HEAT AND FROST INSULATORS

AND

ASBESTOS WORKERS

HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

For Eligible Active Mechanics and their Eligible Dependents

Revised January 1, 2023

Attention: If you are classified as a Local 5 or Local 135 Journeyman, Fire/Safety Tech, Local 5 Apprentice 1st through 5th year, Local 135 Apprentice 1st through 5th year, or a Local 135 Pre-Apprentice/Helper, you are eligible for benefits under this Plan. However, certain classifications of employees have access to limited benefits under this Plan. If you are a Local 135 Pre-Apprentice/Helper you are eligible for self-coverage only, and may only receive these benefits under the Fee-For-Service medical plan and dental plan. Dependent coverage for Local 135 Pre-Apprentice/Helper is available on a self-payment basis. If you are a Local 135 Apprentice or Journeyman or a Local 5 Journeyman, Apprentice or Fire/Safety Tech, you are eligible for all medical and dental benefit options offered by the Trust for you and your family. Please contact the Administrative Office at (800) 433-6692 if you have questions about what benefits are available to you under the Plan as described in this SPD and Plan Document.

HEAT AND FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE TRUST FUND
MECHANICS

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

Employer Trustees
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Michael Curtin
Ernie A. Martinez (Alternate)
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HEAT AND FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE TRUST FUND

To Active Mechanics:

We are pleased to provide you with this new booklet that describes the Fund benefits available to eligible active Mechanics and their eligible dependents.

Review this booklet carefully for information regarding eligibility for Fund benefits. This booklet constitutes your Plan Document and Summary Plan Description ("SPD") and includes important information to help you understand and appropriately access your benefits. For a schedule or any additional information on your other Plan benefits under any insured benefit plans, please refer to the appropriate HMO or Evidence of Coverage insurance booklet for the current Plan year.

You may select either an insured medical and prescription drug plan offered by the Fund of which benefits are further described in detail in separate brochures available from the Administrative Office or the Fee-For-Service medical plan described in this booklet. If you choose coverage under one of the insured plan options, individual Evidence of Coverage booklets are to be read together with this SPD to determine eligibility and benefits provided under the insured plan, as these documents together constitute the Plan Document for the insured plans. You make your plan selection when you first become eligible for benefits. You may change your plan selection once you have been in your current selection for a minimum of twelve (12) months. The plan you choose will apply to you and to your eligible dependents.

We recommend that you contact the Administrative Office before you incur expenses for costly hospitalizations, out-patient testing or surgical procedures so that you will know the plan's benefit in advance. Discuss the costs of the proposed treatment and any alternatives before you receive treatment. The Fee for Service Medical Plan includes a network of preferred providers, so you will receive greater benefits and incur less out-of-pocket expenses by using these providers. In addition, benefit payments are subject to certain limitations and exclusions as well as utilization review procedures described in greater detail in this booklet.

You may select either the prepaid dental plan offered by the Fund described in a separate brochure available from the Administrative Office or the Fee-For-Service dental plan described in this booklet. You make your selection when you first become eligible for benefits. You may change your plan selection once you have been in your current selection for a minimum of twelve (12) months. The plan you choose will apply to you and to your eligible dependents.

A description of the vision plan is contained in a separate brochure.

The life insurance benefits, accidental death and dismemberment benefit, the chiropractic care benefit, smoking cessation program and the vitamins and minerals benefits described in this booklet currently apply to all eligible Mechanics, regardless of the medical or dental options selected.

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 discretion and authority to interpret 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 Participants, their Dependents and Providers.

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 a third party administrator, BeneSys Administrators. If you have any questions, please contact the Administrative Office at the telephone numbers and/or address provided later in this booklet. 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 Summary Plan Description and Plan Document, the Trust Agreement, and the contracts with various providers.

Authorized Source of Information
Questions regarding eligibility, benefits or other matters should be submitted to the Administrative Office. The Administrator is BeneSys 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 this Plan, to interpret the terms of the Plan, to determine or change the eligibility rules, maximum benefits, deductible, self-payment rates and 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 at least 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 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.

Disclaimer
Fee-for-service medical and dental benefits described in this SPD and Plan Document are not insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust collected and available for such purposes. The Trustees reserve the right to amend or terminate any of the benefits described even though such termination or amendment may affect claims that have already accrued, including alteration of the eligibility rules.

Additional Disclaimer and Amendment and Termination information may be found on page 19 of this booklet.

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).

Note: Under the terms of the Fee for Service Plan, no benefit will be payable with respect to any hospital admission of a Dependent child on account of pregnancy, childbirth, miscarriage, or abortion except for involuntary complications of pregnancy.

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 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.

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 11.	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 11 – 14 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 Fee-for-Service Medical Plan Chiropractic Benefits Vitamins and Minerals Benefits Smoking Cessation Program Benefits Fee-for-Service Dental Plan	Administrative Office (BeneSys Administrators) (800) 433-6692 1050 Lakes Drive, Suite 120 West Covina, CA 91790 www.hfawbenefits.org
Smoking Cessation Helpline	In California - (800) 662-8887 (English) (800) 456-6386 (Spanish) In Nevada and other States except California: (800) QUIT NOW or (800) 784-8669
Vision Care Benefits Information and Forms	Vision Service Plan Customer Service - (800) 877-7195 333 Quality Drive Rancho Cordova, California 95670 Fax Out of Network claims to: (916) 851-5152 Internet Website: www.vsp.com
Fee-for-Service Medical Plan: Hospital Pre-admission Certification, Continued Stay Review; Pre-Procedure Review Program	Anthem Blue Cross 1-800-274-7767 Monday through Friday 7:30 a.m. – 5:00 p.m. Internet Websites: www.anthem.com/ca for CA providers or www.bcbs.com for outside CA
OptumRx (formerly Prescription Solutions)	Phone: (800) 797-9791 Internet Website: www.optumrx.com
Kaiser Foundation Health Plan	Phone: (800) 464-4000 Internet Website: www.healthy.kaiserpermanente.org
UnitedHealthcare in California	Phone: (800) 624-8822 Internet Website: www.myuhc.com
UnitedHealthcare in Nevada	Phone: (800) 347-8600 Internet Website: www.myuhc.com
UnitedHealthcare Dental (Nevada)	Phone: (800) 926-0925 Internet Website: www.myuhc.com
DeltaCare USA (California)	Phone: (800) 422-4234 Internet Website: www.deltadentalins.com/deltacare
First Dental Health (Indemnity Plan)	Phone: (800) 334-7244 Internet Website: www.firstdentalhealth.com

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SCHEDULE OF BENEFITS

FOR YOU - PROVIDED BY UNITED OF OMAHA
(Provided regardless of your Medical or Dental Plan selection)

LIFE INSURANCE $10,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
Principal Sum $20,000

FOR YOUR DEPENDENTS - PROVIDED BY MUTUAL OF OMAHA
(Provided regardless of your Medical or Dental Plan selection)

LIFE INSURANCE
Spouse $1,000
Children:
Less than 6 months $100
6 months but less than 21 years (23 years if student)..... $500

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.

FOR YOU AND YOUR DEPENDENTS
Insured Medical Plans - If you are eligible to select one of the Insured Medical Plan options for you and 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, If you and your Eligible Dependents are covered under an insured medical plan, you are also covered for the following benefits which are included in the Fee-For-Service Medical Plan Benefits section on page 38 Chiropractic care, smoking cessation program benefits, and vitamin and mineral benefits.

If you select the Fee-For Service Medical Plan for you and your eligible Dependents, the following benefits will be provided by the Fund:

FEE-FOR-SERVICE MEDICAL BENEFITS
For PPO Providers:
Deductible Amount for each individual..... $200 per calendar year
(Maximum of $400 per family per calendar year)

For Non PPO Providers:
If you are in the PPO Service Area, deductible amount for each individual……$400 per calendar year
(Maximum of $800 per family per calendar year)

The deductible is waived for expenses due to an accident, charges for chiropractic care treatment, charges for vitamins and minerals prescribed by a Physician, smoking cessation program benefits, charges for confinement in a PPO HOSPITAL, charges of a birthing center or for routine physical exams with a PPO provider, and charges in connection with HOSPICE CARE.

Maximum Benefit
Annual Maximum Benefit: There is no Annual Maximum Benefit on Preventative Health Services but may be subject to limitations for certain services as follows:

For Non PPO Providers:
$100 for physician charges and $150 for related tests for routine physical exams (for Dependents only) once every three years up to age 40; once every two years up to age 50 and annually thereafter; and one visit a year for routine gynecological exam and for related tests

For PPO Providers and Non PPO Providers:

- Chiropractic treatment, including any x-ray or laboratory services, limited to 20 visits during a calendar year.
- Acupuncture treatment limited to $30 per visit and 50 visits per calendar year

Percentage Payable:

Accident ..... 100% of the first $300 of Covered Expenses per accident
PPO HOSPITAL, other PPO provider, or emergency care from a Non-PPO provider.. ..... 85%
Non-PPO HOSPITAL or other non-PPO provider 50%
Non-PPO HOSPITAL or other non-PPO provider for out-of-area services 80%

EXTENDED CARE FACILITY 80%
Room and board charges are limited to 50% of the HOSPITAL'S semi-private rate, to a maximum of 60 days per confinement.
Birthing Center 90%
HOSPICE CARE 100%
Acupuncture 50%
ALLOWABLE CHARGES are limited to $30 per visit and 50 visits per calendar year.
Chiropractic treatment 80%
ALLOWABLE CHARGES are limited to 20 visits per calendar year.
All other covered charges 80%
Preventive Care Benefits provided by PPO provider 100%

FEE FOR SERVICE PRESCRIPTION DRUG BENEFITS:
Out-patient Prescription Drugs Percentage Payable 80%

Medical Plan – after the member incurs $15,000 of covered charges payable at 80%, 85% or 90%; the plan will pay 100% of PPO expenses for the remainder of the calendar year. The maximum out-of-pocket will be $3,000 per individual and $6,000 per family and excludes charges payable at 50%, unless required by law, (non-PPO charges except emergency) but includes the PPO deductible of $200.

Prescription Drug Plan – the member pays 20% of covered drug expenses at the counter. Once the individual has paid $3,600 in out-of-pocket expenses ($7,200 per family), the plan will pay 100% of covered expenses for the remainder of the calendar year.

In no event will the combined maximum out-of-pocket for medical and prescription drug expenses exceed $6,600 per individual and $13,200 per family.

Prepaid Dental Plans – If you are eligible to select one of the Prepaid Dental Plan options for you and 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.

If you select the Fee-For-Service Dental Plan for you and your eligible Dependents, the following benefits will be provided by the fund:

FEE-FOR-SERVICE DENTAL BENEFITS

Calendar Year Deductible	$50 per person; Waived for diagnostic and preventive services
Dental Plan Maximum	$3,000 per person each two consecutive calendar year periods for non-orthodontic charges
There is no calendar year maximum for Dependents ages 18 and under.)	
Diagnostic and Preventive Services	100% of ALLOWABLE CHARGES
Basic Services	80% of ALLOWABLE CHARGES
Orthodontics	Covered up to $2,500 lifetime maximum per dependent child only. NOT COVERED for participants over 18 years old.
Implants	NOT COVERED
Periodontic and Endodontic Services	80% of ALLOWABLE CHARGES
Major Restorations (Crowns, Bridges and Dentures only)	50% of ALLOWABLE CHARGES

NOTE: ALLOWABLE CHARGES are defined on page 58.

You must file your claim for fee-for-service medical and dental benefits within 12 months from the date the services or supplies were rendered.

ELIGIBILITY RULES

The eligibility rules described in this booklet apply to all the benefits provided through the Fund to active mechanics and their eligible dependents, including the optional HMO plans and may be changed from time to time at the sole and absolute discretion of the Trustees.

Initial Eligibility

To establish eligibility, 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 320 hour requirement.

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 April you receive coverage during June.

For information of Retiree eligibility for benefits under the Plan please refer to page 16 of this SPD.

Owner/Operator Eligibility

To be eligible for benefits under the Plan an Owner/Operator must be clearly defined as a class of employee for which the Trust will accept contributions.

The Owner/Operator must be an employee of an employer organization even though the Owner/operator may be a substantial, or sole owner of the organization. For practical purposes, and in order to rule out any doubts which might attach to the Owner/Operator's status in partnerships (both regular and limited), joint ventures and similar business associations, the only employer organization the Trust will recognize is a corporation. If the Owner/Operator is an employee of a corporation, he will be regarded by the Trust as an employee; if he is an owner in any other type of business organization, he will not be recognized as an employee, and will not be eligible to participate in the Plan.

