision provider calls for verification of eligibility or benefits during the election period and the Plan Administrator does not have a record of a timely and properly completed election form and payment of premium, the provider will be told that the Qualified Beneficiary does not have coverage but that he/she will be covered as of the COBRA effective date provided that a timely and properly completed election form and premium payment are received. Upon timely receipt of a properly completed election form and payment of all applicable premiums, COBRA continuation coverage shall be in effect.

Notice Requirements
If your dependents would lose coverage due to your divorce or legal separation from your spouse or your child ceasing to be a dependent as defined on page 3, you or your dependent must notify the Administrative

Office within the later of 60 days of (i) the event or (ii) the date coverage would be lost as a result of the event. This allows the Administrative Office to provide the appropriate notice of continuation rights and the terms which apply. If the Administrative Office is not notified within the 60 day time limit, your Dependent(s) will lose the right to elect COBRA.

If coverage would be lost due to your death, termination of employment or insufficient hours, your employer must notify the Administrative Office. However, it is advisable that you or your dependent provide notification as well. The Administrative Office will notify you of the cost of COBRA when it sends you the COBRA notice. The election of COBRA rights must be made in writing within 60 days of the later of (1) the date the notice is sent to you or (2) the date your regular Plan coverage terminates. You must pay the required premium within 45 days of the election. If you reject COBRA coverage, your spouse and dependent children may elect coverage within the 60-day period.

Termination of Continuation Coverage
The continued coverage will cease on the first of the following dates:

- the date the Plan terminates;
- the date a required premium is due and unpaid after any applicable grace period (you will be allowed a 30 day grace period from the premium due date);
- the date you and/or your dependent(s) become insured under another group health plan. This may not apply if you or your dependent have a pre-existing condition which is not covered under the new plan. Contact the Plan Administrator for additional information when you and/or your dependents become insured under another group plan;
- the date the applicable period of continuation is exhausted; or
- the first day of the month which begins 30 days after you or your dependent(s) receive a final determination from Social Security that you or your dependent(s) are no longer disabled. (Applied in situations where the Qualifying Event was termination of employment or reduction in hours and where COBRA coverage was being continued for an additional 11 months.)

Other Options Available To You When Coverage Terminates Under The Plan
You may have other options available to you when you lose health coverage under the Plan through the Health Insurance Marketplace, Medicaid or other group health plan coverage options. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about any of these options at www.healthcare.gov.

If you have questions concerning your Plan or your COBRA continuation coverage rights, you should address these questions to the Administrative Office or the agencies identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through this website.

Full details of this Continuation Coverage will be provided to you or your dependents when a qualifying event occurs.

OTHER FACTS

Enrollment Form

Every active maintenance employee who is working for a contributing employer should be certain to complete an enrollment form. Forms are available at the Administrative Office and at the Local Union Offices. A completed enrollment form and verification of dependent status (such as a marriage certificate or birth certificate) is required before you and your dependents can be properly enrolled in any of the plans offered through the Fund. Without these required documents, your dependent(s) will not be covered. Outside of your initial enrollment and Special Enrollment periods for Dependents, you can add or remove your Dependents during the Dependent open enrollment held each year during the month of November for coverage changes effective in January.

Policy Rules and Regulations

If you are eligible under the Fund, your rights can only be determined by:

- the Fund's rules and regulations, including those outlined in this SPD and Plan Document regarding Medical (Smoking Cessation Program) and Death benefits provided directly by the Fund;
- the Group Policy relating to the life insurance, accidental death and dismemberment benefits provided by Mutual of Omaha;
- the Service Agreement relating to the medical benefits provided by Kaiser Permanente;
- the Service Agreement relating to the dental benefits provided by United Concordia Dental Services; and
- the Agreement relating to the vision benefits administered by Vision Service Plan.

The information contained on these pages is intended to be a summary of the Fund's eligibility rules and benefits provided through the group policy issued by Mutual of Omaha. To determine your benefits under the Fund, read this SPD and Plan Document in conjunction with the applicable group policy or service agreement.

Timely Filing of Claims

You must file your smoking cessation and disability claims within 12 months from the date the services or supplies were rendered. Claim procedures are outlined on pages 14 through 18, and are also described in more detail in the insurance provider service agreements.

Financing

Benefits for active maintenance employees and their eligible dependents are paid for by employer contributions to the Fund as a result of collective bargaining agreements. In some cases a self-payment may be required in amounts determined by the Board of Trustees and may be changed at any time at the sole and absolute discretion of the Board of Trustees.

Amendment and Termination

Plan benefits are provided to the extent of contributions actually received or collected by the Fund. In order that the Fund may carry out its obligation to maintain within the limits of its resources, a program dedicated to providing the maximum possible benefits for all active maintenance employees, the Board of Trustees expressly reserves the right, in its sole discretion at any time to:

- terminate or amend the amount or condition with respect to any benefit though such termination or amendment affects claims which have already accrued;

- terminate the Plan even though such termination affects claims which have already accrued;
- alter or postpone the method of payment of any benefit; and
- amend or rescind any other provisions of the Plan.

