INTERNATIONAL ASSOCIATION OF HEAT AND FROST INSULATORS & ALLIED WORKERS ("IAHFIAW")
LOCAL #3 WELFARE PLAN AND HEALTH AND WELFARE FUND
SUMMARY PLAN DESCRIPTION ("SPD")

Administrative Manager
BeneSys
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Fund Office Hours
7:30 a.m. to 4:30 p.m.
Monday through Friday, except Holidays

Date: August 1, 2018

August 1, 2018

Dear Participant:

We are pleased to distribute this revised Summary Plan Description detailing the benefits provided under the International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund. This Summary Plan Description replaces and supersedes in its entirety your previous Summary Plan Description.

This Summary Plan Description summarizes the eligibility rules for participation in the Plan, the benefits provided to those who are eligible, and the procedures which must be followed when applying for a benefit. In addition, in this Summary Plan Description is important information concerning the administration of the Plan and your rights as a Participant.

Since there have been many plan changes, please take the time to read this Summary Plan Description and make yourself and your family familiar with the Plan benefits.

This document is a Summary Plan Description. It is intended to be a brief description of the pertinent provisions of the Plan and the Agreement and Declaration of Trust (the "Trust"). If there is a conflict between the Summary Plan Description, the Fund, the Trust or any insurance contract, the insurance contract shall govern. If there is a conflict between the Fund, the Trust and the Summary Plan Description, the Fund and the Trust shall govern.

This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Health Care Act ("Affordable Care Act") of 2010. As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which procedures do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 33 Fitch Blvd., Austintown, Ohio 44515, Phone: (800) 435-2388. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions concerning your eligibility, the benefits provided or the general provisions of the Plan, please contact the Fund Office. Please also note that the receipt of this booklet does not infer that you are eligible for benefits. Your eligibility will be determined by the Plan's Rules of Eligibility which are set forth in this Summary Plan Description.

Sincerely,

Board of Trustees
International Association of Heat and Frost Insulators & Allied Workers
Local #3 Health and Welfare Fund

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I. GENERAL PROVISIONS AND INFORMATION

The following information is required by Section 102 of the Employee Retirement Income Security Act (ERISA) of 1974.

Summary Plan Description

A. IAHFIAW Local #3 Health and Welfare Fund.

B. This Plan is maintained by the:

Joint Board of Trustees
IAHFIAW Local #3 Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515
(800) 435-2388

C. The Employer identification number assigned by the Internal Revenue Service is 34-1286578. The Plan Number is 501.

D. This Welfare Plan provides group health, life insurance, accidental death and dismemberment, dental care and vision care. It also provides a wellness program, a medical expense reimbursement account and a bank plan.

E. The day-to-day administration of the Plan is carried out by a contract Administrator, Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515; (800) 435-2388.

F. The Plan Administrator is:

Board of Trustees
IAHFIAW Local #3 Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515
(800) 435-2388
www.insulatorslocal3benefits.org

G. The name and address of the person designated as agent for the services of legal process is:

Board of Trustees
IAHFIAW Local #3 Health and Welfare Fund
1617 East 30th Street
Cleveland, Ohio 44114
(800) 435-2388

H. The names and address of each Trustee of the Plan is as follows:

Union Trustees

Chris Scarl
1617 East 30th Street
Cleveland, Ohio 44114

Employer Trustees

Dan Delaney
3855 W. 150th St.
Cleveland, Ohio 44111

James Gallagher
1617 East 30th Street
Cleveland, Ohio 44114

Thomas E. Dake
3855 W. 150th St.
Cleveland, Ohio 44111

Michael Sweeney
1617 East 30th Street
Cleveland, Ohio 44114

I. The Plan is maintained pursuant to a collective bargaining agreement between the Insulation Contractors Association of Cleveland, Ohio and The International Association of Heat & Frost Insulators & Allied Workers Local No. 3 and a copy of such agreement may be obtained by Participants and beneficiaries upon written request to the Plan Administrator. The Plan is also maintained pursuant to an Agreement and Declaration of Trust Asbestos Workers Local No. 3 dated September 2, 1980.

Any Participant or Beneficiary making request for the above shall pay the Plan's reasonable costs of furnishing these materials. Information about charges that would be made to provide copies of the above described materials shall be provided upon request at the Plan Administrator's office.

The above described materials are also available for examination by Participants and Beneficiaries at all times at the principal office of the Plan Administrator or at the office of the Union.

J. The Plan's requirements respecting eligibility for Participants and for benefits are set forth in the pages that follow which explain in detail the rules for becoming eligible for benefits as well as continuing eligibility for benefits.

K. The following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of benefits:

1. Failure to satisfy eligibility requirements stipulated in the Plan by:
   a. insufficient employment under jurisdiction of the Plan; or
   b. disabled for periods of time prior to or following periods during which credit is available.
2. Non-covered employment.
3. Failure to file necessary forms required.
4. Failure to file claims within time limits specified in the Plan.