In order for an Owner/Operator to be eligible to participate in the Plan, the following conditions must be satisfied:

1. The corporate employer has a written collective bargaining agreement with an Allied Workers Local Union participating in the Trust.
2. The corporate employer must contribute to the Trust on behalf of any participating Owner/Operator contributions at a level of 173 hours per month. This level of contributions approximates the cost of

maintaining benefit coverage for the Owner/Operator employee while permitting efficient Trust operation under the definite hours standard.

3. The Owner/Operator must devote more than 20% of his time to work of the type covered by the employer's collective bargaining agreement with an Asbestos Workers Local.

No self-payments will be permitted on behalf of the Owners/Operators, except as provided by COBRA.

The Board of Trustees reserves the right, if results adverse to the Trust arise from accepting these contributions from Owner/Operators, to discontinue receipt of such contributions or amend the conditions on which such contributions are accepted.

Hour Bank

Hours worked in a month in excess of 120 hours will be credited to your Hour Bank up to a maximum of **30 hours.**

All Active Mechanics will be able to accumulate up to **360** hours in his/her Hour Bank.

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 current journeyman hourly contribution rate multiplied by the number of hours needed to reach the 120 hour requirement for coverage for the month. 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, firestopper 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

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 be covered under the Plan 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.

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 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 Booklet. **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 Dependent Coverage Becomes Effective

Your eligible dependents will become covered on the date your coverage is effective or on the date you acquire the dependent, or the first day of any calendar month following dependent enrollment in coverage, whichever is later. Dependents can be added up to 6 months after your initial eligibility only if you are enrolled in one of the fully insured options.

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).

If you are enrolled in the Plan's self-insured option, your Dependents who lose coverage under MediCal can be added up to four (4) months after MediCal coverage has ended. For all other special enrollments, you must request enrollment within 60 days (6 months for the HMO/PPO Fully Insured Plans) 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 in this Plan within 60 days after the date your eligibility for the subsidy is determined (6 months for the HMO/PPO Fully Insured Plans).

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 within 60 days after the marriage, birth, adoption or placement for adoption (6 months for the HMO/PPO Fully Insured Plans).

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 10 for a description of the Fund's self-pay provisions);

- the date your full-time military service exceeds 31 days.
- 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
- you are an owner operator and your company is delinquent in payment of its contributions.
- the date the benefit programs are terminated by the Board of Trustees.

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 4, and your residual hours may be terminated.

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 if 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** and the Employee’s Contributing Employer submits a contribution to the Plan on behalf of the Employee, 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, and 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 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.

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 5;

- 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.

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

Refer to "Special Extensions" below.

Special Extensions

Disabled Active Mechanics
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 that 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 and dental and vision benefits.

Total disability means that as a result of injury or illness, you are unable to perform your regular duties as a Heat and Frost Mechanic.

If you exhaust this extension, you and your Dependents may continue coverage in accordance with the Fund's COBRA provisions described on page 11. 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 mental or physical handicap on the date his eligibility would otherwise terminate because of age, his coverage will be continued if sufficient proof of incapacity is submitted to the Administrative Office.

Self-Pay Provisions

Active Mechanics 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: return to active employment, become eligible to participate in another health and welfare plan, or 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. An extension may be granted if you contact the Administrative Office immediately upon receiving a monthly voucher notifying you of your eligibility status and make payment as reasonably possible but not later than 30 days.

Example:

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

The amount of the self-payment is determined by the Board of Trustees and subject to change from time

to time. The Board of Trustees use the current hourly journeyman contribution rate for employers to determine the self-payment required to continue coverage after loss of eligibility.

If you exhaust this nine month self-payment option and you had 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 the length of your self-payment coverage is deducted from the number of months of any COBRA coverage to which you or your eligible dependents may be entitled.

Surviving Dependents of Deceased Active Mechanics
In the event of your death, coverage for your surviving eligible dependents will be extended at no cost. This Trust provided coverage will terminate on the earliest of:

- the date your last contributing employer stops making contributions to the Fund;
- the date your surviving spouse remarries;
- the last day of the 24th month following the date of your death;
- the date the benefit programs are terminated by the Board of Trustees; or
- the date your surviving spouse is eligible for similar medical coverage under another group plan.

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

If your surviving eligible dependents exhaust their 24 month coverage extension, your surviving spouse may continue their coverage, including life insurance, 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 is determined by the Board of Trustees and is subject to change from time to time.

Self-pay coverage for your surviving dependents may be continued until the earliest of the following:

- 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; or

- the date the benefit programs are terminated by the Board of Trustees.

COBRA Continuation Coverage

For All Mechanics 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 1975 (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 certain 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, accidental death and dismemberment benefits or the physical exam benefit. You may select "core" coverage, which provides medical benefits only, or "core plus" coverage which includes medical, 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 5. A child eligible to be continued under the Plan's special extension for mentally and physically handicapped children will be considered to have dependent status;
- 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.

New dependents acquired while you are covered under COBRA can be added by notifying the Administrative 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.
- There are also ways in which this 18 month period of COBRA continuation coverage can be extended:

If the Social Security Administration determines that you or any of your covered dependents were disabled at any time 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 coverage 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 Plan Administrator, as described below, of this second qualifying event.

- Special rules apply for retired employees and their spouses and dependents covered by the Plan if the former employer is involved in federal bankruptcy proceedings. If the retiree's coverage is eliminated or substantially reduced within one year before or after the bankruptcy proceeding began, the retired Employee will become a qualified beneficiary as well as the retired Employee's spouse, registered domestic partner, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. The retired employee and any eligible dependents may choose to continue coverage for the life of the surviving spouse. Eligible dependents may continue coverage for up to 3 years after the retiree's death.

- Please note, once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the 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.

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.

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 coverages 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 5, 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 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(s) 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. (Applies 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 Plan Administrator 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.

CHOICE OF PLANS FOR ELIGIBLE ACTIVE MECHANICS

Medical

Two types of medical benefit plan options are available to eligible active mechanics and their eligible dependents in some areas.

- An insured health plan provided through a health maintenance organization (HMO) or other insurance carrier is paid for by direct payments from the Fund to insurance carriers in the form of premiums from employer contributions. As of the publish date of this SPD you may choose the **Kaiser Foundation Health Plan, UnitedHealthcare in California or UnitedHealthcare in Nevada**;

  No new participants shall be allowed to enroll in the United Health Care California HMO option effective May 1, 2020. Participants that are enrolled in the United Health Care California HMO option as of May 1, 2020 shall be grandfathered into that option. If the participant loses eligibility on or after May 1, 2020, they shall be allowed to re-elect coverage in the United Health Care California HMO option if they re-establish eligibility within twelve (12) months. If eligibility is not re-established within twelve (12) months, the participant must select another available health plan option.

  *You must live within the service area of one of the insured plans to enroll. If you are enrolled in the insured plan option, you and your eligible dependents are covered **under that plan** for HOSPITAL, medical and prescription drug services and supplies. If you are enrolled in an insured plan and later move out of that plan's service area, you must contact the Administrative Office to discuss your other plan options through the Trust.*

- The "fee-for-service" plan under which benefits are paid for and provided directly by the Fund. If you are enrolled in the Fee-For-Service option, you and your eligible dependents are covered under the Fund's Fee-For-Service Plan for HOSPITAL, medical and prescription drug services and supplies. You may receive medical care from any licensed HOSPITAL, PHYSICIAN or other health provider. To receive the maximum available benefits, use a PPO HOSPITAL or other PPO provider and comply with the utilization review programs. As of the publish date of this SPD, Anthem Blue Cross provides its network of Hospitals and Medical Providers from which you are to obtain services under the Plan.

Dental

Two types of dental plan options are available to eligible active mechanics and their eligible dependents:

- Current prepaid dental plan provided through DeltaCare USA in California, and UnitedHealthcare Dental in Nevada; and

- The "fee-for-service" plan provided directly by the Fund.

If you enroll in the pre-paid dental plan, you must live within the service area and receive all dental care through DeltaCare USA or UnitedHealthcare.

If you enroll in the fee-for-service dental plan, you may receive dental services from any licensed DENTIST although the Trust has a contract with First Dental Health to provide a panel of Preferred Providers who have agreed to discounted fees.

Other Coverages

Regardless of which health plan option you are enrolled in, as long as you continue to meet the Fund's eligibility rules, you and your eligible dependents will be covered under the life insurance, accidental death and dismemberment benefits, and for chiropractic care benefits, smoking cessation program benefits and the vitamins and minerals benefit, described in this booklet. You will also be covered under the vision benefits described in a separate brochure.

When To Make Your Health Plan Selections

You are given the opportunity to make your health plan selection and add Dependents when you first become eligible for benefits from the Fund. Once enrolled in the health plan you have selected, you may change your plan selection once you have been enrolled in your current selection for a minimum of twelve (12) months. You may also change your selection if you are enrolled in an insured medical/dental plan and you move away from its service area. If you do not make a plan selection when first eligible, your dependents will not be covered and you will automatically be enrolled in the fee-for-service medical and dental plans and will remain in those plans for twelve (12) months.

In the event you lose Eligibility for Fund benefits, you may change your health plan selection as of the date you re-establish eligibility under the Fund.

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.

How To Make Your Health Plan Selection

When making your initial health plan selection, you must complete and return any required enrollment card(s) to the Administrative Office. During subsequent open enrollment periods, you complete a change form and any new enrollment cards if you wish to change plans. If you do not want to make a change, you do nothing.

Remember, you can only make a health plan selection during the periods noted in the preceding section.

RETIREE BENEFITS

Eligibility for Retirees

If you retire you are eligible to receive benefits under this Plan under a retiree basis. You are eligible to receive **dental and vision benefits** under this Plan as a Retiree if:

- you are receiving either:

    1. an Unreduced Retirement Benefit under the Western States Asbestos Workers Pension Plan rules in effect as of January 1, 1977,

    2. are an employee will qualify for an Unreduced Retirement Benefit upon reaching Normal Retirement Age (attainment of age 62 with at least 5 years of Total Credited Benefit Service without a Permanent Break in Covered Employment; or the later of (1) attainment of age 65 or (2) the fifth anniversary of participation in the Pension Plan without a Permanent Break in Covered Employment) or at any age if he or she has at least 30 years of Total Credited Benefit Service at the time of retirement,

    3. a Reduced Retirement Benefit (retiring prior to attainment of age 62 with at least 10 years of total credited Vesting Service) under the Western States Asbestos Workers Pension Plan rules in effect as of January 1, 1997 and has attained the age of 57, or

4. disability benefits under the Federal Social Security Act;

AND....

5. he/she has maintained eligibility under the Plan for a minimum of 120 out of the most recent 180 months immediately preceding the month in which Plan coverage would have otherwise ceased as a result of retirement. The minimum 120 month requirement will include months in which coverage was extended under the Active Plan hour bank, disability and self-pay provisions. An employee who has attained the age of 57 at the time of his retirement, but who does not have the necessary 120 months of eligibility, may self-pay towards attainment of such 120 months until such time as he acquires an Unreduced Retirement Benefit.

The self-pay requirement will be waived for an employee age 57 and over who is Disabled provided that he:

- was eligible for Health and Welfare Plan coverage on the date of his disability; and
- maintained eligibility under the Health and Welfare Plan for a minimum of 60 months out of the most recent 180 months preceding the month in which Plan coverage would have otherwise ceased.

Disabled means that the employee is prevented from engaging in any occupation due solely to an illness or injury.

A RETIREE who does not qualify under the rules above may qualify for coverage under this Plan if he:

- is at least 57 years old;
- has at least 30 years of Total Credited Benefit Service at the time of retirement;
- has been employed for at least 20 years with an Employer signatory to the Trust with Local 5 or Local 135 and who was required to make contributions to the Heat and Frost Insulators and Allied Workers Health and Welfare Fund; and
- maintained eligibility under the Health and Welfare Plan for a minimum of 60 months of the last 120 months preceding the month in which Plan coverage would have otherwise ceased. An employee who does not have the minimum 60 months coverage will be required to make self-payments until the 60 month requirement is met.

Your coverage will become effective on the first day of the month following the date you satisfy the requirements described above, provided you complete the necessary enrollment forms and make any required self-payment. However, if you are still covered for health and welfare benefits under the Active Plan (i.e., Hour Bank, disability or self-payment provisions), your effective date under this Plan will be deferred until the first day of the month following exhaustion of Active Plan coverage.