The existence and continuation of Plan benefits depends on the continuation of the collective bargaining agreement between the Union and the Association. If the collective bargaining agreement terminates, benefits will be continued as long as the cash in the reserve fund permits. The Board of Trustees may amend the terms of the Plan and any benefits provided under the Plan by a majority vote. Any agreed to changes will be adopted as of the established effective date, and required notices of such changes will be provided to Participants (if applicable).

CLAIMS FILING AND APPEALS PROCEDURES

The claims filing and appeals procedure described below will apply to claims and appeals over which the Board of Trustees has discretion, which consists of Disability and Smoking Cessation benefits provided under the Plan. For all other benefits provided under the plan, including HMO medical benefits, prepaid dental benefits and vision benefits, claims are administrated through the insurance provider. Please refer to any documentation provided by the insurance carrier regarding claims and appeals for information on how to file claims. We have also provided, for your reference, a chart detailing the time frames the Plan has to respond to claims and appeals and the time frames afforded for extensions and the provision of additional information.

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Concurrent Care Claim
Notification of Initial Claim Approval	As soon as possible but not later than 72 hours after the Plan's receipt of the claim.	Within a reasonable period but not later than 15 days after the Plan's receipt of the claim.	Notification not required.	Same as urgent care or pre-service claim as applicable where the claim is a request for extension of concurrent care.
Notification of Initial Adverse Benefit Determination	As soon as possible but not later than 72 hours after the Plan's receipt of the claim.	Within a reasonable period but not later than 15 days after the Plan's receipt of the claim. 15 day extension permitted with notice to the participant prior to the end of the initial 15 day period.	Within a reasonable period but not later than 30 days after the Plan's receipt of the claim. 15 day extension permitted with notice to the participant prior to the end of the initial 15 day period.	Same as urgent care or pre-service claim as applicable where the claim is a request for extension of concurrent care, to ensure that the determination is provided to the claimant within a reasonable time before the end of treatment, or within 24 hours if the claim is made within 24 hours of the end of the period or number of treatments.

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Concurrent Care Claim
Notice of Extension of Initial Determination Period	No extension permitted.	Up to one 15-day extension for "matters beyond the control of the plan." 15 day period does not begin until the earlier of the receipt of a completed claim or additional information requested, or the date of the deadline to provide such information (45 days to complete).	Up to one 15-day extension for "matters beyond the control of the plan." 15 day period does not begin until the earlier of the receipt of a completed claim or additional information requested, or the date of the deadline to provide such information (45 days to complete).	Same as pre-service, where the claim is a request for extension of concurrent care but no urgent care is involved. If urgent care is involved no extension is permitted.
Incorrectly Filed Claim Notice	As soon as possible but not later than 24 hours after the Plan's receipt of the claim. The Plan will notify you of claim determination the earlier of 48 hours after.	As soon as possible but not later than 5 days after the Plan's receipt of the claim.	Not required, but may be a reason for extension as provided above.	Same as urgent care or pre-service claim as applicable where the claim is a request for extension of concurrent care.
Incomplete Claim Notice	As soon as possible but not later than 24 hours after the Plan's receipt of the claim. The Plan will notify you of claim determination the earlier of 48 hours after you provide the specified additional information or 48 hours after the deadline given to provide such information.	Not required, but may be a reason for extension as provided above.	Not required, but may be a reason for extension as provided above.	Same as urgent care or pre-service claim as applicable where the claim is a request for extension of concurrent care

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Concurrent Care Claim
Notification of Benefit Determination on Review (Appeal)	As soon as possible but not later than 72 hours after the Plan's receipt of the appeal. No extensions are allowed.	Within a reasonable period, but not later than 30 days after the Plan's receipt of the appeal. No extensions are permitted.	Not later than 5 days after the next regularly scheduled Board of trustees meeting following the Plan's receipt of the appeal, unless the appeal is filed less than 30 days before the next period, in which case, no later than 5 days after the second Board of Trustees meeting scheduled after the Plan's receipt of the appeal.	Before treatment ends or is reduced, where the adverse benefit determination is a plan decision to reduce or terminate care early.

Except for questions of eligibility under the Plan, the Board of Trustees does not have any say over benefit determinations made by an HMO (Kaiser), prepaid dental provider (United Concordia), vision provider (Vision Service Plan), service organization or other insurance carrier. Claims for benefits under such arrangements must be pursued using the claims and appeals procedures provided by such HMO, prepaid dental provider, vision provider, service organization or insurance carrier. **DO NOT USE THE HEAT AND FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE FUND CLAIMS FILING AND APPEALS PROCEDURE.** For such claims, please read the provider's Evidence of Coverage or Insurance Policy for the claims and appeals procedure applicable to the benefit.