L. Contributions to the Plan are made by individual employers under the provisions of a collective bargaining agreement.

M The Plan is financed by contributions to the Trust and any income earned from investment of contributions. All monies are used exclusively for providing benefits to eligible employees or their dependents, and the paying of all expenses incurred with respect to the operation of the Plan. The Fund provides a number of plans of benefit. Health, Dental, Vision, Life Insurance, Accidental Death and Dismemberment, Wellness, Medical Expense Reimbursement Account and a Bank Plan option. Each benefit has its own rules pertaining to eligibility, the scope of benefits provided and other terms and contributions governing such benefits. Most of the benefits are insured benefits which the Fund pays a premium. The exceptions are the Bank

Plan and the Medical Expense Reimbursement Account, the rules for which are set forth in Sections XII and XIII.

The Fund has contracted with the insurance issuer or issuers of insurance named herein to provide you and your dependents with certain fully-insured health and welfare benefits. These fully-insured benefits and the various provisions of that particular insurance contract are outlined in the Certificate of Coverage, Schedule of Benefits, and Benefit Riders, if any, issued to you free of charge, by the insurance issuer or issuers of insurance. You will need to refer to these documents in order to determine the terms, conditions and any benefit limits under the welfare benefit plan, including but not limited to:

- Cost-sharing, provisions, including premiums, deductibles, coinsurance, and copayment amounts for which you and/or dependents will be responsible
- Any annual or lifetime caps or limits on benefits
- Extent to which preventive services are covered
- Whether, and under what circumstances, existing and new drugs are covered
- Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures
- Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services
- Conditions or limits, if any, on selecting a primary care or specialty care providers
- Conditions or limits, if any, applicable to obtaining emergency medical care
- Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the Plan

The insurance issuer or issuers of insurance named herein includes a list of network providers with whom the insurance issuer or issuers of insurance has contracted with to provide benefits to you and/or your covered dependents. Generally, the benefits provided under the insurance plan are higher if you seek care from a network provider than from a non-network provider or, a provider who is not part of the network of the insurance issuer or issuers of insurance. You will need to refer to your Certificate of Coverage and other documents provided to you by the insurance issuer or issuers of insurance to determine what the level of benefits payable are for accessing in-network and out-of-network health care providers under the Plan as well as what, if any, your out-of-pocket responsibilities will be if you use non-network health care providers. The listing of network providers will be furnished to you automatically without charge.

Information relevant to the provision of these fully insured benefits is as follows:

- Health insurance, prescription and drug benefits is provided through CIGNA Healthcare.

- Supplemental Health Insurance for Medicare - Eligible Participants is also offered through CIGNA Healthcare.

- Retirees may also receive a $60.00 credit per month for the purchase of supplemental health insurance regardless of the Medicare Supplement they have chosen.

- Dental insurance is provided by Anthem Dental (877) 604-2142.

- Vision benefits are provided through Union Eye Care (800) 443-9699.

- Group Term Life and Accidental Death and Dismemberment Insurance is provided through 5 Star Life Insurance Company.

- An Employee Assistance Program is provided through Ease @ Work that offers counseling and other assistance. 4500 Euclid Avenue, Cleveland, Ohio 44103; (216) 432-7200.

- The Bank Plan is not a medical insurance plan. The Bank Plan can be utilized to accumulate dollars to be utilized to pay for eligible health insurance expenses. This Bank Plan may be utilized if the Participant has basic medical insurance under some other group insurance through his or her spouse.

- A Medical Expense Reimbursement Account is an individual subaccount for each Participant to which contributions are made pursuant to the applicable collective bargaining agreement. When a Participant or his or her Eligible Dependant has eligible unreimbursed medical expenses, and an existing balance in his or her Medical Expense Reimbursement Account, the Participant may submit proof of such expenses and apply for reimbursement from his or her Medical Expense Reimbursement Account.

N. The Plan's annual year end date is May 31st.

II. YOUR RESPONSIBILITIES AS A PARTICIPANT

The primary purpose of this Plan is to pay benefits to all those who are entitled to benefits. However, in order for the Trustees and the Fund Office staff to achieve this objective, we need your cooperation. There are certain responsibilities which you, as a Participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable. A list of your responsibilities under the Plan follows. As you review this list, you will notice that none of these responsibilities is extremely burdensome. In fact, just a little time and effort on your part will aid in protecting your best interests in the Plan.

1. Take Time to Read this SPD.

This SPD is the primary source of information. This SPD contains information you need to know about how to qualify for benefits, the benefits which are available and how to file a claim for benefits. We have tried to organize the SPD into sections dealing with specific aspects of the Plan and have tried to simplify the language, where possible.

REMEMBER: You owe it to yourself and your family to become familiar with the details of this SPD which provides that information. Of course, if you have any questions that are not answered in the SPD, be sure to contact the Fund Office.