Your eligible dependents must be enrolled at the same time you first enroll for Retiree Plan benefits. Coverage for eligible Dependents begins on the same day as your Retiree Plan coverage. If you decline dependent coverage on the enrollment form when first offered, your dependents will not be able to enroll at any future date.

Retirees who are eligible to receive dental and vision benefits, are eligible to receive these benefits on a self-pay basis, i.e. the retiree pays the premium for coverage. The amount of monthly self-payments will be determined by the Trustees, who in their sole discretion may adjust the cost of self-payments for coverage each year if deemed necessary. Medical and prescription coverage is not available to Retirees

under the Plan. New Retirees are given the option to purchase this coverage at the time their active coverage under the Plan terminates and they qualify for retirement.

OTHER FACTS

Enrollment Card

Every active mechanic who is working for a contributing employer should be certain to complete all required enrollment cards. 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, your dependents will not be covered and you will be defaulted into the fee-for-service medical and dental plans.

Policy Rules and Regulations

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

- the Fund's complete Rules and Regulations, including this SPD and Plan Document, relating to the HOSPITAL, medical, prescription drug and dental benefits provided directly by the Fund;
- the Group Policy relating to the life insurance, accidental death and dismemberment benefits and stop loss insurance provided by United of Omaha;
- the Group and Hospital Service Agreement relating to the Kaiser Foundation HMO hospital and medical benefits;
- the Medical and Hospital Group Subscriber Agreement relating to the hospital and medical benefits provided by UnitedHealthcare in California;
- the Medical and Hospital Group Subscriber Agreement relating to the hospital and medical benefits provided by UnitedHealthcare in Nevada;
- the Service Agreement relating to the dental benefits provided by UnitedHealthcare in Nevada;
- the Service Agreement relating to the dental benefits provided by DeltaCare USA in California; and
- the Agreement relating to the vision benefits administered by Vision Service Plan.

Timely Filing of Claims

You must file your Fee-For-Service medical and dental claims within 12 months or one (1) year from the date the medical and dental services were rendered. Claim filing procedures are outlined on pages 25 through 35.

Financing

Benefits for active mechanics 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.

Recovery of Benefit Payments Made in Error

In the event a benefit payment has been made in error, the Fund has the right to recover the erroneous payment by demand for immediate repayment, offset from future benefit payment or any other legal means. The Fund will also be entitled to reasonable attorney's fees and costs of audit.

Disclaimer

The Fee-For-Service dental benefits and a portion of the Fee-For-Service medical benefits described in this booklet are not insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Fund collected for such purpose.

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 mechanics, 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.

As stated above, the Board of Trustees is given the sole authority to amend the terms of the Plan and the benefits provided under the Plan. The agreed to changes in plan terms or benefits provided will be adopted as of the established effective date and required notice of such changes will be provided to Participants, if applicable.

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.

COORDINATION OF BENEFITS – FEE-FOR-SERVICE MEDICAL AND DENTAL PLANS

If both husband and wife work, each is covered by a group health plan and includes the other as a dependent, two or more plans may provide coverage for the same expenses.

Coordination of benefits is simply a way of dividing responsibility for payment among the group plans which cover an individual so that the total of all usual and customary expenses for covered services will be paid. The amount received from all plans will never be more than 100% of covered charges. Charges include all items of care covered under at least one of the plans.

Payment Rule

In processing claims where two or more plans are involved, this Fund follows the "Primary-Secondary Rule".

The primary plan is determined as follows:

1. The plan without a coordination provision is always primary.
2. The plan that covers the individual as an employee pays first.
3. If you are covered as an employee under two plans, the plan under which you have had the longest continuous eligibility pays first.
4. The plan which covers you as an active employee determines benefits before the plan which covers

you as a laid-off or retired employee.

5. The plan which covers a dependent of an active employee determines benefits before the plan which covers such person as a dependent of a laid-off or retired employee.

6. When both plans cover the claimant as a dependent child of an active employee or when both plans cover the claimant as a dependent child of a laid-off or retired employee, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan which has covered the parent longer is primary.

7. If the claim is for a dependent child of divorced or separated parents, the following rules will apply:

   a. The plan of the parent with financial responsibility by virtue of a court decree is primary.
   b. If there is no court decree, the plan of the parent with legal custody is primary.
   c. If there is no court decree and the parent with legal custody has remarried, the order of benefit determination will be as follows:

      1) The plan of the parent with legal custody;
      2) The plan of the spouse of the parent with legal custody; and
      3) The plan of the parent without legal custody.

How Benefits Are Computed

Once responsibility for first payment is established, the plan proceeds in one of two ways:

1. If this Fund is responsible for first payment as the primary plan, it pays benefits in the regular manner, with no consideration of what the secondary plan may or may not pay.

2. If this Fund is the secondary plan, it first determines how much would have been paid had there been no other group coverage. Next it finds out what the primary plan will/did pay. Then a payment is made for the difference between the total "allowable expenses" and the amount paid by the primary plan, but not to exceed the liability under the Fund's coverage. For the purpose of coordination of benefits, "allowable expenses" are any necessary and reasonable expenses for medical or dental services, treatment or supplies covered by one of the plans under which you or your dependents are insured.

For example:

If this Fund is Primary		**If this Fund is Secondary**	
$600	charges	$600	charges
-200	(deductible)	-400	(primary plan paid)
$400		$200	(this plan will pay)
x 80%	(percentage payable)		
$320	(this plan pays)		

When this Fund pays reduced benefits due to this provision, only the reduced amount is charged against the payment limits of the Plan.

Coordination of Benefits with Preferred Provider Agreements

In addition to any other limitations applicable to this Plan or its Coordination of Benefits provisions, where this Plan, as "secondary," is coordinating benefits with another plan which has entered into a preferred provider agreement with a medical or hospital provider, this Plan will pay no more than the difference between:

A. The lesser of: (1) the normal charges billed for the expenses by the provider; (2) the contractual rate for such expense under the preferred provider agreement between the provider and the plan that this Plan is coordinating with, or (3) this Plan's contractual rate with its preferred provider; and

B. The amount that the other plan pays as "primary".

MEDICARE BENEFITS

If you or your Dependent is entitled to benefits under Medicare because you are age 65, the following rules will determine which Plan is primary under this provision.

For Active Members and Their Dependents

This Plan will be the primary Plan to Medicare for an active Member, or a Dependent of an active Member, who is age 65 or older.

Medicare Benefits Due to Total Disability

You or your Dependent may become entitled to Medicare benefits prior to age 65 due to total disability or end stage renal disease. Special rules apply with respect to coordination with Medicare due to total disability or end stage renal disease prior to age 65. Contact the Administrative Office for additional information.

Electing Medicare as Primary Plan

If you or your Dependent are entitled to Medicare benefits at age 65, or as a result of total disability, you or your Dependent may elect to have Medicare as the primary Plan by giving notice to the Contributing Employer. If Medicare is elected as the primary Plan, health insurance under this Plan will cease.

Note: These coordination of benefits provisions apply to all plans except an individual policy you may have purchased on a non-group basis. Self-pay coverage under this Fund is not regarded as an individual policy.

THIRD PARTY LIABILITY – EXCLUSION OF BENEFITS

Benefits will not be due or paid for by this Fund for you or your dependent in connection with any illness or injury in any way caused by the act or omission of another person (a third party). The Fund will make a limited exception to this exclusion and pay benefits for such injury or illness until liability is established and you obtain a recovery from the third party, if you comply with the following conditions. You and your dependents must comply with all of the following:

1. Provide written notice to the Fund within ten (10) days of any accident, injury or illness for which another person may be liable;

2. Provide written notice to the Fund of any claim made against the third party for damages as a result of the injury or illness within ten (10) days of the initiation of any claim;

3. Provide the Fund with a “Subrogation, Assignment of Rights and Reimbursement Agreement” executed by you, and if applicable, by your or your dependent’s attorney, stating that to prevent unjust enrichment, you will reimburse the Fund for all benefits paid by the Fund from the proceeds of any recovery obtained from or on behalf of the third party or the insurer of the third party, in an amount up to, but not exceeding, the recovery and reciting the Fund’s Subrogation rights;

4. Provide written notice to the Fund of Recovery of any amount from any third party or parties in connection with the accident, injury or illness, within five (5) days of an agreement or award of recovery;

5. Provide the Fund with a lien executed by you and your dependent in favor of the Fund for the amount of all benefits provided or to be provided by the Fund in connection with the injury or illness

and a lien executed by any attorney handling your or your dependent's claim against the third party.

6. Keep any Recovery whether in your possession or control or in the possession or control of your attorneys or other representatives received from a third party or from any insurer of a third party, segregated and not commingled with any other funds until paid to the Fund.

7. Agree in writing that the portion of the Recovery required to satisfy the lien of the Fund be held in trust for the sole benefit of the Fund until such time as it is paid to the Fund.

8. Ensure that the portion of the Recovery to which the Fund is entitled is held in trust for the sole benefit of the Fund, comply with the terms of the Fund, and facilitate the reimbursement to the Fund of the amount of benefits advanced by the Fund, including directing any legal counsel retained by you or any other person acting on your behalf, to hold that portion of the Recovery to which the Fund is entitled, in Trust for the sole benefit of the Fund as described below.

9. Provide all information requested by the Fund about any claim, legal action or administrative proceeding, and respond to periodic requests for information from the fund or the fund's representative regarding the status of the claim against the third party or their insurers.

10. Reimburse the Fund from any recovery for the full amount of benefits advanced by the Fund within thirty (30) days after Recovery has been obtained.

You and your dependents must comply with the conditions above prior to any benefits being paid by the Fund in connection with the injury or illness. The term "Recovery" includes any amount received or to be received by way of a court judgment, arbitration award, settlement or any other arrangement from a third party or third party insurer, or from your uninsured or underinsured motorist coverage, including amounts received from uninsured motorist coverage, and amounts received prior to initiation of a lawsuit related to the illness or injury, without reduction for any attorneys' fees paid or owed by you or your dependent, and without regard to whether you or your dependent has been "made whole" by the Recovery. The Recovery includes all monies received regardless of how held, and includes monies directly received by the Participant or eligible Dependent, as well as any monies held in any account or Trust on their behalf, such as an attorney-client trust account not a special needs trust.

If you or your dependent fail to comply with the aforementioned requirements, no benefits will be paid with respect to the injury or illness. Any benefits mistakenly paid will be considered an overpayment, or benefit payment made in error.

If you or your dependent receive any money from a third party as a result of an injury or illness, through any means, including a settlement, court judgment or arbitration award and the Fund has paid benefits on your behalf with respect to the injury or illness, you cannot be unjustly enriched. The amounts due to the fund are deemed held in trust by you as soon as you or your authorized representative obtains possession of any Recovery, and you must honor the Fund's equitable lien. You must reimburse the Fund for any and all benefit payments the Fund made or will make on you or your dependent's behalf in connection with such injury or illness within 30 days after any Recovery has been obtained. In no event will the reimbursement exceed the lesser of the amount of benefits actually paid by the Fund or the amount of the recovery. The Fund will not pay any portion of your attorney fees incurred in connection with your claim against the third party. Any attorney's fees you pay to your attorney will not reduce the amount of the recovery.

In addition, if you or your dependent receive any benefit payments from the Fund for any accident, injury or illness, the Fund is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such accident, injury or illness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such accident, injury or illness in you or your dependent's name and also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy.

The Fund's rights to reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the accident, injury or illness, and regardless of whether you or your dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the accident, injury or illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under you or your dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The "make whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments. This amount is not offset by legal costs, attorneys' fees or other expenses incurred by you or your dependent in obtaining Recovery. The Fund shall have a lien on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the fund until paid to the Fund.

If you or your Dependent receives money from a third party and you do not execute a lien, you will still be responsible to honor the Fund's equitable lien and reimburse the Fund for any benefits paid by the Fund from any monies received from a third party.

If benefits are paid by the Fund without the pre-conditions set forth in this section being met or if you do not reimburse and restore to the Fund the benefits paid by the Fund for an injury or illness for which you or your dependent have received any Recovery from a third party or received reimbursement from uninsured motorist coverage for an injury or illness caused by a third party; the Fund's payment of any benefits in connection with the injury or illness will be considered an overpayment of benefits. In addition to other remedies, the amount of the benefits extended in connection with the illness or injury will be deducted from all future benefit payments up to the amount of overpayment, or the amount of the Recovery, if Recovery is obtained by the Participant, until the overpayment is resolved.