Filing a Claim

You or your authorized representative may file a claim for Disability and/or Smoking Cessation benefits by contacting the Administrative Office at (800) 433-6692. The Administrative Office will provide you with further instructions for filing your claim. The Administrative Office may also require you to provide an authorization certifying that you have authorized another individual to act on your behalf (i.e., your "authorized representative") in pursuing a claim or appeal. **Claims must be filed at the Administrative Office within 12 months following the first day of treatment or date of service.**

Upon receipt of your claim, it will be categorized as a Pre-Service Claim, Post-Service Claim, an Urgent Care Claim or a Concurrent Care Claim. The categorization of your claim will dictate the Plan's time frame for responding to your claim. PLEASE NOTE THAT MOST OF YOUR CLAIMS WILL BE POST-SERVICE CLAIMS.

A **Pre-Service Claim** is any claim for benefits that requires approval before medical care is obtained.

A **Post-Service Claim** is any claim for reimbursement of payments from you or a provider for services or care you have already received.

An **Urgent Care Claim** is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim.

You may make a verbal request to the Administrative Office for determination on an Urgent Care Claim or submit an Urgent Care Claim in writing to the Administrative Office. A physician or other health care professional who has knowledge of your medical condition may act as your authorized representative. Such physician or health care professional need not be certified as your "authorized representative".

You may be asked to explain or describe whether medical circumstances exist that may give rise to a need for expedited processing of your claim, and what these medical circumstances are, i.e., what medical circumstances exist that make your claim an Urgent Care Claim.

A **Concurrent Care Claim** is a claim for ongoing care or a treatment plan that has been reviewed and approved by the Plan. An example would be physical therapy or chiropractic care for which a treatment program would include a limited number of visits.

A **Disability Claim** is a claim for a benefit for which the Administrative Office must make a determination regarding an individual's ability to engage in gainful activity due to a physical or mental impairment.

Time Frames for Initial Decision Making

Pre-Service Claim
If you have a Pre-Service Claim and the Plan denies your claim in whole or in part the Plan will provide you with written notice of the Plan's benefit determination in the form of an Explanation of Benefits within **15** days of the Plan's receipt of your claim, unless circumstances beyond the control of the Plan require an extension of time. If an extension is required, you will be given written notice of the extension prior to the termination of the initial **15** day period. The extension will not exceed **15** days from the end of the initial period.

In the event that an extension is necessary because you failed to submit information necessary to decide your claim (including the report of a required medical examination), your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will also be suspended until the earlier of the Plan's receipt of all the requested information or the date established by the Plan for the furnishing of the information (**45** days or other longer period specified in the Plan's notice). A decision will be made on your claim within **15** days after you respond to the request for additional information or within **15** days after the end of the **deadline given to provide additional information**, whichever is earlier.

Post-Service Claim
If you submitted a Post-Service Claim and the Plan denies your claim in whole or in part, the Administrative Office will provide you with written notice of the Plan's benefit determination in the form of an Explanation of Benefits within **30** days of the Plan's receipt of your claim, unless circumstances beyond the control of the Plan require an extension of time. If an extension is required, you will be given written notice of the extension prior to the termination of the initial **30** day period. The extension will not exceed **15** days from the end of the initial period.

In the event that an extension is necessary because you failed to submit information necessary to decide your claim (including the report of a required medical examination), your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will also be suspended until the earlier of the Plan's receipt of all the requested information or the date established by the Plan for the furnishing of the information (**45** days or other longer period specified in the Plan's notice). A decision will be made on your claim within **15** days after you respond to the request for additional information or within **15** days after the end of the **deadline given to provide additional information**, whichever is earlier.

Urgent Care Claims
If you properly submitted an Urgent Care Claim with all the necessary information, the Plan will provide you with written notice of its benefit determination as soon as possible, taking into account medical needs, but not later than **72** hours after the Plan's receipt of your claim. However, if you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan will notify you within **24** hours after the Plan's receipt of your claim of the specific information necessary to complete your claim. You must provide the specified information within **48** hours (or any longer period specified in the Plan's notice, if applicable). Thereafter, the Plan will notify you of the Plan's benefit determination no later than **48** hours after the earlier of the Plan's receipt of the specified information, or the end of the period given to you to provide the specified additional information.

If you fail to follow the procedure for filing an Urgent Care Claim, you will be notified of the failure and the proper procedures to be filed as soon as possible, but not later than **24** hours after the Plan's receipt of the improper claim. You may be notified orally, in which case a confirmation letter will be sent in writing within three (3) days of the oral notice. You will receive a notice if the claim or your communication to the Plan fails to include any of the following information: a) the name of the specific claimant, b) the specific medical condition or symptom, and c) the specific treatment, service, or product for which Plan approval is requested.