2. If You Have Not Filed an Enrollment Card -- Do it Now!

When you first became eligible for benefits under the Plan, you should have received enrollment cards for you to complete and return to the Fund Office. These cards request certain basic information needed for your records in the Fund Office, such as: your Social Security Number, Address, Birth Date, Name and age of Dependents and Name of Beneficiary. This information is vital. Without it, the Fund Office will have difficulty keeping you informed about Plan changes (if your correct address is not on file), and you run the risk of not having a permanent record of your

participation under the Plan. So, if you have not yet completed an enrollment card, do it now! Complete a new card if there has been any change in address, beneficiary, or dependent status since you first filed an enrollment card. If you are not sure whether you have filed these cards with the Fund Office, please contact the Fund Office staff. The staff will advise you whether or not your card is on file. If not, a card will be sent for your completion.

3. Notify the Fund Office Promptly Regarding Any Change in Address, Beneficiary or Dependents.

When there are Plan changes or benefit improvements, we advise you by first class mail. This means that in order to get in touch with you, we must have your current address. So, if you move, make sure the Fund Office has your new address.

Also, if your marital status changes, or if for some other reason, you wish to change the name of your beneficiary, do not forget to send the change in writing to the Fund Office. Unless you do, the latest enrollment card which we have on file will determine who receives any benefit which may be payable in the event of your death. Failure to change your beneficiary, even when you intend to, is often just an oversight, but such an oversight could be costly to your survivors. Finally, if you add any dependents to your household, the Fund Office should be notified regarding the name and age of the new dependent(s). Since the Plan does provide certain benefits for dependents, the Fund Office must know who your dependents are. Additionally, if you have a Dependent who has reached age twenty-seven (27), see Section IV regarding Rules of Eligibility for rules regarding Dependants.

The forms are also available at www.insulatorslocal3benefits.org

4. Insurance Contracts

The insurance issuer or issuers of insurance named herein, not the Plan Administrator. Plan Fiduciary, (Trustees, if any) or Plan Sponsor, is responsible for the day-to-day benefit determinations, administration and adjudication of claims and various other provisions including, but not limited to circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (i.e. - by exercise of subrogation or reimbursement rights on a third party) of any benefits that a Plan Participant or beneficiary might otherwise reasonably expect the plan to provide based on the Certificate of Coverage or other benefit related documents provided by the insurance issuer or issuers of insurance. The insurance issuer or issuers of insurance has established procedures for the submission, payment and appeal of claims. These procedures are outlined in detail in the Certificate of Coverage and/or other benefit related documents issued to you by the insurance issuer or issuers of insurance which you will need to refer to in the event your benefits are denied or otherwise. For example if your claim for benefits is denied, you have the right under ERISA to appeal this decision. The insurance issuer or issuers of insurance will then make a determination regarding your appeal in accordance with the claims procedures outlined in your Certificate of Coverage. If you do not appeal within the appropriate timeframe as set forth in the Certificate of Coverage, you may lose your right to sue. In the event that there is a conflict between this SPD and the insurance policy, the insurance policy shall supersede this document and be the controlling authority.

III. GENERAL INFORMATION

1. The Trustees Interpret the Plan

Only the Board of Trustees has the power to interpret and construe the Plan, determine all questions of eligibility and status under the Plan and determine all questions arising in the administration of the Plan, including the power to determine the rights of eligibility of employees, participants, and their dependents and beneficiaries, and to make factual determinations. No union or management

representative, individual Trustee, business representative or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given that authority by the Board of Trustees and is acting on their behalf. However, the Board of Trustees has authorized the Administrative Manager to handle routine requests from Participants regarding eligibility rules, benefits and claims procedures. If there are questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for the final determination.

2. Benefits Are Not Guaranteed; the Plan Can Be Changed

Benefits offered by the Plan are not guaranteed to the Eligible Participants and/or their Eligible Dependents, and the Board of Trustees reserves the right to make any changes to the benefits which the Fund currently provides.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To achieve this goal may require Plan changes from time to time.

3. Limitation of Actions

No legal action may be taken to recover benefits until all claim appeals have been exhausted. No such action may be taken later than three (3) years after expiration of the time within which proof of loss is required.

4. Your Plan is Tax Exempt

Your Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means that the Employer's contribution to the Trust are tax deductible and are not included as part of your income. Also, in most cases, the benefit paid on behalf are not taxable as personal income. Additionally, investments earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to Participants and their Eligible Dependents. Such tax exemption works to the benefit of both the Employer and the Employee, in effect, it means that the money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses. The Trustees are well aware of these advantages and will take whatever measures are necessary to keep your Plan qualified as a tax-exempt trust under Internal Revenue Services rules.