Please refer to page 18 under **Recovery of Benefit Payments Made in Error.**

In the event the Fund is required to pursue recovery of unreimbursed benefits advanced to you or your dependent, or enforce its lien on you or your dependent's recovery, the Fund shall be entitled to recover in addition to the full amount of benefits advanced and accrued interest at 7% per annum, as provided in the current contribution collection policy, all attorney's fees and costs incurred by the Plan in connection with the Plan's efforts to obtain the Funds owed to them.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of you or your dependent's receipt of any recovery. You or your dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependent choose not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you or your eligible dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid the acceptance of benefits obligates you and your dependent (and your attorney, if you have one) to cooperate with the Fund in seeking its recovery and in providing relevant information with respect to the accident.

If the injured person dies, the heirs, beneficiaries and personal representative shall be bound by these obligations.

The Board of Trustees shall have full discretion and authority to interpret and apply these provisions relating to reimbursement of benefits advanced where an injury or illness results from the act of a third party.

INDUSTRIAL ILLNESS OR INJURY

Benefits will not be paid in connection with any illness or injury covered by any workers' compensation statute or similar statutory provision, including:

A. Injuries sustained or aggravated while performing any act pertaining to any occupation or employment for remuneration or profit, or

B. Sickness, disease or injuries covered under any Workers' Compensation or Occupational Disease Act or Law.

Important items to remember include:

1. If you suffer an industrial injury or illness and obtain an award before the Workers' Compensation Appeals Board, that award is your total compensation for the injury or illness. The Fund will not provide benefits for expenses in connection with the injury or illness.

2. If you elect not to seek a workers' compensation award for an industrial illness or injury, the Fund will not provide benefits for expenses in connection with the illness or injury.

3. If the Fund provides benefits for the treatment of an industrial illness or injury, the Fund will have a lien against any workers' compensation award received by you to the extent of the benefits provided.

4. If the Fund determines that the injury or illness is work related, no benefits will be paid.

5. In the event that you settle a Workers' Compensation claim, you should attempt to have your employer's workers compensation insurance agree to pay expenses for future medical treatment of the alleged work-related condition. If the Workers' Compensation settlement does not contain such an agreement, the Fund will make its own determination whether future medical expenses related to your work-related condition are excluded from coverage under "A", "B", "1", "2", "3" or "4" (previously described).

Benefits from the Fund are not intended to duplicate any benefits which are available under Workers' Compensation Law – whether or not you or your employer has actually purchased Workers' Compensation Insurance.

If you or your dependent is injured through the act or omission of another person, this Plan will pay benefits under the following conditions:

1. You or your dependent shall reimburse the Fund up to the actual benefits paid by the Plan. Reimbursement shall be made upon receipt of damages, whether by judgment, compromise, settlement or otherwise, or

2. You or your dependent shall provide the Fund a lien, to the extent of benefits provided by the Plan, upon the damages recovered or to be recovered on account of you or your dependent's injuries.

If the injured person dies, the heirs, beneficiaries and personal representatives shall be bound by these obligations.

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, including a Disability claim, and the Fee for Service Medical and Dental Plans. We have also provided, for your reference, a chart detailing the time frames the Plan has to respond to claims and appeals for fee-for-service claims 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.
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.

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Concurrent Care Claim
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
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 insured medical or dental plan (Kaiser and UnitedHealth Care), prepaid dental provider (DeltaCare USA), service organization or the Life and AD&D insurance carrier. Claims for benefits under such arrangements must be pursued using the claims and appeals procedures provided by such HMO, prepaid dental provider, service organization or insurance carrier. **DO NOT USE THE HEAT AND FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE TRUST 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 related to Disability, Fee for Service Medical Plan and Fee for Service Dental Plan 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 generally must be filed at the Administrative Office within one (1) year following the date the expenses were incurred. There is an exception to this one (1) year limit in cases where an Anthem Blue Cross contract provider has an agreement with Anthem Blue Cross that allows for a longer time period than this one (1) year limit. In such cases, the claim filing limits contained in the agreement between Anthem Blue Cross and the PPO provider will prevail. In no event shall claims from non-contract providers be considered under the Plan that are not filed within one (1) year from the date services were incurred.

Disability Claim
You must request an authorized form from the Administrative Office. Complete the forms and return them to the Administrative Office with the required documents.

For Life Insurance
The Administrative Office should be notified immediately and the necessary forms will be sent to the beneficiary. Complete the forms and return them to the Administrative Office with a certified copy of the death certificate, carrying the deceased's Social Security number.

For Accidental Death And Dismemberment Insurance
The Administrative Office should be notified immediately and the necessary forms will be sent to the claimant. Complete the forms and return them to the Administrative Office with the required documents.

For Vision Care Services
The procedure for how to obtain vision care services is contained in the brochure describing your vision benefits. Follow these procedures BEFORE you make your vision care appointment.

Fee-For-Service Dental Services
Your DENTIST should be advised to submit a pre-authorization if charges are expected to exceed $300.

1. Obtain a dental claim form from First Dental Health or Dental Provider. You must complete the top portion where indicated.

2. On your first appointment, present your claim form to your DENTIST and advise him that you are covered by the Health and Welfare Fund's Dental Plan that includes the First Dental Health (FDH) PPO dental network.

3. Have your DENTIST complete the balance of the claim form.

4. When the service has been completed, forward the claim form to the First Dental Health.

Fee-For-Service Medical Benefits
The following claim procedures for HOSPITAL and medical services apply only to active mechanics and their eligible dependents who are enrolled in the Fund's Fee-For-Service Plan. If you are enrolled in an insured plan you should refer to its booklet on how to use the program.

For Hospital Services
When you or an eligible dependent are hospitalized, show your identification card to the HOSPITAL admitting office. Instruct them to submit claims to Anthem Blue Cross. To receive the maximum available HOSPITAL benefits, you must comply with the Pre-admission Review. Call Anthem Blue Cross at (800) 274-7767.

For Other Medical Services or Supplies
If you use a provider in the Anthem Blue Cross network (or local Blue Cross Blue Shield network if out California), show your Plan identification card. The provider will submit your claim for you. A Non-contract provider will usually submit claims for you as well but non-contractor provider claims must be submitted timely.

Fee For Service Out-Patient Prescription Drugs
No claims are to be filed for out-patient prescription drugs. The Fund has a contract with Optum to provide a network of preferred pharmacies that will dispense covered prescriptions. You will be required to pay 20% of the discounted cost at the time your prescription is filled by the preferred pharmacy.

Filed Claims
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 (including dental care) 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 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). 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 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 (to 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 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 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 determination of disability, if applicable.

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;
- If your Urgent Care Claim is denied, the notice will also include a description of the Plan's expedited appeal procedure; and
- If you are a participant in the Fee for Service Medical Plan the notice will further provide a description of any available External Review process and how to initiate an External Review. It will also provide the denial code and its corresponding meaning as well as a description of the standard, if any, that was used in denying the claim, including a discussion of the decision. The notice will include the date of service, name of health care provider, claim amount and a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and External Review processes.

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, Disability Claim, 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/ 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 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.

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.

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;

- 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 you are a participant in the Fee for Service Medical Plan the notice will further provide a description of any available External Review process and how to initiate an External Review. It will also provide the denial code and its corresponding meaning as well as a description of the standard, if any, that was used in denying the claim, including a discussion of the decision. The notice will include the date of service, name of health care provider, claim amount and a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and External Review processes. If the Board of Trustees considers, relies upon or generates new or additional evidence in the process of considering your claim, such evidence will be provided to you free of charge as soon as possible in advance of the date by which the Board of Trustees is required to

  provide notice of its final decision on appeal. If the Board of Trustees intends to issue an adverse final decision on appeal (deny your appeal in whole or part) based on a new or additional rationale, the Board of Trustees will provide you, free of charge, with the rationale as soon as possible in advance of the date by which the Board of Trustees is required to provide notice of its final decision on appeal.

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

Appeal Procedures in the Fee for Service Medical Plan

This sub-section is applicable only to participants in the Fee for Service Medical Plan.

In accordance with the federal Patient Protection and Affordable Care Act and applicable regulations, the Plan provides for a two-step Claims Review and Appeals procedure in the Fee for Service Medical Plan. The first step is an internal appeal to the Plan as set forth above on page 25. If your claim is denied, you may be eligible to have your claim reviewed by an Independent Review Organization (IRO) pursuant to a process called "External Review."

Generally, External Review is available only after your claim denial has been upheld after the final level of appeal under the Plan. You may, however, in limited circumstances have the right to have your claim reviewed by an IRO prior to exhausting the Plan's appeal process. See Expedited External Review for further details.

External Review is available for claims that involve medical judgment (including, for example, those based on the Plan's requirement for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or a determination as to whether a treatment is experimental or investigational) and for Rescission of Coverage.

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

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 months after the date you receive the appeal denial notice. If there is no corresponding date four 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 External 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; or

- 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 an 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.

LIFE INSURANCE - FOR ALL ELIGIBLE ACTIVE MECHANICS

The Benefit

$10,000 group life insurance will be paid to your beneficiary in the event of your death from any cause. This amount is 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 are under 60 years of age, the full amount of your 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 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.

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.

LIFE INSURANCE FOR YOUR FAMILY – FOR ALL ELIGIBLE DEPENDENTS OF ELIGIBLE ACTIVE MECHANICS

The Benefit

The amount of life insurance shown in the schedule below is payable to you in the event of the death of an eligible dependent from any cause while insured under the Plan.

Spouse	$1,000
Children - according to age:	
Less than 6 months	$100
6 months to age 21 (23 if student)	$500

If your dependent's life insurance ends because he or she no longer qualifies as a dependent or because of your death or termination of eligibility, he or she may convert his coverage to an individual policy without having to furnish evidence of good health, by making application to United of Omaha within 31 days from the termination of the dependent's insurance.

The premiums will be the same as would ordinarily be paid if she or he applied for an individual policy at that time. Should you again become eligible, your dependent may not avail herself or himself of this provision if any individual policy is in effect as a result of previous conversion.

If your dependent dies within 31 days after his or her life insurance ends, you will be paid the amount for which he or she was insured.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS - FOR ALL ELIGIBLE ACTIVE MECHANICS

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 or are 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 or Hearing $20,000
(Paid to you)

Loss of:

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

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

Your beneficiary may be any person or persons you name. You may request a change of beneficiary at any time by submitting a new form.

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.

FEE-FOR-SERVICE MEDICAL BENEFITS - FOR ELIGIBLE ACTIVE MECHANICS AND THEIR DEPENDENTS ENROLLED IN THE FEE-FOR-SERVICE MEDICAL PLAN

How Does The Fee-For-Service Medical Plan Work?

Once the calendar year deductible is satisfied, the Plan will pay the stated percentages for Covered Expenses. The Plan does not impose any annual maximums on Preventative Health Services except for certain services as noted on the following page.

Certain hospitals, physicians and other medical professionals have entered into agreements with Anthem Blue Cross to provide medical care at negotiated rates. This Plan will pay a higher percentage (85%) of Covered Expenses if you use a PPO hospital, PPO providers, or you receive treatment by a non-PPO provider for a bona fide emergency, and will pay a reduced percentage (50%) if you use a non-PPO hospital or non-PPO provider. The Plan will pay regular benefits (80%) if:

- you are outside of the geographic area served by contract providers; or
- you require specialized facilities or medical services (such as ambulance) for which contract providers are not available.

A current listing of PPO providers is available on Anthem Blue Cross's website www.anthem.com/ca (for California) or www.bcbs.com (Outside California) or you may write or call the Fund Office.

This Plan has pre-admission certification, continued stay review surgical opinion programs and Pre-Procedure Review program. If you do not use these programs, the Plan will pay only 75% of its usual reimbursement for HOSPITAL and medical benefits, including PHYSICIAN charges. For further details, please refer to pages 46 through 47.

What Is The Deductible?

You are responsible for the first $200 of Covered Expenses during a calendar year. This is called your "deductible". If you use non-PPO providers in a PPO area, it is $400.

The deductible for each calendar year applies separately to you and each eligible member of your family. However, the deductible is considered satisfied when the covered expense which has been applied toward the deductibles of you and your family members totals $400 for PPO providers or $800 for Non PPO providers in a calendar year.

Eligible PPO expenses incurred for PPO providers during the last quarter (October, November, December) of a calendar year and applied against the deductible for that year is carried over and used toward satisfying the deductible expense for the following year. For example, suppose you have $75 in medical bills in November of a certain year that is used for that year's deductible. This $75 will be carried over and applied to your next year's deductible. This means you only have to satisfy $125 during the next year ($200 minus $75). This deductible carry over does not apply to the $400 family deductible.