Concurrent Care Claim
If the Plan approved an ongoing course of treatment to be provided over a period of time or number of treatments and there is a reduction or termination of the course or number of treatments before the end of the period of time or number of treatments, the Plan will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision before the benefit is reduced or terminated.

Disability Claim
If you properly submitted your claim for coverage under the Plan based upon a disability with all of the necessary information, the Plan will provide you with written notice of its benefit determination as soon as possible, but not later than 45 days after the Plan's receipt of your claim. This 45-day period may be extended for up to 30 days (to a total of 75 days) if the Plan determines that an extension of time for making the determination is necessary due to matters beyond the control of the Plan, and notifies you prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the Plan determines that an additional extension of time is necessary due to matters beyond the control of the Plan, and notifies you prior to the expiration of the first 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be extended by the Plan for an additional 30 days (for a total of 105 days). However, if you fail to provide sufficient information to determine the claim, the Plan will notify you within 30 days of receiving the claim of the specific information necessary to complete your claim. You must provide the specified information within 45 days from your receipt of the request. The period for making the decision will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Notification Requirements for an Initial Claim
If your claim for benefits is denied in whole or in part, the Plan will provide you with a notice of the adverse determination that includes the following information:

- Information sufficient to identify the claim involved (i.e. date of service and claim amount, etc.);
- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

- A description of the Plan's appeal procedure and the time limits applicable to such procedures;

- A statement regarding your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request;

- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- If your Urgent Care Claim is denied, the notice will also include a description of the Plan's expedited appeal procedure.

- If a claim for Special Extension for Disabled Active Mechanics, Mentally and Physically Handicapped Children Special Extension, or Life Insurance During Total Disability extension of coverage benefits is denied, the notice providing the reason for denial of the claim will include the standards and basis for disagreeing with healthcare or vocational professionals, or any third party determinations of disability, if applicable

Filing an Appeal

If you disagree with the Plan's determination of your Claim, you may appeal the determination to the Board of Trustees. You may request such a review by sending a letter to the Administrative Office within **180** days of receiving the denial notice. If you are appealing a denial of an Urgent Care Claim, you may submit your request for review to the Administrative Office orally or in writing. As with the decision-making on the initial claim, the time frames for responding to your appeal will depend on the categorization of your claim as a Pre-Service, Post-Service Claim, an Urgent Care Claim or a Concurrent Care Claim.

If your appeal involves an Urgent Care Claim, all necessary information, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

Time Frames for Decision Making on Appeal

Post-Service/Concurrent Care Claim/Disability Claim

If you submitted an appeal of a denied Post-Service Claim or an appeal of a reduction or termination of a previously approved course of ongoing treatments or number treatments, the Board of Trustees will notify you of its determination on appeal as soon as possible, but not later than **5** days after the next regularly scheduled Board of Trustees meeting, unless the appeal is filed less than **30** days before the next meeting. In such case, the Board of Trustees will notify you no later than **5** days after the second Board of Trustees meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, the Board of Trustees will notify you of its determination no later than **5** days after the third meeting of the Board of Trustees following the Plan's receipt of the request for review. The Board of Trustees will provide you with a written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension.

Urgent Care Claim

If you submitted an appeal of a denied Urgent Care Claim, Pre-Service or a Concurrent Care Claim that is also an Urgent Care Claim, the Plan will notify you of its decision within **72** hours after the Plan's receipt of your appeal.

Pre-Service Claim/Concurrent Care Claim
If you submitted an appeal of a denied Pre-Service Claim or a Concurrent Care Claim for benefits that requires the Plan's prior approval and that does not involve urgent medical care or treatment, the Plan will notify you of its decision no later than **30** days after the Plan's receipt of your appeal.

Additional Rights on Appeal

If you choose to pursue an appeal, you will have the following rights:

- You will have the opportunity to submit written comments, documents, records, and other information relating to your claim to the Board of Trustees/Claims Administrator;

- You will have the opportunity to request reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits free of charge;

- The appeal will take into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

- The reviewer, i.e., the Board of Trustees will consider the full record of the claim and will independently make a determination;

- The appeal will be conducted by a named fiduciary who is neither the individual who made the initial adverse determination, nor the subordinate of such individual;

- If the denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the named fiduciary will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment;

- The health care professional consulted on appeal will not be the individual consulted in connection with the initial denial nor the subordinate of any such individual; and

- You may request the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial denial, without regard to whether the advice was relied upon in making the benefit determination.

- If any new or additional evidence or rationale is considered, relied on, or generated to make a benefit determination for an appeal of a claim for Special Extension for Disabled Active Maintenance Employees. Mentally and Physically Handicapped Children Special Extension, or Life Insurance During Total Disability extension of coverage benefits, it shall be produced to the claimant free of charge .as soon as possible prior to the determination of the benefit denial on review.