5. In the Event of Plan Termination

In the event the Plan, in the opinion of the Trustee, is inadequate to carry out the intent and purpose under the Agreement and Declaration of Trust, or to meet the payments due or to become due to Participant, the Plan may be terminated by the Trustees. Upon termination of the Plan, providing there are funds remaining, the Trustees shall:

(a) First pay the unpaid expenses and the expenses involved in terminating the Plan;

(b) Pay premiums on any policies existing at the time to provide one or more of the benefits authorized by the Trust Agreement, as the Trustees determine;

(c) Provide one or more of the benefits on a fully or partially self-funded basis authorized by the Trust Agreement, as the Trustees determine.

The Participants shall continue to receive such benefits as may be provided in the policies then in force and in such additional or substitute policies as the Trustee are able to secure by the assets then in the Fund. In the event of self-funding, the Participants shall continue to receive such benefits as the Trustees in their discretion are able to secure by use of the assets then in the Fund. If at any time there are insufficient funds to pay premiums on such policies or to provide self-funded benefits,

the Trustees shall transfer such balance to charitable organizations, as they may select. No portion of the assets of the Plan, directly or indirectly, shall revert or accrue to the benefit of any Employer or Union.

6. About Your Plan

The International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund is maintained as a result of a Collective Bargaining Agreement between your Employer and the Union. Decisions on Plan operations and benefits are made by the Board of Trustees on which labor and management are equally represented. Working together, the Board of Trustees establishes rules of eligibility, strives constantly to improve benefits, supervise the investments of the Fund's money and sees that the Fund is in compliance with all applicable federal and state laws.

7. Gender

In the construction of this SPD, the masculine shall also include the feminine and the use of singular will also include the plural where required in order being appropriate for your situation.

IV. RULES OF ELIGIBILITY

A. RULES OF ELIGIBILITY FOR ELIGIBLE EMPLOYEES

NOTE: It will be the responsibility of each Participant to ascertain his own eligibility status, and any notification of impending loss of eligibility will be considered a courtesy to the Participant.

1. Initial Eligibility

To be eligible, you must be a member of IAHFIAW Local #3, and an active employee of a Contributing Employer or Retiree, who has made written application to the Fund to be covered as an Eligible Retiree. An Employee working under the terms of the Collective Bargaining Agreement between the Union and Employer or for a Participating Employer who is otherwise authorized to participate in the Plan by agreement of the Board of Trustees, who has accrued contribution of not less than 288 hours paid in his name by Participating Employers to the Fund Office for work performed by him within the preceding nine (9) month period, is eligible for coverage the first day of the second month following the month in which contributions are received. For example, if you work 288 hours in January and February and the Fund Office receives and credits the contribution for those hours in March, you will be eligible for coverage May 1.

2. Continuation Of Eligibility

An individual account of hours worked is maintained for you once you have one hour of contributions made on your behalf. Once you become an Eligible Employee because you fulfill the initial eligibility requirements, you will remain an Eligible Employee provided you are credited with a minimum of 148 hours of contributions received per calendar month with one or more contributing Employers or through reciprocal contributions.

Continuous coverage will commence on the first day of the second month following the work month reported to the Fund Office or the month in which Reserve Hours are applied to maintain your eligibility.

For Example: Once you reach your initial 288 hours, you will be eligible for coverage based upon 148 hours worked for which contributions are received as follows:

Contributions Received For The Work Month Of:	Provides Coverage For:
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

a) Reserve Bank

All contribution hours in excess of 148 hours per month are credited to your Bank up to a maximum accumulation of hours converted to dollars equaling $15,000.00 in reserve. This Reserve in your Bank can be used to maintain eligibility until exhausted, provided you are actively seeking work through the Union. To be actively seeking work, you must maintain membership through the Union and register with the Union that you are available for work according to the Union rules.

In the event that your Bank contains more than zero (0) dollars, but less than the number of dollars necessary to maintain one (1) month of eligibility, the dollars remaining in the account shall be exhausted and you may preserve eligibility for only that month through a self-payment of a rate established by the Trustees.

If a Participant did not elect to use the reserve dollars to make a self-payment, the reserve dollars will be used towards reinstatement eligibility under Section 3. If you do not complete the appropriate application for coverage, contributions will still be deducted from your bank of hours.

b) Self Payments

Once your Reserve Bank is insufficient or exhausted, you are still entitled to preserve eligibility, other than through Reinstatement of Eligibility, by making a self payment of the required rate as set by the Trustees for each month. The self payment may be made from the Medical Expense Reimbursement Account. Once you have exhausted your self payments or fail to make your self payments as required under the Plan, you may still be entitled to continue your eligibility under the provisions as set forth in the section entitled COBRA Continuation Of Coverage Option, and the amount required for payment to maintain eligibility under COBRA shall be the COBRA rate established by the Trustees.

3. Reinstatement of Eligibility

If you were an Eligible Employee who fails to maintain your eligibility through work hours, use of your Reserve Hours Bank, use of your Medical Expense Reimbursement Account or by making self-payments, other than through COBRA, you can become a Eligible Employee again on the first day of the second month following the month in which 288 hours of contributions are received from one or more contributing Employers within a period of nine (9) consecutive months after termination of such eligibility. If you seek to become an Eligible Employee again after the lapse of this nine (9) month period, you will be required to re-qualify as set forth under the Initial Eligibility requirements above.