The deductible is waived for Covered Expenses incurred:

- as a result of an accident which occurs while covered under the Plan;
- as an inpatient in a PPO HOSPITAL (refer to page 38);
- in connection with chiropractic care treatment;
- in a birthing center;
- in connection with a covered physical exam;

- in connection with HOSPICE CARE;
- for vitamins and minerals prescribed by a physician rendering covered services; and
- for the smoking cessation program

Limitations To Annual Maximum Benefit

The overall annual maximum benefit includes charges for certain services which have the following limitations:

For PPO and Non PPO Providers:

- Chiropractic treatment, including any x-ray or laboratory services ordered by a chiropractor, are limited to 20 visits during a calendar year.

- Acupuncture treatment limited to $30 per visit and 50 visits per calendar year

Percentage Payable

To receive the maximum available benefits, you must comply with the HOSPITAL utilization review program, the second surgical opinion program and the pre-procedure review program described on page 46. Failure to comply with these programs will result in a reduction of 25% of benefits otherwise payable.

The Plan will pay the following percentages of Covered Expenses, subject to the Deductible, the Maximum Benefit and other Plan provisions. Some Covered Expenses are limited as described on pages 38 – 46. The following percentages represent the percentage that the Plan will pay for Covered Services in relation to the REASONABLE or ALLOWABLE CHARGES as defined on page 58.

Accident.....100% (of the first $300 of Covered Expenses per accident)
PPO HOSPITAL, other PPO provider, or emergency services from a Non-PPO provider 85%
Non-PPO HOSPITAL or other non-PPO provider 50%
Non-PPO HOSPITAL or other non-PPO provider for out-of-area services 80%

Extended Care Facility.....80%
(Room and board charges are limited to 50% of the HOSPITAL'S semi-private rate, to a maximum of 60 days per confinement.)

Birthing Center 90%

Hospice Care 100%

Second Surgical Opinion, when arranged by Anthem Blue Cross 100%

Acupuncture 50%
ALLOWABLE CHARGES are limited to $30 per visit and 50 visits per calendar year.

Chiropractic treatment.....80%
ALLOWABLE CHARGES are limited to 20 visits per calendar year.

Preventive Care Benefits provided by a PPO Provider 100%
All other covered charges 80%

Medical Plan – after the member incurs $15,000 of covered charges payable at 80%, 85% or 90%; the plan will pay 100% of PPO expenses for the remainder of the calendar year. The maximum out-of-pocket will be $3,000 per individual and $6,000 per family and excludes charges payable at 50% (non-PPO charges except emergency) but includes the PPO deductible of $200.

Prescription Drug Plan – the member pays 20% of covered drug expenses at the counter. Once the individual has paid $3,600 in out-of-pocket expenses ($7,200 per family), the plan will pay 100% of covered expenses for the remainder of the calendar year.

In no event will the combined maximum out-of-pocket for medical and prescription drug expenses exceed $6,600 per individual and $13,200 per family.

What Are Covered Expenses?

Covered Expenses are the Reasonable Charges for services and supplies described on pages 40 through 43 which are certified by the attending PHYSICIAN and determined to be MEDICALLY NECESSARY for the care and treatment of injury or condition.

This means that services and supplies which are not MEDICALLY NECESSARY, such as CUSTODIAL CARE or homemaker services, are not covered by the Plan.

Covered Expenses for a particular service or supply do not include charges that are more than the amount considered reasonable or allowable for that particular service or supply in the area in which the service or supply was provided, as will be determined by the Board of Trustees, in the sole discretion.

Inpatient HOSPITAL Services

If hospitalization is recommended, have your doctor contact Anthem Blue Cross for a pre-admission certification. Refer to page 47. The Plan will pay a higher percentage of the bill and the deductible is waived if you are confined in a PPO HOSPITAL.

If you or your dependent are a registered bed patient in a HOSPITAL for treatment of injury or sickness, the Plan will pay the applicable percentage of the HOSPITAL's charges for a semi-private room and for ancillary charges.

Outpatient HOSPITAL Services

If you or your dependent are not confined in a HOSPITAL as a registered bed patient but receive treatment in the outpatient department of a HOSPITAL, the Plan will pay the applicable percentages of Covered Expenses.

Extended Care Facility Services

These services are covered if you or your dependent have been confined in an acute care (general) HOSPITAL for at least five consecutive days and then enter an EXTENDED CARE FACILITY for additional treatment or rehabilitation within seven days of the confinement. For each day, the Plan will pay 80% of ALLOWABLE CHARGES. Such services provided by PPO providers are covered up to the amount allowed under the Blue Cross Network.

ALLOWABLE CHARGES for non-contracted providers are the lesser of:

- the EXTENDED CARE FACILITY'S semi-private room rate; or
- 50% of the average semi-private room rate for HOSPITALS in the area where the EXTENDED CARE FACILITY is located.

Benefits for EXTENDED CARE FACILITY charges are payable for a maximum of 60 days per confinement.

Birthing Center Services
If you or your dependent use the services of a Birthing Center, the expenses are not subject to the deductible. The Plan will pay 90% of Covered Expenses.

Hospice Care
If you or your dependent incur charges in connection with HOSPICE CARE, the charges are not subject to the deductible. The Plan will pay 100% of the ALLOWABLE CHARGES that are incurred (i) during a period for which a PHYSICIAN certifies that the covered person is a terminally ill patient, and (ii) during the bereavement period (the 12 month period that begins on the date of the death of the terminally ill patient).

Covered services include:

- confinement of a terminally ill patient for up to a total of eight days of inpatient respite care;

- home health care furnished to the terminally ill patient in the patient's home, including:

  - services of a home health aide;
  - professional services of a nurse;
  - physical therapy or other therapy;
  - nutrition counseling and special meals;
  - medical support charges;
  - social services furnished to the terminally ill patient or to the family unit; and
  - bereavement counseling furnished to the family unit during the bereavement period.

Surgical Services
If elective surgery is recommended, you must contact Anthem Blue Cross to determine if a pre-procedure review is necessary. Refer to page 47. **Benefits otherwise payable will be reduced by 25% if you do not comply with the Pre-Procedure Review Program.**

The Plan will pay the applicable percentage of the ALLOWABLE CHARGES made by a surgeon, assistant surgeon and anesthetist. The percentage depends on whether or not your PHYSICIAN is a PPO provider.

Diagnostic X-ray and Laboratory Tests
The Plan will pay the applicable percentage of ALLOWABLE CHARGES for diagnostic treatment by a radiologist or laboratory. The percentage depends on whether or not you use a PPO provider.

Refer to page 47 for a description of the Pre-Procedure Review Program. Benefits otherwise payable will be reduced by 25% if you do not comply with this program.

Physician Visits
If you or your dependent receive non-surgical treatment of an injury or condition from a PHYSICIAN, the Plan will pay the applicable percentage of the ALLOWABLE CHARGES made by the PHYSICIAN. The percentage depends on whether or not you use a PPO provider.

Preventive Care Benefits
Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations requires non-grandfathered group health plans, such as this one, to cover certain preventive care benefits without the imposition of any cost-sharing component on the participant when the participant receives care from a participating provider. The categories of preventive care benefits are as follows:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

A comprehensive list of the specific services covered under these preventive care benefits categories can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/. The list of covered services will be updated by the applicable government agency from time to time. Please note that the Plan has one year from the date that new guidelines or recommendations are issued to incorporate such guidelines or recommendations into the Plan's operations. If you have any questions regarding the types of services covered under this sub-section, please contact your health insurance provider or the Administrative Office for the Trust at (800) 433-6692.

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive care benefits, then the plan or issuer may use reasonable medical management techniques to determine any such coverage limitations.

If a recommended preventive care benefit or item is billed separately from an office visit, then cost-sharing may be applied to the office visit. If a recommended preventive care benefit or item is not billed separately from an office visit and the primary purpose for the visit is preventive care, then cost-sharing requirements may not be imposed with respect to the office visit. If a recommended preventive care benefit or item is not billed separately from an office visit and the primary purpose of the office visit is not preventive care, then cost-sharing may be applied to the office visit.

Vitamins and Minerals
If you or your dependents incur expenses for vitamins and/or minerals prescribed by a PHYSICIAN rendering covered services, the Plan will pay 80% of the ALLOWABLE CHARGES.

Acupuncture Treatment
If you or your dependent undergo acupuncture treatment, the Plan will pay 50% of the ALLOWABLE CHARGES made by an eligible provider up to a maximum payment of $30 per visit. An eligible provider under this benefit is a PHYSICIAN or a certified acupuncturist.

A maximum of 50 sessions are covered per person per calendar year.

Chiropractic Treatment
If you or your dependent receive chiropractic treatment, the plan will pay 80% of the ALLOWABLE CHARGES. The ALLOWABLE CHARGES are limited to 20 visits in any calendar year for all chiropractic treatment combined.

Nutritional Counseling and Treatment
For any of the conditions indicated below, the Fund will cover an initial visit for assessment, treatment visits and follow up visits provided that your Physician **refers you in writing** to a registered dietitian or other nutritional professional. The Plan will pay 80% of covered expenses for approved treatment programs or 100% of covered expenses if it is a preventive care benefit listed on pages 40 through 43.

1. Diagnosed Diabetes or family history of Diabetes;
2. Diagnosed Cardiovascular disease or family history of Cardiovascular disease;
3. Renal disease;
4. Pediatric metabolic disorders and cystic fibrosis;

5. Certain metabolic disorders such as malabsorptive disease, ulcerative colitis, celiac disease or Crohn's disease; or
6. Diagnosed food allergies.

A "registered dietitian" is an individual licensed by the State in which services are rendered as a Registered Dietitian and such individual is licensed to provide nutritional and dietary counseling, assessments and treatment upon referral from a health care provider.

The Plan will cover the services of an individual not designated as a registered dietitian provided:

1. the individual has a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, and who is deemed qualified to provide nutritional and counseling ser ices by the referring Physician; **and**

2. the individual has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian; **and**

3. the individual is licensed or certified as a nutritional professional by the State in which the services are rendered. In a State that does not provide for licensure or certification, the nutritional professional will be an eligible provider if he/she is recognized as a "registered dietitian" by the Commission of Dietetic Registration.

You must follow the procedure stated below in order for services to be covered under the Plan.

1. Obtain a referral in writing from your Physician. Make sure your physician is aware the Fund will only pay for the services of a registered dietitian or other nutritional professional as defined above. Referral to a non-eligible health care provider will not be paid for by the Fund.

2. Make an appointment with the provider you have been referred to and have the provider submit the Physician referral and proposed treatment program to the Fund Office.

Treatment of Mental Conditions

If you or your dependents undergo outpatient treatment of a mental condition, the Plan will pay the applicable percentage of the ALLOWABLE CHARGES made by an eligible provider. The percentage depends on whether or not you use a PPO provider. An eligible provider under this benefit is a PHYSICIAN or psychologist.

Chemical Dependency

The Plan will pay the applicable percentage of the ALLOWABLE CHARGES made by an eligible provider. The percentage depends on whether or not you use a PPO provider for in-patient and out-patient chemical dependency treatment. To receive the maximum available benefits, you must comply with the pre-admission certification.

If you do not use this program, benefits otherwise payable for the confinement and related PHYSICIAN'S charges will be reduced by 25%.

Smoking Cessation Program Benefits

The Fund has made arrangements with the California Smokers' Helpline and the Nevada Tobacco Users Helpline (for non-California residents) 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.

Residents of California must contact the California Smokers' Helpline 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)

Residents of Nevada and any other state except California must contact the Nevada Tobacco Users Helpline from Monday through Friday 10:00 a.m. to 9:00 p.m. and Saturday 1:00 p.m. to 5:00 p.m. which they can reach at the following number:

All Other States (including Nevada) – 1-800-QUIT NOW (800-784-8669)

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 Heat 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 page 26 through 27.

Other Services and Supplies

The Plan will pay the applicable percentage of Covered Expenses for the items listed below:

1. Services of a licensed psychotherapist or registered nurse, provided the services were ordered by a PHYSICIAN, excluding those of a member of your family;
2. Licensed ambulance service to the nearest HOSPITAL where care and treatment of the injury or sickness can be given;
3. Drugs and medicines requiring the prescription of a PHYSICIAN;
4. Oxygen;
5. Initial artificial limbs or eyes replacing natural ones lost while covered;
6. Rental of durable medical equipment used exclusively for treatment of injury or sickness, but not to exceed the reasonable purchase price;
7. Anesthesia; and
8. Blood and other fluids to be injected into the circulatory system.