You do not have the right to appear before the Board of Trustees personally. The Board of Trustees may authorize a hearing if it determines that a hearing would be of assistance in its deliberation.

Notification Requirements for Denial on Appeal

If the Board of Trustees denies your appeal, the Board of Trustees will provide you with a notice of the adverse determination that includes the following information:

- Information sufficient to identify the claim involved (i.e. date of service and claim amount, etc.)

- The specific reason or reasons for the adverse determination;

- A reference to the specific plan provisions on which the benefit determination is based;
- A statement regarding your entitlement to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- A statement of your right to bring an action under section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If you have any questions regarding the above procedures, please contact the Administrative Office at (800) 433-6692.

The External Review Process

Your request for External Review must be filed in accordance with the instructions contained in your appeal denial notice and must be received not later than four (4) months after the date you receive the appeal denial notice. If there is no corresponding date four (4) months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the denial notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

Within five (5) business days after receiving your External Review request, the Plan Administrator will complete a preliminary review to determine whether your request is complete and eligible for External Review. That preliminary review will determine: whether you were covered under the Plan at the time the item or service was requested or provided; whether the final denial of your appeal related to your failure to meet the Plan's eligibility requirements; whether you exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether you have provided all the information and forms required to process an External Review. Within one business day after the Plan Administrator completes its preliminary review, it will issue you a written notification. If your request is complete, but not eligible for External Review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for External Review within the original four month filing period or, if later, the 48-hour period following your receipt of the notification.

If your request for External Review is complete and eligible, the Plan Administrator will assign a qualified IRO to conduct the Eternal Review and within five (5) business days after making the assignment will provide the IRO with the documents and information the Plan Administrator considered in making its final appeal denial.

You will have at least ten (10) days to submit additional information to the IRO. If you submit additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan does not reverse its determination, the IRO will review all of the information and documents received and will not be bound by any decisions or conclusions reached by the Board of Trustees during

the Plan's internal claim and appeal process. The IRO may also consider the following in reaching its decision: your medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Plan Administrator, you or your treating provider; the terms of the Plan, to insure that the IRO's decision is not contrary to the terms of the Plan; appropriate medical practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO will provide written notice to you and the Plan Administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. The IRO's notice will contain, to the extent required by law: a general description of the reason for the request for External Review, including information sufficient to identify the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial; the date the IRO received the assignment and the date of the IRO's decision; references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidenced-based standards; a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you; a statement that judicial review may be available to you; and, if applicable, current contact information for any applicable office of health insurance consumer assistance or ombudsman. If the IRO reversed the Plan's determination, the Plan will immediately provide coverage or payment for the claim but reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law and regulations.

Expedited External Review

Under the following circumstances, you may be eligible to file for an expedited External Review:

- If you receive a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Board of Trustees would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal;

- If you receive a claims denial that involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services but has not been discharged from a facility and the claimant has filed a request for an expedited internal appeal; or

- If you receive a final appeal denial from the administrator and:

  - You have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or

  - If the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the Plan Administrator will complete a preliminary review of your request in order to determine your eligibility for an expedited External Review. Immediately after completion of the preliminary review, the Plan Administrator will issue you a written notification of your eligibility for an expedited External Review. If your request is complete but not eligible for and expedited External Review, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to make the request complete and you will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the Plan Administrator will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice, to you and the Plan Administrator of the final External Review decision as expeditiously as

possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review. If notice of the IRO's decision is not in writing, then the IRO will provide written confirmation of its decision within 48 hours after the date of such notice of the decision.

Right to Bring Civil Action

If any person is dissatisfied with the External Review decision or the final decision of the Board of Trustees either after written notice of the Board of Trustees' initial denial of their claims appeal, or after its reconsideration, if any, of the appeal, a Claimant has a right to bring a civil action under section 502(a) of ERISA in either state or federal court.

No action may be filed by any person against the Plan, the Trustees, or any of the Trustees' agents more than 180 days after a Claimant is given written notice of the denial of an appeal or if applicable the External Review decision. Unless a Claimant is otherwise expressly advised in writing, the 180-day period will not be extended even if the Board of Trustees again considers the appeal after the denial. This 180-day limitation period will apply to all legal and equitable actions arising out of, or relating to, a claim for benefits including, but not limited to, any legal or equitable action under ERISA to the extent the claim relates to the provision of benefits or rights under the Plan.

PHYSICAL EXAMINATION BENEFIT FOR QUALIFIED MAINTENANCE EMPLOYEES

The Physical Examination benefit provides medical examination review and medical tests through the WorkCare Medical Testing Program ("Program") to employees in Covered Employment (or those who have applied for Covered Employment) with certain Employers who are required to make contributions to the Plan on behalf of their employees to receive the specific Program benefits. The purpose of this benefit is to identify an employee's exposure-related health issues early.