4. Delinquency Procedure for Self Payments

The Fund Office will calculate each month the number of dollars necessary to maintain your eligibility in the Plan. If you do not have the proper hours paid by your Employer, **or** in your Reserve Bank, you will receive a self payment statement from the Fund Office. Your Self Payment is required to be paid on the due date reflected on the billing statement. If your self payment is not received by that date, your coverage will terminate on the termination date reflected on the billing statement. Once your coverage terminates due to the failure to make a self-payment, you will be required to reinstate your eligibility as provided in paragraph 3 above, or you may be eligible for COBRA Continuation Coverage depending upon your circumstances.

5. VA Coverage

If a retired member who has attained the age of sixty-two (62) obtains coverage through the Veteran's Administration ("VA"), then the retired member can discontinue coverage through the Plan if he maintains the VA coverage. The spouse of a retired member with VA coverage can continue coverage in the Plan until he or she attains age sixty-five (65).

B. ELIGIBLE RETIREES

NOTE: It is the responsibility of each Eligible Retiree to ascertain his or her own eligibility status, and any notification of impending loss of eligibility will be considered a courtesy to the Retiree.

1. Retirement of Eligible Employees Between the Ages of 62 and 65

If an Eligible Employee has been covered under the Plan for at least one (1) full year immediately prior to retirement, and if the Eligible Employee retires on or after attaining age 62 but prior to attaining age 65, then he or she will be eligible to continue to participate in the Plan but must self-pay at a rate established by the Trustees on an annual basis.

2. Retirement of Eligible Employee at Age 65

If an Eligible Employee has been continuously covered under the Plan for at least one (1) full year immediately prior to retirement, and if the Eligible Employee retires on or after attaining age 65 and is receiving either a Retirement Benefit from Social Security, or the International Association of Heat and Frost Insulators & Allied Workers Local #3 Pension Fund, he must notify in writing the Fund Office no later than sixty (60) days after his receipt of a retirement benefit. If the Retiree's Spouse has not attained age 65, the Retiree's Spouse may continue coverage under the Plan at the normal cost of coverage for single Participants which is at a rate established by the Trustees on an annual basis. Otherwise, Retirees or the Retiree's Spouse will receive a reimbursement on a monthly basis for the first $60.00 for Medical Supplemental Coverage purchased by the Retiree or Spouse.

3. Application of Your Reserve Bank

For Retirees who have not attained age 65, Reserve Bank dollars can be utilized to defray the self-pay expense. If you retire between the ages of 62 and 65 and complete the appropriate application, the self-pay expense will be at a rate established by the Trustees on an annual basis. As of the day you attain age 65, the dollars in your Reserve Bank will be utilized to defray expenses of the General Fund.

4. Application of Medical Expense Reimbursement Account

For Retirees who have not attained age 65, the dollars in your Medical Expense Reimbursement Account can be utilized to defray the self-pay expense. If you retire between the ages of 62 and 65

and complete the appropriate application, the self-pay expense will be at a rate established by the Trustees on an annual basis.

C. ELIGIBLE DEPENDENTS

1. Dependent Coverage

It is the responsibility of each Eligible Participant to ascertain his own Dependents' eligibility status and any notification of impending loss of eligibility will be considered a courtesy to the Eligible Participant and their Dependents. For the definition of an eligible dependent for each coverage please refer to each individual insurance contract. For purposes of the Bank Plan and Medical Expense Reimbursement Account, an Eligible Dependent effective June 1, 2011 shall also include any child (as defined in Section 152(f)(1) of the Code) who has not attained the age of twenty-seven (27). Ohio law also allows you to add eligible, unmarried dependent children to your health insurance until they reach the age of twenty-eight (28) if they meet certain criteria. If this applies to your circumstance, please contact the Plan Administrator.

2. Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order made pursuant to a state domestic relations law (including community property law) that relates to the provision of support for a child of a participant (Alternative Recipient) and which:

(a) Creates or recognizes the existence of an Alternative Recipient's right to, or assigns to an Alternative Recipient the right to receive, benefits for which a Participant, Dependent or Beneficiary is eligible under this Plan; and

(b) Specifies (i) the name and last known mailing address (if any) of the Participant and each Alternate Recipient covered by the Order, and (ii), a reasonable description of the type of coverage to be provided by the Plan or the manner in which the coverage is to be determined; and

(c) Does not require the Plan to:

(i) Provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of any law relating to medical child support as described in Section 1908 of the Social Security Act.