Special Alternative Medical Care Benefits

(in Lieu of Hospitalization or other costly conventional out-patient medical therapy)

If the patient's Physician recommends alternative medical treatment in lieu of hospitalization or other costly conventional out-patient medical therapy, the Plan may include medical or prescription drug benefits otherwise not covered provided the following conditions are met:

9. the treatment program is the lowest cost item or service that meets the patient's medical needs and is less costly than all other conventional alternatives;

10. the treatment is not being performed as part of a research study or clinical trial;

11. clinical studies demonstrate that the proposed alternative treatment program will prolong the intended patient's life and will maintain or restore physical or social function suited to the activities of daily living more effectively than conventional therapy.

The proposed treatment program must be submitted to the Administrative Office who will coordinate approval with the Plan's Utilization Review Organization. Additional benefits may be payable for prescription drugs, skilled nursing care, home health care based on the recommendation of the Utilization Review Organization using the guidelines stated in (a) through (c) above.

Payment of benefits under this Plan provision will be limited to Plan's calendar year benefit payment provision and benefit percentages for similar medical benefits and will further be limited to the specific services and number of days approved by the Review Organization.

Medical Exclusions

In addition to the General Exclusions listed on page 54 and any limitations or exclusions contained in the benefit descriptions, fee-for-service medical benefits are not provided for expenses in connection with:

1. Gene Therapy Drugs and Related Treatments and Services.

2. Medical examinations, services and supplies not MEDICALLY NECESSARY for the treatment of an injury or sickness, except where specifically noted.

3. Routine nursery care of a newborn dependent child during HOSPITAL confinement, except in PPO HOSPITALS.

4. Eye refractions, eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses except:

   a. contact lenses used in the treatment of Keratoconus; and

   b. replacement of a lens removed because of a cataract (other items may be covered under the Plan's separate, routine vision benefits. Refer to the separate brochure describing these benefits).

5. Hearing aids.

6. Cosmetic surgery except:

   a. treatment of a birth defect; and

   b. operation(s) necessary to repair disfigurement due to an accident occurring while covered under the Plan, provided the operation(s) is performed while covered under the Plan no later than two years after the accident.

7. Any operation or treatment in connection with the fitting or wearing of dentures or for treatment of the teeth or gums except:

   a. tumors; and

   b. treatment of accidental injury to sound natural teeth (including their replacement) and fractures due to an accident occurring while covered under the Plan, (for dental care, refer to the Plan's separate dental benefits on page 51.

8. Expenses in connection with conditions of pregnancy of a dependent child, except complications of pregnancy. Complications of pregnancy includes, but is not limited to, puerperal infection, eclampsia, ectopic pregnancy and toxemia.

9. Radial keratotomy surgery, Lasik, or other procedures for surgical correction of myopia and/or other refractive errors.

10. Housekeeping or CUSTODIAL CARE.

11. EXPERIMENTAL and/or INVESTIGATIONAL PROCEDURES except that nothing herein shall apply to a QUALIFIED INDIVIDUAL in an APPROVED CLINICAL TRIAL.

12. HOSPICE CARE expenses incurred by a terminally ill patient or a family unit member who is not an eligible mechanic employee or an eligible dependent under the Plan.

Are There Any Benefits After I Lose Eligibility?

Fee-for-service medical benefits will be continued for Totally Disabled persons for covered expenses incurred in connection with the treatment of the condition causing total disability for up to 12 months

following the date coverage terminates or until the maximum limits of the Plan have been reached, whichever occurs first. If the person recovers from total disability, benefits will cease as of the date of recovery.

THIS EXTENSION OF BENEFITS WILL CEASE AS OF THE DATE THE PERSON BECOMES COVERED FOR THE DISABLING CONDITION UNDER ANY OTHER GROUP PLAN, INCLUDING MEDICARE.

PRE-ADMISSION CERTIFICATION AND CONTINUED STAY REVIEW PROGRAM - FOR ELIGIBLE ACTIVE MECHANICS AND THEIR DEPENDENTS ENROLLED UNDER THE FUND'S FEE-FOR-SERVICE MEDICAL BENEFITS

As noted in the description of HOSPITAL benefits, the Plan has a pre-admission certification and continued stay review program. This program is provided through Anthem Blue Cross.

If you do not use this program, the Plan will pay only 75% of what would have been paid for HOSPITAL and medical expenses, including PHYSICIAN charges.

What Is Pre-Admission Certification?

Pre-admission certification is designed to avoid unnecessary hospitalizations. Through this review process, you and your PHYSICIAN will be advised if an inpatient HOSPITAL stay is appropriate. Perhaps a recommended surgery can be performed on an outpatient basis, thus saving you out-of-pocket expense. If Anthem Blue Cross has a question as to the necessity of a hospitalization, your PHYSICIAN will be contacted and the problem will be resolved.

How Does The Program Work?

If you are advised of a non-emergency HOSPITAL admission, you must tell your PHYSICIAN that you are required to receive pre-admission certification. Ask him to call:

Anthem Blue Cross
Monday through Friday 7:30 a.m. – 5:00 p.m.
(800) 274-7767

You, your PHYSICIAN, the HOSPITAL, and the Administrative Office will be advised if the hospitalization is approved. In the event there is disagreement as to whether hospitalization is MEDICALLY NECESSARY, your PHYSICIAN and the PHYSICIAN from the review organization will resolve the problem.

If it is not resolved, you will be advised at that time and told about the appeals procedure. However, before any expenses are incurred, you will know that your claim may be denied because the hospitalization is not MEDICALLY NECESSARY. This program protects you.

Important Note:

In accordance with the Newborns' and Mothers' Health Protection Act, this Plan will provide coverage for up to a 48 hour hospital stay following a normal delivery and up to a 96 hour hospital stay following a caesarean delivery with requiring Pre-admission Certification or Continued Stay Review. However, you or your physician must contact Anthem Blue Cross if the hospital stay following delivery is expected to be longer than the 48 or 96 hour periods allowed under the Act.

What Is Continued Stay Review?

Once you have entered the HOSPITAL following the pre-admission certification, Anthem Blue Cross will continue to monitor your stay to determine the appropriate length of confinement and the necessity of medical services.

If the review organization concludes your continued hospitalization is unnecessary, you and your PHYSICIAN will be notified. You may continue to stay in the HOSPITAL, however, you must be aware that payment of unapproved days will be your responsibility. You, of course, have the right to appeal this decision.

What Happens In Emergency Hospitalizations?

If it is necessary for you to be admitted to the HOSPITAL on an emergency basis, it will not be necessary to get prior authorization. However, Anthem Blue Cross will then review your records to determine the necessity of your admission and the required length of stay. It is important to have the HOSPITAL, your PHYSICIAN, or a family member call Anthem Blue Cross as soon as possible in the event of an emergency hospitalization.

How Does The Program Affect Medical Benefits?

Your benefits will only be reduced if you do not receive pre-admission certification for non-emergency hospitalizations or continued stay review for all admissions. In the event that these requirements are not met, your benefits will be reduced to 75% of what would otherwise be paid.

PRE-PROCEDURE REVIEW PROGRAM - FOR ELIGIBLE ACTIVE MECHANICS AND THEIR DEPENDENTS ENROLLED IN THE FEE-FOR-SERVICE MEDICAL BENEFITS

Certain outpatient procedures such as surgeries performed at ambulatory surgery facilities, home health care, infusion therapy some durable medical equipment and diagnostic x-ray procedures such as some MRI, CT scans, PET scans require utilization review. **It is best to make sure you or your physician contact Anthem Blue Cross to see if utilization review is required for any proposed course of treatment or special tests. If you do not obtain the proper authorization, the Plan will only pay 75% of its usual reimbursement for HOSPITAL and medical expenses, including PHYSICIAN charges.**

How Does The Program Work?

When confronted with the question of whether or not to have surgery or a major diagnostic procedure, it is important for you to know as much as possible about your condition, alternative treatment possibilities and surgical risks involved.

If your PHYSICIAN recommends elective surgery, he should call:

Anthem Blue Cross
Monday through Friday 7:30 a.m. – 5:00 p.m.
(800) 274-7767

FEE FOR SERVICE PRESCRIPTION DRUG BENEFITS

The Fee for Service Prescription Drug Plan covers 80% of the reasonable cost of covered prescription drugs for you and your eligible dependents obtained through the retail and/or mail service pharmacy programs. You will be required to pay the pharmacist or mail order facility 20% of the discounted cost.

Participating Retail Pharmacy

Take your prescription to any OptumRx participating pharmacy, give your prescription to the pharmacist and identify yourself as a participant in the Heat and Frost Insulators and Asbestos Workers Health and Welfare Fund. Present your prescription identification card to the pharmacist who will transmit the prescription online to OptumRx to verify eligibility and your copayment amount.

The OptumRx retail pharmacy network includes Albertsons, Costco, CVS, Rite Aid, Sav-On Drugs, Vons and Walgreens as well as many independent pharmacies in and outside California. Contact the Administrative Office for a complete listing of OptumRx participating chain pharmacies, or you may call OptumRx or the Administrative Office for information regarding independent pharmacies participating in the nationwide OptumRx network.

Mail-Service Pharmacy

The OptumRx Mail Service Prescription Program is a convenient and inexpensive way for you to order up to a 90-day supply of maintenance medications for direct delivery to your home. Please encourage your doctor to write your prescription for a full 90 days in order to take full advantage of your mail service benefit.

What Are The Advantages of the Mail Service Program?

- **You can save money:** Order up to a 90-day supply of medication.
- **You can save time:** Medications are conveniently delivered to your home via U.S. Mail. Since you can receive up to a 90-day supply, you will be spared the bother of frequent re-orders.

How To Use The Mail Service Program

1. Call OptumRx at 1 (800) 562-6223 and they will request a new prescription from your doctor. OptumRx will need to know the medication name(s), strength, e.g., 50 mg, 10 meq, etc., and dosage and the full name and phone number of your doctor.

2. If you prefer to order by mail, obtain an OptumRx mail service envelope from the Administrative Office or by calling the OptumRx toll-free number **(800) 562-6223**.

3. Complete the information required and enclose your prescription and payment information in the envelope. OptumRx will process your order and send your medications to your home by U.S. Mail or UPS. For first time fills of a prescription, your prescription will usually arrive within seven workings days after your order is received. Refills will usually be shipped within 48 hours.

4. Your doctor may also call-in or fax your prescription to OptumRx. Please instruct your doctor to provide OptumRx with your member identification number and coverage information from your drug card and your daytime phone number. You will be contacted by OptumRx to arrange for payment.

5. For convenient refills by phone, contact OptumRx at (800) 562-6223 and have your prescription numbers and credit card information ready. You may also process refills atwww.optumrx.com

TOLL FREE NUMBER:
(800) 797-9791 or (800) 562-6223
WEBSITE: www.rxsolutions.com
5:00 a.m. to 9:00 p.m. (PST) Weekdays
7:00 a.m. to 7:00 p.m. (PST) Saturday-Sunday

Utilization Management Review
The benefits provided under the Fee-For-Service prescription benefits plan are subject to Utilization Management Review. Utilization Management Review is the process under which the Plan determines which services are covered under the Plan and also involves the determination of what services or treatment are medically necessary. Limitations are placed upon the coverage of prescription drugs and treatments pursuant to the following Utilization Management Review Programs:

- Prior Authorization: Certain drugs will be subject to prior authorization, including certain specialty and non-specialty drugs, which requires prescriber verification of specific clinical criteria implemented by OptumRx to help manage the appropriate use of drugs and determine whether coverage of the drug is medically necessary. Once the prescriber provides the necessary information and specific criteria is satisfied, OptumRx will approve your medications and the Plan will cover their portion of the prescription cost.

- Quantity Limits: Certain prescription drugs will be subject to quantity limits. These quantity limits will be implemented using quantity guidelines based on FDA recommendations to prevent inappropriate dosage and treatment duration.

- Step Therapy: Certain prescription drugs will be subject to step therapy guidelines, prior to the approval of requested prescription drug treatment. The prescription drugs subject to these guidelines are generally prescription drugs with more cost effective or clinically preferred alternatives. Under the Step Therapy guidelines, OptumRx will look at your individual claims history to ensure that such cost effective or clinically preferred alternatives were utilized prior to the requested prescription drug treatment.

- Specialty Drugs: Certain prescription drugs are considered specialty drugs and must be dispensed through the OptumRx specialty pharmacy. To receive prescription drug benefits, you must enroll in OptumRx's clinical management program prior to filling your first specialty drug prescription. A maximum 30 day supply (for each fill) will be provided under this program throughout the duration of the prescription therapy.