The benefit consists of medical examination reviews by a participating provider under the Program and applicable medical tests, which include a pre-employment examination and a base line X-ray, and an annual examination thereafter. Upon receiving the medical examination review under the Program, the reviewing physician will issue a medical clearance on your behalf so that you may begin work with the Employer.

To schedule your Physical Examination, you may contact WorkCare at (800) 455-6155.

Please note, this benefit is not available to all Participants. You must be in or about to begin Covered Employment with an Employer who contributes to the Plan for this specific benefit. For more information on the benefit, as well as whether this benefit applies to you, please contact the Trust Fund Office.

LIFE INSURANCE – FOR ALL ELIGIBLE ACTIVE MAINTENANCE EMPLOYEES

The Benefit

In the event of your death, due to any cause, you beneficiary will be paid:

- $2,000 group life insurance benefit, and
- $3,000 death benefit

These amounts are subject to change by the Board of Trustees.

Insurance During Total Disability

If you become totally disabled while your protection under the Fund is in effect and before age 60, the full

amount of your $2,000 group life insurance will be continued for the remainder of the disability without any cost to you. Please contact the Administrative Office for further details.

Your Beneficiary

Your beneficiary may be any person or persons you name, in writing on the enrollment form supplied by the Administrative Office. You may request a change of beneficiary at any time by submitting a new enrollment form with the Administrative Office. If you fail to designate a beneficiary or if your beneficiary does not outlive you, and you do not select another, your beneficiary will be the surviving person or persons in the order of priority of listing of the following classes:

1. Spouse

2. In equal shares, children, including legally adopted children.

3. In equal shares, parents

4. In equal shares, the persons next entitled to succeed to intestate property as provided under applicable State probate laws.

How to Continue Your Life Insurance if You Lose Eligibility

If your eligibility terminates while the Group Insurance Policy remains in force, your $2,000 group life insurance will be paid in the event your death occurs during the next 31 days.

During the 31 day period you may change your group life insurance to an individual policy without having to furnish evidence of good health. You may select any type of individual policy then customarily being issued by United of Omaha, except term insurance or a policy containing disability benefits. The individual policy will be made effective at the end of the 31 day period. The premiums will be the same as you would ordinarily pay if you applied for an individual policy at that time. For further details about this arrangement, contact United of Omaha at (800) 775-8805

Should you again become eligible, you may not avail yourself of this provision if any individual policy is in effect as a result of a previous conversion.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – FOR ALL ELIGIBLE ACTIVE MAINTENANCE EMPLOYEES

The Benefit

Your accidental death and dismemberment benefit will be paid for any of the following losses through accidental means, on or off the job. The injury must be sustained while you are insured and the loss must occur within 12 months after such injury. Payment will be made regardless of any other benefits you may receive. The 12 month period will be waived if you are in a coma being kept alive by an artificial support system as the result of a covered accident.

Loss of Life $20,000
(Paid to your beneficiary)

Loss of (two or more):
Hands; feet; sight of eye; or loss of Speech and Hearing $20,000
(Paid to you)

Loss of:
One hand; one foot; or sight of one eye, Speech or Hearing $10,000
(Paid to you)

Loss of:
Thumb and index finger of same hand.....$5,000
(Paid to you)

If you suffer more than one loss in an accident, payment will be made only for the one loss for which the largest amount is payable.

Exclusions

Benefits will not be paid for any loss which:

- is not permanent;
- occurs more than 90 days after the injury;
- is caused by carbon monoxide poisoning;
- is caused by allergic reaction;
- is caused by using unauthorized controlled substances;
- results from injuries you receive while operating or riding in any aircraft, except as a passenger in a commercial aircraft on a regularly scheduled flight;
- results while you are sane or insane from:
  - an intentionally self-inflicted injury or sickness; or
  - suicide or attempted suicide;
- results from your participation in a riot or in the commission of a felony;
- results from an act of declared or undeclared war or armed aggression; or
- any governmental body or its agencies are liable while you are on active duty or training in the:
  - Armed Forces;
  - National Guard; or
  - Reserves of any state or country.

Please note that all exclusion for other benefits, are included in more detail in the service agreements and/or evidence of coverage booklets provided by the insurance carrier of the other benefit plans.

SMOKING CESSATION PROGRAM BENEFITS – FOR ALL ELIGIBLE ACTIVE MAINTENANCE EMPLOYEES

The Fund has made arrangements with the California Smokers' Helpline to provide counseling services to employees and their dependents who wish to quit or are thinking about quitting tobacco products. THE HELPLINES ARE AVAILABLE TO YOU AND YOUR ELIGIBLE DEPENDENTS AT NO COST TO YOU.

The California Smokers' Helpline is available Monday through Friday 9:00 a.m. to 9:00 p.m. and Saturday 9:00 a.m. to 1:00 p.m. at the following numbers:

English – 1-800-NO-BUTTS (800-662-8887)
Spanish – 1-800-45-NO-FUME (800-456-6386)

Separate brochures describing the counseling programs are available from the Administrative Office.