(ii) Upon receipt of any judgment, decree or order (including approval of a property settlement agreement) relating to the provision of payment by the Plan to an Alternate Recipient pursuant to a state domestic relations law, the Trustees shall promptly notify the affected Participant and any Alternate Recipient of the receipt of such judgment, decree or order and shall notify the affected Participant and any Alternate Recipient of the Trustees' procedures for determining whether or not the judgment, decree or order is Qualified Medical Child Support Order.

(iii) The Trustees shall establish procedures to determine the status of a judgment, decree or order as a QMCSO and to administer Plan benefits in accordance with Qualified Medical Child Support Orders. Such procedures shall be in writing, shall include a provision specifying the notification requirements enumerated in the preceding paragraph, and shall permit an Alternate Recipient to designate a representative for receipt of communications from the Trustees and shall include such other provisions as the Trustees shall determine, including provisions required under regulations promulgated by the Secretary of the Treasury. A copy of such procedures

is available without charge, upon request, from the Office of the Administrative Manager.

3. Surviving Spouse of Active Participants

(a) Rules for Continued Participation

If you are an Active Participant upon the date of your death, your spouse will be eligible to continue coverage under the terms of each individual insurance policy or through COBRA Continuation Coverage. Your spouse may first utilize your Bank Plan balance at the same rate as an Active Participant and then self-pay at the same rate as a Retiree at one-half (1/2) of the coverage rate. This coverage will be terminated if you don't make required payments, or if other coverage is available through employment, marriage or Medicare eligibility.

V. EXPLANATION OF MEDICAL BENEFITS

A. EXPLANATION OF MEDICAL BENEFITS

If you are an Eligible Employee, or Eligible Retiree Under Age 65, or an Eligible Union Member over the Age 65, then your covered Medical Benefits are explained in this Section.

Medical coverage is automatically purchased for Participants and Dependents pursuant to an insurance contract with CIGNA Healthcare. The terms and conditions of these contracts are contained in separate written documents governing each respective benefit.

VI. EXPLANATION OF DENTAL BENEFITS

If you are an Eligible Employee, Eligible Retiree Under Age 65, or Eligible Dependents of any of these Participants, then your covered Dental Benefits are explained in this Section.

Dental Benefits coverage is automatically purchased for Participants pursuant to an insurance contract with Anthem Dental.

VII. EXPLANATION OF VISION BENEFITS

If you are an Eligible Employee, Eligible Retiree Under Age 65, or Eligible Dependents of any of these Participants, then your covered Vision Benefits are explained in this Section.

Vision Benefits coverage is automatically purchased for Participants pursuant to an insurance contract with Union Eye Care.

VIII. EXPLANATION OF PRESCRIPTION DRUG BENEFITS

If you are an Eligible Employee, Eligible Retiree Under Age 65, or Eligible Dependents of any of these Participants, then your covered Prescription Benefits are explained in this Section.

Prescription Drug Benefits are provided through CIGNA Healthcare.

IX. EXPLANATION OF LIFE INSURANCE BENEFITS

If you are an Eligible Employee, Eligible Retiree Under Age 65, or an Eligible Retiree over age 70 of any of these Participants, then your covered Life Insurance Benefits are explained in this Section.

Life Insurance Benefits are provided through 5 Star Life Insurance Company.

X. EXPLANATION OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Accidental Death and Dismemberment Benefits are provided through 5 Star Life Insurance Company.

XI. EXPLANATION OF EMPLOYEE ASSISTANCE PROGRAM

If you are an Eligible Employee, Eligible Retiree Under Age 65, or Eligible Dependents of any of these Participants, then your covered Medical Benefits are explained in this Section.

The Employee Assistance Program is offered through Ease@Work. Services offered include:

- 24 hour help line
- short term counseling
- dependent care services
- legal resources
- financial planning assistance

XII. BANK PLAN

The Bank Plan, is not a basic medical insurance plan. The purpose of the Bank Plan is to serve as a supplement to any other group health insurance coverage you or your dependents may have. In order to select this plan, you must have basic medical coverage through your spouse under some other group insurance plan.

Under the Bank Plan, contributions made by your Employer for hours of work credited to your account are used to pay premiums for life insurance, accidental death and dismemberment coverage and dental and vision insurance coverage, which are required under the plan. Participant's Bank Plan balances are charged 32 hours per month to pay premiums for these coverages. A balance of 96 hours is maintained in your account to cover these benefits. Any portion of your account which is in excess of 96 hours can then be used to reimburse you for eligible expenses incurred by you or your dependents that are not covered by any other group insurance plan you may have. The maximum that can be accumulated is hours equivalent to $15,000.00.

In addition to those dependents eligible for coverage under the eligibility rules of any unmarried grandchildren, nieces, nephews or parents who live with you and are dependent on you for support within the meaning of the Internal Revenue Code are eligible for benefits from the Bank Plan.

In general, the Bank Plan will reimburse those medical expenses included in Internal Revenue Service Publication 502, Medical and Dental Expenses, and that are deductible under Internal Revenue Code Section 213.