Vigilant Drug Programs
Many new medications are introduced into the market every year; some at a higher cost and without additional therapeutic value. The following drug program strategies will be implemented to ensure that the Trust covers the most clinically appropriate and affordable medications as recommended by OptumRx.

Me Too, High-Cost Brand with Generic and High-Cost Generics Drug Strategies
The *Me Too Strategy* excludes new medications with similar composition to existing medications and have no additional advantage.

The *High-Cost Brand with Generic Strategy* excludes higher cost brand name drugs when a lower cost generic is available.

The ***High-Cost Generics Strategy*** excludes generic drugs that cost significantly more than other generics within the same therapeutic class. A generic will be added to this list if it meets one or more of these criteria (1) a high total plan paid cost or (2) a high ingredient cost per prescription or ingredient cost per 30 days with multiple lower-cost alternatives available in the same therapeutic class. Generics within the immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral and antineoplastic classes will not be targeted unless lower-cost alternatives with similar active ingredients and dosage forms are available.

High Cost Specialty Drugs
Certain specialty prescription drugs may be subject to a separate cost share. For further information, call OptumRx at the number on your ID Card. To review your claims, go to OptumRx.com.

Diabetes Management Program
The OptumRx Diabetes Management Program is a holistic approach to caring for diabetic members by identifying and addressing initial diabetic clinical concerns including medication adherence and optimization, addressing gaps in therapy, and supporting high-risk diabetics with a high-engagement model.

The Diabetes Management Program helps reduce the overall cost of care while improving member health outcomes. Patients with controlled diabetes who are enrolled in the OptumRx Diabetes Management Program have the potential to reduce associated diabetes cost by 10 percent. Additional program benefits include enhanced member engagement and satisfaction through increased medication adherence, reduced gaps in care and improved glucose control.

You or your covered family member will be contacted by OptumRx to discuss interest in participating in the Program and we encourage active participation in the Program.

What is Covered?
The following Drugs are covered by the Plan:

- Drugs that can only be obtained by Prescription as required by state and federal law;
- Insulin;
- Have been approved by the Food and Drug Administration (FDA) for general marketing;
- Are dispensed by a licensed Pharmacist and are prescribed for the Participant's use by a Physician; and
- **Drugs required to be covered under Preventive Health benefits described on pages 40 through 43**

Covered drugs include insulin, insulin syringes and chem strips.

Exclusions
The following Drugs and supplies are not covered under this Prescription Drug Benefit:

1. Drugs which are sold over-the-counter (except those covered under Preventive Health benefits), or do not legally require a Physician's written Prescription, and Prescription equivalents sold over-the-counter.
2. Prescription Drugs which may be properly received without charge under local, state, or federal programs – including Workers' Compensation programs or Occupational Disease law.
3. Devices of any type, (with the exception of Ostomy supplies), even though they may require a Physician's Prescription.

4. Drugs prescribed for cosmetic purposes, including (but not limited to): Rogaine solutions; external preparations of Minoxidil and any mixtures or compounds containing Minoxidil; weight reducing Drugs; and Retin-A in all forms, except when prescribed for Acne Vulgaris.

5. Hypodermic needles, syringes or similar devices used for any purpose other than the administration of insulin.

6. Prescriptions related to any non-covered services.

7. Prescriptions dispensed in a Physician's office.

8. Charges for the administration of any Drug.

9. Fertility Drugs, and all medications used for the treatment of infertility.

10. Experimental or investigational Drugs, except that nothing here in shall apply to a QUALIFIED INDIVIDUAL in an APPROVED CLINICAL TRIAL.

11. Prescriptions dispensed by a Hospital during confinement.

12. Any items prescribed for purposes other than the treatment or diagnosis of a specific Illness or Accident or covered Preventive Service.

13. Non-sedating antihistamines.

14. Vitamins unless specifically indicated.

15. Growth hormones.

16. Weight-loss medications.

17. Compound Medications which include bulk chemicals for vitamins/supplements that are typically available over the counter, bulk chemicals used in compounding formulations that are not approved by the FDA, and products used for cosmetic uses.

18. Gene Therapy Drugs and Related Treatments and Services.

Please note, the Plan requires the use of generic drugs when available. If a generic medication is available as a substitution for a prescribed name brand drug, the Plan will only provide coverage for the generic prescription drug. If you insist on having a brand name prescription filled, you will be responsible for the 20% copayment for the generic equivalent, plus 100% of the cost difference between the brand name and generic drug. Any additional expense incurred by you to receive the brand name drug in lieu of the generic version will not count toward the annual out-of-pocket maximum.

FEE-FOR-SERVICE DENTAL BENEFITS – FOR ALL ELIGIBLE ACTIVE MECHANICS AND THEIR DEPENDENTS

Once the calendar year deductible is satisfied, the Plan will pay the stated percentages for covered expenses up to a maximum of $3,000 per person every two consecutive calendar year periods for non-orthodontic charges. This maximum does not apply to payments for teeth cleanings (prophylaxis). The Plan will pay the stated percentages for covered expenses for each individual age 18 and younger, as well as cover up to a $2,500 lifetime maximum in orthodontic services per dependent age 18 and younger. There is no calendar year limit on dental benefits for dependents ages 18 and under.

THE TRUSTEES HAVE CONTRACTED WITH FIRST DENTAL HEALTH (FDH) TO PROVIDE YOU AND YOUR FAMILY MEMBERS WITH ACCESS TO THE FDH PREFERRED PROVIDERS.

You may use the First Dental Health network of dentists to receive your dental care. The plan will pay the dentist up to the negotiated PPO fees.

You should have an ID Card which has the First Dental Health PPO logo. **You must show this card every time you go to the dentist**. Also make sure each time you go to the dentist that you confirm that he/she is still a member of the PPO network.

What Is The Deductible?

You are responsible for the first $50 of covered expenses during a calendar year. This out-of-pocket expense is called your "deductible".

The deductible each calendar year applies separately to you and each member of your family.

As with the deductible under the fee-for-service medical benefits, eligible expenses are incurred during the last quarter (October, November, December) of a calendar year and applied against the deductible for that year is carried over and used toward satisfying the deductible for the following year.

Pre-Determination of Benefits

Your Dental Plan requires that a predetermination of benefits be obtained for charges of $300 or more. This means your DENTIST must complete a dental claim form indicating the treatment plan and submit it to First Dental Health at PO Box 919029, San Diego, CA 92191 along with the supporting X-rays before the services are performed. The phone number for First Dental Health is (800) 334-7244. You must include your group name on the claim form. The Fund will then advise your DENTIST whether or not the services are covered under the Plan. For claim status and questions, you may contact the Trust Fund Office.

What Are Covered Dental Services?

Each period of consecutive months specified in the following list of services shall be determined retroactively from the date of the applicable procedure for which a claim is made.

Diagnostic

Procedures to assist the DENTIST in evaluating the existing conditions to determine the required dental treatment. An oral examination, including bitewing X-rays, will be covered once every six months and a full mouth series of X-rays will be covered once every 24 months.

Preventive

These services include prophylaxis and topical application of fluoride solutions. Prophylaxis will be covered once every six months, or every three months if recommended by your DENTIST. Topical application will be covered once every 12 months. These services also include sealants applied to permanent molars for any dependent child under age 15.

Oral Surgery

Procedures for extractions and other oral surgery including pre- and postoperative care.

General Anesthesia

When administered for a covered oral surgery procedure performed by a DENTIST.

Restorative Dentistry

Provides for the restoration of decayed, diseased or damaged natural teeth to a satisfactory state of health, function and esthetics. This includes the use of amalgam or composite resin restorations, but excludes gold restorations, crowns and jackets.

Endodontics
Procedures for pulpal therapy and root canal filling.

Periodontics
Procedures for the treatment of diseases of the tissues supporting the teeth.

Prosthodontics
Procedures for construction or repair of fixed bridges, partial or complete dentures.

Orthodontics
Procedures for the realignment of teeth in children ages 18 years and younger up to the prescribed lifetime maximum.

Alternate Benefit Provision

In many cases, there is more than one method of satisfactory treatment or material that may be utilized to correct a dental condition. Under the provisions of this Plan, Covered Dental Expenses are limited to those services or supplies which are customarily employed in dental treatment, and which are recognized by the dental profession to be appropriate according to broadly accepted national standards of practice. The Plan takes into account the overall dental condition of the Participant.

You may choose a more costly custom or precision dental procedure. However, if you do, you will be responsible for paying the difference between the charges for the elaborate procedure and the Dental Care Benefit paid by the Plan. **All treatment decisions rest with you and your dentist.**

Some examples of how the Alternate Benefit Provision may be applied:

- If a tooth can be satisfactorily restored with a resin, amalgam, or silicate filling, this is the covered expense. You may apply this covered expense toward a more elaborate or precision restoration that you and your dentist choose.

Dental Exclusions

- Procedures which began before the date coverage started. X-rays and prophylaxis shall not be deemed as the start to a dental procedure.
- Treatment for cosmetic reasons except for treatment which is:
  - needed for repair of damage to sound natural teeth resulting from an accident occurring while eligible; and
  - furnished while eligible, no later than two years after the date of the accident.
- Procedures other than minor spot grinding, which are for the purpose of or relating to correction of the bite.
- Procedures whose main purpose is to change vertical dimension.
- Diet planning, or training in oral hygiene or preventive care.
- Replacement of a lost or stolen appliance.
- Orthodontics for participants over the age of 18 years old.
- Treatment of the Temporomandibular joint (TMJ)

- Dental Veneers and Implants, including repairs, adjustments, relines, replacement appliances and temporary appliances.

Are There Any Benefits After I Lose Eligibility?

If you or your dependent incurs dental expense within one month after the date eligibility terminates, benefits will be paid if the treatment, excluding X-rays and prophylaxis, began prior to the date eligibility was lost.

GENERAL EXCLUSIONS – FEE-FOR-SERVICE MEDICAL AND DENTAL BENEFITS

In addition to the exclusions listed under the medical benefits and dental benefits sections, the Plan will not provide benefits for:

1. Any injury or sickness for which the patient is not under the care of a PHYSICIAN or DENTIST.

2. Treatment rendered that is determined by the Plan not to be medically necessary for the injury or illness.

3. Any disability covered by any worker's compensation or occupational disease law.

4. Any injury or sickness arising from or sustained in the course of any gainful occupation or employment.

5. Any expense incurred for injury or sickness resulting from war, declared or undeclared.

6. Any supplies or services:

    a. for which no charge is made;

    b. for which you are not required to pay; or

    c. furnished by a HOSPITAL or facility operated by the United States Government or any authorized agency thereof, or furnished at the expense of such Government or Agency, or for court-ordered care, including charges in connection with correctional or mental health programs, unless required by law.

7. Services rendered by the spouse, child, brother, sister or parent of you or your spouse.

8. Intentionally self-inflicted injuries or sickness, unless the individuals' injuries are otherwise covered by the Plan and if the injuries are not the result of a medical condition, such as depression.

9. Any expense incurred on a date on which you or your dependent are not eligible for benefits.

10. Any injury or sickness resulting from or occurring during the commission of a felony by you or your dependent unless the injury or sickness is a result of an act of domestic violence or a medical condition.

11. Care or treatment in any penal institution, jail facility or jail ward of any state or political subdivision.

DEFINITIONS

1. **APPROVED CLINICAL TRIAL** means a Phase 1, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

   a. A federally funded or approved trial; or

   b. A clinical trial conducted under an FDA investigational new drug application; or

   c. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

2. **BEREAVEMENT COUNSELING** means counseling by a licensed or certified social worker or licensed pastoral counselor to assist the family unit in coping with the death of the terminally ill patient.

3. **BEREAVEMENT PERIOD** means the 12 month period that begins on the date of the death of the terminally ill patient.

4. **BIRTHING CENTER** means a licensed facility set up, equipped and operated solely as a setting for prenatal care, delivery, and immediate postpartum care for patients with low risk pregnancies. The facility must be directed by a PHYSICIAN (MD or DO) which provides skilled nursing care under the direction of a graduate registered nurse (RN) in the delivery and recovery rooms. The center must have a written agreement with a HOSPITAL for immediate transfer in case of emergency.

5. **CUSTODIAL CARE** means treatment, services, or confinement, regardless of who recommends, prescribes, or performs them, or where they are provided, which could be rendered safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with daily living activities. CUSTODIAL CARE includes personal care (such as help in walking, getting in and out of bed, bathing, eating, exercising, dressing, using the toilet); or homemaking (such as preparing meals or special diets); moving the patient; acting as companion or sitter; and supervising medication which can usually be self-administered.