When calling for counseling services, please identify yourself as a member of the Health and Frost Insulators and Asbestos Workers Health and Welfare Fund.

Zyban and Nicotine replacement products such as gum, inhaler, patch or spray are covered by the Fund. You will be reimbursed by the Fund upon submission of claims as described on pages 14 through 18.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

1. **Name of Plan.** This Plan is known as the Heat and Frost Insulators and Asbestos Workers Health and Welfare Trust Fund. (Please note that the Plan is also known as "Heat and Frost Insulators and Allied Workers Health and Welfare Fund" and the use of either name refers to this plan).

2. **Plan Administrator and Sponsor.** The Board of Trustees is the Plan Administrator. This means that 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 the Employee Retirement Income Security Act of 1974. As Plan Administrator, the Board of Trustees is responsible for determining eligibility for and payment of benefits.

   The Administrative Office will provide you, upon written request, information as to whether a particular employer or union is contributing to this Plan on behalf of participants in the Plan and if the employer or union is a contributor, the address of the employer or union.

3. **Board of Trustees.** The Board of Trustees consists of an equal number of employer and union representatives selected by the employers and union in accordance with the Trust Agreement which relates to this Plan.

   If you wish to contact the Board of Trustees, you may use the address and phone number below:

   Heat and Frost Insulators and Asbestos Workers
   Health and Welfare Trust Fund
   P.O. Box 430
   West Covina, CA 91793
   (800) 433-6692

   The Trustees have engaged the independent contractor named below to perform the routine functions of the Plan and assist the Board of Trustees in their execution of certain duties and responsibilities under the Plan:

   BeneSys Administrators.
   1050 Lakes Drive, Suite 120
   West Covina, CA 91790
   (800) 433-6692

4. **Names, Titles and Addresses of Any Trustee or Trustees.** As of October 1, 2021, the Trustees of this Plan are:

Union Trustees	**Employer Trustees**
Michael Patterson, Chairperson Business Manager Heat and Frost Insulators and Allied Workers Local 5 3833 Ebony Street Ontario, CA 91761	Patrice Reynolds, Co-Chair Farwest Insulation Contracting 1220 S Sherman St Anaheim, CA 92805
Daniel Haguewood, Business Manager H.F.I.A.W. Local 135 4316 E. Alexander Road Las Vegas, NV 89115	Craig Skeie Irex Corporation 11807 East Smith Avenue Santa Fe Springs, CA 90670
Eddy Pena Heat and Frost Insulators and Allied Workers Local 5 3833 Ebony Street Ontario, CA 91761	Michael Curtin General Manager Performance Contracting, Inc. 1822 Main St, Ste A San Diego, CA 92113
Fredi Flores (Alternate) Heat and Frost Insulators and Allied Workers Local 5 3833 Ebony Street Ontario, CA 91761	Ernie Martinez (Alternate) Performance Contracting, Inc. 1822 Main St, Ste A San Diego, CA 92113

5. **Identification Numbers.** The number assigned to the Plan by the Internal Revenue Service is 95-6093752. This Plan Number is 501.

6. **Agent for Service of Legal Process.** The name and address of the agent designated for the service of legal process is:

Ms. Kim Gould
c/o BeneSys Administrators
1050 Lakes Drive, Suite 120
West Covina, CA 91790

A copy should be sent to:
Jeffrey L. Cutler
Wohlner Kaplon Cutler Halford Rosenfeld & Levy 16501 Ventura Blvd., Suite 304
Encino, CA 91436

Legal process may also be served on any Plan Trustee.

7. **Collective Bargaining Agreement.** Contributions to this Plan are made on behalf of each employee in accordance with Collective Bargaining Agreements between Local Unions 5 and 135 of the International Association of Heat and Frost Insulators and Allied Workers and employers in the industry.

The Administrative Office will provide you upon written request, a copy of the Collective Bargaining Agreement. The Collective Bargaining Agreement is also available for examination at the office of the Plan Administrator.

8. **Source of Contributions.** The benefits described in this SPD and Plan Document are provided through employer contributions to this Plan. The amount of employer contributions to this Plan is determined by the provisions of the collective bargaining agreements with employer representatives. The collective bargaining agreements require contributions to this Plan at a fixed rate per hour worked. The Administrative Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreement. There are provisions allowing employees whose eligibility under the Plan has terminated to make premium self-payments.

   As discussed previously in this SPD, certain classifications also require self-payments for Dependent coverage.

9. **Type of Plan.** This Plan is maintained for the purpose of providing life insurance, accidental death and dismemberment, hospital, medical and dental benefits in the event of sickness or accident for active maintenance employees and their eligible dependents.

10. **Trust Fund.** The Trust's assets and reserves are held in trust by the Board of Trustees (item 4 above) of the Heat and Frost Insulators and Asbestos Workers Health and Welfare Trust Fund.