Examples of eligible expenses which can be reimbursed under this plan include:

- Hospital room and board
- Surgery
- Physicians/surgeon fees
- X-rays
- Laboratory tests
- Ambulance
- Dental
- Prescribed drugs
- Vision examinations
- Prescribed lenses, frames and contact lenses
  (solutions and care kits are not a covered expense)
- Appliances prescribed by a doctor to aid in recovery and/or therapy as needed due to an accident, illness or deformity
- Other valid medical expenses not covered by any other group insurance program.
- Expenditures for non-prescription medicines and drugs purchased to treat or remedy a medical condition. However, for Plan Years beginning after December 31, 2010, this is limited to medicine and drugs: (i) that require a prescription; (ii) that are available without a prescription (i.e., OTC drugs) and the individual obtains a prescription; or (iii) insulin.

The Bank Plan will cap reimbursement for therapeutic spas and hot tubs at $2,000.00 per Participant per purchase.

Bank Plan benefits may also be used to supplement the dental and vision benefits offered by the Fund.

IMPORTANT - The Bank Plan is not a vested benefit and does not entitle you to any cash distribution other than as reimbursement for medical expenses you incur while covered under the Fund

If you are covered under the Bank Plan at the time of your death, hours remaining in your reserve account may be used to pay premiums to continue dental and vision benefits for your surviving spouse and dependents.

Claims Procedure

To receive benefits from your Bank Plan account, you must file a claim with the Fund office. Claim forms can be obtained at the Fund Office, or you may call or write the Fund and request that the forms be sent to you. For Participants who are no longer members of IAHFIAW Local No. 3, claim forms must be filed within twelve (12) months of the date the Participant is no longer a member of IAHFIAW Local No. 3 in order to obtain reimbursement

Claim forms must be completed in full. All medical charges must be filed first with your hospitalization carrier. Your Bank Plan claim must be accompanied by the carrier's explanation of payment if partial payment was made, or a copy of the carrier's rejection letter if no payment was made. The same procedure applies to dental and vision claims.

An itemized bill must also be submitted with the claim. Each bill submitted must indicate:

- Name of the patient;

- Nature of medical or dental problem requiring treatment;
- Service rendered;
- Date service was provided;
- Charge for each service rendered;
- Name of doctor. dentist or other provider of service.

For prescription drugs, you must submit a druggist's receipt showing:

- Name of Patient;
- Prescription number;
- Prescribing physician's name;
- Amount of the charge;
- Type of drug.

We suggest that you accumulate a minimum of $50 in bills for covered expenses before submitting a claim.

The claim will be processed as quickly as possible after the claim forms and all necessary supporting records and documents are filed with the Fund Office. If additional information is required, you will be notified.

Approval or denial of the claims will normally be made within 90 days after the claim and all necessary data have been received by the Fund Office. If additional time is required in special cases, you will be notified in writing, before the expiration of the 90-day time period, of the special circumstances requiring an extension of time, and of the date by which the Plan expects to render the final decision, which will not be more than an additional 90 days.

ARTICLE XIII - MEDICAL REIMBURSEMENT ACCOUNTS

Effective August 1, 2010, a Medical Reimbursement Account ("MRA") benefit was established for all active participants. Employer contributions to the MRA must be made in accordance with applicable collective bargaining agreements. The MRA is an individual sub-account of the Plan for each Participant for whom such contributions are made. <u>These contributions and accounts shall not create or constitute a vested benefit for any Participant, dependent or beneficiary</u>. Participants may first make claims against the MRA on or after August 1, 2011.

When a Participant, or his/her Eligible Dependent, has eligible unreimbursed medical expenses and an existing balance in his/her individual MRA, the Participant may submit, on a form provided by the Fund office, proof of such expenses and apply for reimbursement from his/her individual MRA. Reimbursement checks shall be issued to Participants on a quarterly basis.

Medical expenses will be reimbursed only to the extent that reimbursement for such medical expenses is not available to the Participant under any health insurance policy or plan provided through any employer of the Participant. Reimbursement, to the extent the Participant has funds in his/her individual MRA, shall be made for those medical expenses allowed in Section 213 of the Internal Revenue Code, a complete listing is contained in Internal Revenue Service Publication 502. Some examples of reimbursable medical expenses include :

1) Deductibles, co-payments and expenses in excess of benefit maximums applied to covered medical expenses under the International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund (hereinafter "Health and

Welfare Fund") or other qualified plan for which the Participant or Dependent spouse receive medical benefits;

2) Self-payments to maintain eligibility under the Health and Welfare Fund or other qualified plan or arrangement or premium or other payments required to maintain coverage under the Plan of Participant's Spouse;

3) Unreimbursed prescription medicines (prescribed by a doctor) and insulin, including co-pays;

Any individual who engages in covered employment (bargaining unit work) for a non-contributing employer shall have his/her account cancelled and the account balance will revert to the General Fund. In the event of a Participant's death, his or her individual MRA balance shall be placed in an individual MRA for his or her Spouse, or if unmarried or widowed, for his or her Dependent(s) as allowed by applicable provisions of the Internal Revenue Code or regulations promulgated thereunder. This individual MRA may only be used for reimbursement purposes and shall not be paid directly to the surviving Spouse or the above Dependent other than for reimbursement for eligible expenses.