6. **DISABILITY** shall mean any period of disability arising out of the same or related causes, including all complications. One accident and its complications (including recurrences) are considered as one disability. A disability shall commence with the date the employee leaves full-time active employment as the result of a Non Occupational Accidental Bodily Injury or Sickness and shall end with the date of return to full time active employment. Expenses incurred for totally unrelated conditions will be recognized as a separate disability.

7. **DENTIST** means a person who is licensed to practice or perform oral surgery and who is practicing within the scope of his license. A licensed denturist will also be considered a DENTIST while practicing within the scope of his or her license, and to the extent that benefits are provided. DENTIST shall not include any of the following persons: you or your spouse, parent, child, brother or sister of you or your dependent.

8. **EXPERIMENTAL** and/or **INVESTIGATIONAL** means a service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan or its designee, (based on the information and resources available at the time the service was performed or at the time the supply was provided, or the service or supply was considered for Precertification under the Plan's Utilization Management Program), any of the following conditions were present with respect to one or more essential provisions of the service or supply:

   a. The service or supply is described as an alternative to more conventional therapies in written documents by the health care provider that performs the service or prescribes the supply;

   b. The prescribed service or supply may be given only with approval of an Institutional Review Board as defined by federal law;

   c. There is an absence of authoritative medical or scientific literature on the subject, or that literature indicates that the service or supply is Experimental and/or Investigational or that more research is needed;

   d. Food and Drug Administration (FDA) has not approved marketing of the service or supply or has it under consideration; or

   e. The service or supply is available only through clinical trials sponsored by the FDA, the national Cancer Institute or the National Institutes of Health.

9. **EXTENDED CARE FACILITY** means an institution which is primarily engaged in providing inpatients with (i) skilled nursing care and related services for patients who require medical or nursing care, or (ii) rehabilitation services for the rehabilitation of injured, disabled or sick persons and which meets all of the following requirements:

   a. it is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a PHYSICIAN and surgeon (MD) or a graduate registered nurse (RN);

   b. it has available at all times the services of a PHYSICIAN and surgeon (MD) who is a staff member of a general HOSPITAL;

   c. it has on duty 24 hours a day a graduate registered nurse (RN), licensed vocational nurse (LVN), or skilled practical nurse, and it has a graduate registered nurse (RN) on duty at least eight hours per day;

   d. it maintains a clinical record for each patient;

   e. it is not, other than incidentally, a place for rest, a place for CUSTODIAL CARE, a hotel, or a similar institution; and

   f. it complies with all licensing and other legal requirements, and is recognized as an "EXTENDED CARE FACILITY" by the Secretary of Health, Education and Welfare of the United States pursuant to Title XVIII of the Social Security Amendments of 1965.

10. **FUND** means the Heat and Frost Insulators and Asbestos Workers Health and Welfare Trust Fund.

11. **HOSPICE CARE** means care that:

    a. is furnished or arranged by an approved hospice, or is provided as part of a coordinated plan of home and inpatient care designed to meet the special needs of the terminally ill patient and the family unit due to the terminal illness;

    b. for the terminally ill patient, may include medical care, palliative care, respite care and medical social services; and

    c. for the family unit, may include medical social services and bereavement counseling.

12. **HOSPITAL** means a place for the diagnosis and treatment of illness, which operates legally and meets all of the following requirements:

    a. it is equipped to provide constant care for at least five resident patients on a full time basis;
    b. it has a PHYSICIAN in regular attendance;
    c. it provides services by graduate registered nurses (RNs) at all hours; and
    d. it is not a rest home, a nursing home, or a place for the aged.

13. **HOSPITAL** also means a psychiatric health facility operating within the scope of a state license, or in accordance with a license waiver issued by the state.

14. **MEDICARE** means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

15. **MEDICALLY NECESSARY** means any service, supply, treatment, or HOSPITAL confinement (or part of a HOSPITAL confinement) which:

    a. is essential for the diagnosis or treatment of the injury or sickness for which it is prescribed or performed;

    b. meets generally accepted standards of medical practice in the United States; and

    c. is ordered by a PHYSICIAN.

16. **NON-OCCUPATIONAL ACCIDENTAL BODILY INJURY** shall mean an accidental bodily injury resulting from an occurrence which is not expected, foreseen or intended and which does not arise out of or in the course of employment (including self-employment) or any occupation for wage or profit.

17. **NON-OCCUPATIONAL SICKNESS** shall mean a sickness or disease which does not arise out of or in the course of employment (including self-employment) or any occupation for wage or profit. For the purpose of this Plan, “non-occupational sickness” shall also include pregnancy, childbirth or related medical condition.

18. **PHYSICIAN or ELIGIBLE PROVIDER** means a person who is practicing within the scope of his or her license as:

    a. a doctor of medicine;
    b. a doctor of osteopathy;
    c. a dentist;
    d. a podiatrist;
    e. a chiropractor;
    f. an optometrist;
    g. a psychologist;
    h. a certified acupuncturist; or
    i. an advanced nurse practitioner, including a midwife.

19. **PHYSICIAN** shall not include any of the following persons: you or the spouse, parent, child, brother or sister of you or your dependent.

20. **PLAN** means the benefit program as adopted under the Trust Agreement for the Heat Frost Insulators and Asbestos Workers Health and Welfare Trust Fund, also known as “Heat and Frost Insulators and Allied Workers Health and Welfare Fund” and thereafter amended by the Board of Trustees.

21. **PREFERRED PROVIDER (PPO)** is a HOSPITAL, PHYSICIAN or other medical provider who has arranged with Anthem Blue Cross to provide participants with medical care at negotiated rates. All other providers are considered Non-PPO providers.

22. **PROTECTED HEALTH INFORMATION (“PHI”)** is individually identifiable information that is created or received by the Trust Fund, whether in oral, written, or electronic form, that relates to (i) the past, present or future physical or mental health or condition of a participant or dependent; (ii) the provision of health care to a health plan participant or dependent; or (iii) the past, present or future payment for the provision of health care to a participant or dependent. Health information becomes individually identifiable when it either identifies the participant or dependent or provides a reasonable basis to believe the information can be used to identify the participant or dependent. The following items may cause health information to become individually identifiable: i) name; ii) street, city, county, precinct, zip code; iii) dates directly related to a participant’s or dependent’s receipt of health care treatment, including birthdate, health facility admission and discharge date, or date of death; iv) telephone numbers, fax numbers, and electronic mail addresses; v) social security numbers; vi) medical record numbers; vii) account numbers; viii) certificate/license numbers; ix) vehicle identifiers and serial numbers, including license plate numbers; x) device identifiers and serial numbers; xi) Web Universal Resource Locators (URLs); xii) internet protocol (IP) address numbers; xiii) biometric identifiers, including finger and voice prints; xiv) full ace photographic images and any comparable images; and xvi) any other unique identifying number, characteristic or code.

23. **QUALIFIED INDIVIDUAL** means an individual:

    a. Who is a Participant in this Plan; and

    b. Who is eligible to participate in an APPROVED CLINICAL TRIAL according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition; and

    c. The individual’s participation in the APPROVED CLINICAL TRIAL is determined to be appropriate to treat the disease of condition. Such determination may be based upon the referring health care professional’s conclusions or on the provision of medical and scientific information by the individual.

24. **REASONABLE CHARGES** or "**ALLOWABLE CHARGES**" means the customary charges, in the area in which they are incurred, but not exceeding such charges as would have been made in the absence of the benefits provided under the Plan. A "customary charge" means the usual charge made by a HOSPITAL, EXTENDED CARE FACILITY, PHYSICIAN, or other professional person or firm which does not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for bodily injuries or sicknesses comparable in severity and nature to the bodily injuries or sicknesses treated or being treated.

    The term "area," as it would apply to any particular item for which a covered charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items.

Reasonable charges shall not exceed the amount determined by the Board of Trustees, in their sole discretion.

25. **REGISTERED DOMESTIC PARTNER** is an individual of the same or opposite sex that is in a committed relationship with the Employee and has properly registered in the state where the individual resides, and has been recognized as a domestic partner under the laws and jurisdiction in which the domestic partnership was entered.

26. **RETIREE(S) or RETIRED** shall mean withdrawing from employment for wages or profit in the type of work included in the Labor Agreement. Performance of such work by a retiree, on a non-cumulative basis, up to and including hours in excess of 40 hours in any three (3) months in a calendar year and 39½ hours in any other calendar month in the calendar year, shall not result in the loss of retiree status.

27. **SUMMARY HEALTH INFORMATION** is health information that may identify a health plan participant or dependent, and (i) summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the health plan; and (ii) from which the information described at 42 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

28. **TOTALLY DISABLED** shall mean, in the case of an employee, a DISABILITY which prevents such employee from engaging in gainful employment for profit or gain; and in the case of a dependent, from engaging in normal activity of a person of like age and sex in good health.

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 the "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
   PO 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) 433-6992

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
Fredi Flores (Alternate) 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
Eddy Pena 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 a 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/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.

9. **Type of Plan.** This Plan is maintained for the purpose of providing life insurance, accidental death and dismemberment, physical exam, hospital, medical, dental and vision care benefits in the event of sickness or accident for active mechanics 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, accidental death and dismemberment benefits are underwritten by United of Omaha. Vision care benefits are administered by Vision Service Plan. Prepaid medical benefits are provided by Kaiser Foundation Health Plan and UnitedHealthcare of California and UnitedHealthcare of Nevada. Prepaid dental benefits are provided by DeltaCare USA and UnitedHealthcare.

    Dental benefits, vision benefits, and fee-for-service medical and certain prescription drug benefits are provided directly from the Plan itself. The complete terms of the life insurance, accidental death and dismemberment benefits are set forth in the Group Policy. The complete terms of the vision care benefits are set forth in the Vision Service Plan Agreement. The complete terms of the insured medical benefits are set forth in the Kaiser Foundation Health Plan Group Hospital and Medical Service Agreement, the UnitedHealthcare Group Service Agreements and any individual coverage booklets, and should be read together with this SPD/Plan Document to determine the terms for benefits under the Plan. The complete terms of the insured dental benefits are set forth in the DeltaCare USA Dental Plan and UnitedHealthcare Dental Service Agreements. The complete terms of the self-funded benefits are set forth in this document.

    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 Mechanics ,or Maintenance plan who elect coverage under the Kaiser option.
    (800) 464-4000

    Anthem Blue Cross
    21555 Oxnard Street
    Woodland Hills, CA 91367
    Provides Case Management and Access to its network of Hospitals and Medical Providers to the self-funded (fee-for-service) medical benefits plan provided to Mechanics.
    (800) 999-3643

    First Dental Health
    P.O. Box 919029
    San Diego, CA 92191
    Administers self-funded dental benefits provided to Mechanics under the Plan.
    (800) 334-7244

    UnitedHealthcare
    700 E. Warm Springs Road
    Las Vegas, NV 89119
    Provides prepaid medical and prescription drug benefits to participants covered under the Mechanics plan who elect coverage under the UnitedHealthcare in Nevada option.
    (866) 633-2446

DeltaCare USA
P.O. Box 1810
Alpharetta, GA 30023
Provides prepaid dental benefits to participants covered under the Maintenance Plan and Mechanics plan who elect coverage under the DeltaCare USA Dental option.(800) 424-4234

United of Omaha (Mutual of Omaha)
Mutual of Omaha Plaza
Omaha, NE 68175
Provides fully insured life and accidental death and dismemberment benefits to Active Mechanics and Maintenance Workers and provides fully insured life insurance (mortuary fund) benefit for Local 135 Mechanics.

UnitedHealthcare
5856 Corporate Avenue
Cypress, CA 90630
Provides prepaid medical and prescription drug benefits to participants covered under the Mechanics plan who elect coverage under the UnitedHealthcare in California option.
(800) 624-8822

UnitedHealthcare Dental
1432 South Jones
Las Vegas, NV 89102
Provides prepaid dental benefits to participants covered under the Mechanics, or Maintenance workers plan who elect coverage under the UnitedHealthcare Dental option.
(800) 926-0905

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
Administers self-funded vision benefits provided to Mechanics and, Maintenance Workers Plan participants.
(800) 797-9791

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 4 through 6.

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

15. **Procedures to Follow for Filing a Claim.** The procedure to be followed in filing a claim for benefits is outlined on pages 25 through 35.

    All claims for benefits must be submitted on claim forms made available by the Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

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 30 through 35.

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 Administrator.

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 pre-existing 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 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, EBSA 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 U.S. Department of Labor, EBSA, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, 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 Officer700 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 TRUST 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