11. **Identity of Providers of Benefits.** The life insurance benefits are underwritten by United of Omaha. The accidental death and dismemberment benefit is underwritten by Mutual of Omaha. The smoking cessation program benefits are provided by the Fund. The Vision program is administered by Vision Service Plan. Prepaid medical benefits are provided by Kaiser Permanente. Prepaid dental benefits are provided by United Concordia. The Physical Examination Benefit is provided by WorkCare.

    The complete terms of the life insurance and accidental death and dismemberment benefits are set forth in the Group Policy issued by United of Omaha. The complete terms of the prepaid medical benefits are set forth in the Kaiser Permanente Service Agreement. The complete terms of the prepaid dental benefits are set forth in the DeltaCare USA Service Agreements.

    Following are the names and addresses of all Health Providers for the Health and Welfare Fund:

Kaiser Foundation Health Plan
California Region - Southern California area
393 East Walnut Street
Pasadena, CA 91188
Provides prepaid medical and prescription drug benefits to participants covered under the plan who elect coverage under the Kaiser option.

DeltaCare USA
P.O. Box 1810
Alpharetta, GA 30023
Provides prepaid dental benefits to participants covered under the plan who elect coverage under the DeltaCare USA Dental option.

United of Omaha (Mutual of Omaha)
Mutual of Omaha Plaza
Omaha, NE 68175
Provides fully insured life and accidental death and dismemberment benefits to participants covered under the plan.

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
Administers self-funded vision benefits to participants covered under the plan.

WorkCare
300 S. Harbor Blvd. Suite 600
Anaheim, CA 92805
Provides physical examination benefits funded by Employers required to contribute funds to the Plan on behalf of their employees eligible to receive these benefits.

12. **Fiscal Plan Year.** The fiscal records of the Plan are kept separately for each Fiscal Plan Year. The Fiscal Plan Year begins on January 1 and ends on December 31.

13. **The Plan's Requirements With Respect to Eligibility for Participation and Benefits.** The eligibility requirements are specified on pages 2 through 4.

14. **Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits.** Loss of eligibility is described on pages 6 through 7.

15. **Procedures to Follow for Filing a Claim.** The procedure to be followed in filing a claim for benefits is outlined on pages 14 through 18.

16. **Review Procedure.** If your claim is denied in whole or in part, you will receive a written explanation giving detailed reasons for the denial, specific reference to the Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such information or material is necessary, as well as an explanation of our claim appeal procedure. A description of the appeal procedure appears on pages 17 through 20.

17. **Availability of Documents and Other Important Information.** As a participant in the Heat and Frost Insulators and Asbestos Workers Health and Welfare Fund, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

    a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksite 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.

    b. Obtain, upon written request to the Plan Administrator, 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 updated summary plan description. The administrator may make a reasonable charge for the copies.

    c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

    d. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description/Plan Document for the rules governing your COBRA Continuation Coverage rights.

    e. Reduction or elimination of 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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

    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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may 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 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. 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 state or 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. 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 office of the Office of Pension-Welfare Benefit Programs, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Nothing in this statement is meant to interpret or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan, or the benefits provided in the Plan, whenever, in their judgment, conditions so warrant.

18. **Health** Insurance and Accountability Act of 1996 (“HIPAA”) Privacy Notice

A law, known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy rules issued under the law, gives you certain rights with respect to your health information. It is required that the Fund protect the privacy of your personal health information and establish a formal policy and procedure for maintaining the privacy of your Protected Health Information (PHI).

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.

- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights. To do so, contact the Privacy Officer by using the information provided on the last page of this Notice.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and in accordance with the HIPAA Privacy Rules. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We *never* share your information in the following circumstances unless you give us written permission:

- Marketing purposes
- Sale of your information
- Psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: *We use health information about you to develop better services for you under the Plan.*

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
We may disclose de-identified health information to the Board of Trustees for plan administration.

Example: *We provide de-identified claims information to the Board of Trustees so that they may determine employer contribution rates.*

Other Uses and Disclosures
Any other use or disclosure not described in the Notice will only be made with your authorization.

Revocation of Prior Authorization
You may revoke a prior authorization granted for psychotherapy notes, marketing, sales or any other authorized use and disclosure mentioned above.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

- We must follow the duties and privacy practices described in this notice.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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 Privacy Officer, specified below:

BeneSys Administrators
Privacy Officer
700 Tower Drive, Suite 300
Troy, MI 48098
Phone: (248) 813-9800 or Fax: (248) 206-4903 confidential fax

For Further Information Call or Write

HEAT AND FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE FUND
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(800) 433-6692

BE SURE TO STATE YOUR SOCIAL SECURITY NUMBER OR IDENTIFICATION NUMBER ON ALL COMMUNICATIONS REGARDING BENEFITS