Participants will have the ability to permanently opt-out of the Medical Reimbursement Accounts. This means that, starting June 1, 2014, a Participant can elect to remove himself from the MRA.

If you opt-out, you are NOT permitted to re-enroll in the MRA. Choosing to opt-out is PERMANENT. Any money that is in your MRA at the time you opt-out would be forfeited. Future employer contributions would not be given to you. Instead, they would simply go into the general International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund.

In other words, if you opt-out of the MRA, you will receive ***no*** further benefit from the MRA. You will ***not*** receive the money that was going into the MRA in your pocket. You will ***not*** have the ability to send that contribution anywhere else.

If you want to remain in the MRA, you do not need to do anything. Your MRA will continue as it always has. However, if you do opt-out, it is PERMANENT and you will forfeit any amount you have in your MRA at the time that you opt-out.

The Health and Welfare Fund may assess an administrative fee against the Participant's MRA for the administrative costs of processing such reimbursement claims.

XIV. CLAIMS

Appeal Procedure for Denied Claims:

1. Insurance Claims Procedures:

The insurance issuer or issuers of insurance named herein is responsible for the day-today administration of claims under the International Association of Heat and Frost Insulators & Allied Workers Local No. 3 Health and Welfare Fund. The insurance issuer or issuers of insurance has established procedures for the submission, payment and appeal of claims which are automatically made available to without charge and contained in the Certificate of Coverage booklet and/or other benefit related documents provided to you as issued by the insurance issuer or issuers of insurance. If your claim is denied by the insurance issuer or issuers of insurance, you have the right under ERISA to appeal this decision. See, "Information on Your Rights Under ERISA" contained in this SPD

for more summary information. The insurance issuer or issuers of insurance, not the Plan Sponsor or Plan Administrator, will then make a determination regarding your appeal in accordance with the claims procedures outlined in the Certificate of Coverage booklet. If you do not appeal within the appropriate time frame as set forth in the Certificate of Coverage booklet, you may lose your right to sue.

2. Bank Plan. Medical Expense Reimbursement Account and Eligibility Claims Procedures:

If you have been denied eligibility for benefits under the Fund's eligibility rules, or if a claim for benefits under the Bank Plan or Medical Expense Reimbursement Account is denied in whole or in part, written notice will be mailed to you which sets forth the specific reference to pertinent Plan provisions on which the denial was based, describes any additional material or information necessary for you to perfect your claim, explains why such material or information is necessary, and also explains the Plan's Review Procedure.

You may request a review of a denial of eligibility for benefits or of a denied claim for benefits under the Bank Plan or Medical Expense Reimbursement Account by filing a written application with the Fund Office not more than 60 days after receipt of the written notification of such denial. Your request for review must state:

- Your name, address, and social security number;
- Your telephone number;
- Patient's name;
- Date of claim;
- Type of claim;
- Reasons why you disagree with the decision.

You are entitled to be represented by a duly authorized representative without expense to the Plan, and you or your representative may review pertinent documents and submit issues and comments in writing. You or your representative are not entitled to appear personally before the Trustees, and no hearing is required to be held in connection with the review.

Review decisions shall be made promptly, but no later than the date of the meeting of the Board of Trustees which immediately follows the Plan's receipt of a request for review, unless the request is filed within 20 days preceding the date of such meeting. In such case, a decision may be made not later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, written notice of such extension shall be furnished to the claimant, and a decision shall be rendered no later than the third meeting of the Board of Trustees following the Plan's receipt of the review request.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or SPD upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;
- A notice of your right to file a voluntary appeal to the Board of Trustees as outlined below; and
- A notice of your right to file a lawsuit in federal court under ERISA Section 502(a).

The decision of the Board of Trustees is final and binding.

Voluntary Appeal to the Board of Trustees

Once you have filed your appeal through the two levels or review, you have the right to file a lawsuit in federal court. However, prior to filing a lawsuit, you can file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice by the Trustees.

The Appeal should be addressed as follows:

Board of Trustees
33 Fitch Boulevard
Austintown, Ohio 44515

The Board of Trustees will review the appeal at their next regularly scheduled meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive a notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

- The Fund will not assert a failure to exhaust administrative remedies;
- The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;
- The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
- You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:
    - A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;
    - A statement that you have the right to have a personal representative with regard to your claim;
    - A notice of any circumstances which may impair the impartiality of the Board of Trustees;
- The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

In the event the denial is upheld, you will receive a written notice which includes the following information:

- The specific reason for the denial;

- The sections of the Plan and/or Summary Plan Description upon which the denial was based;

- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable, and

- A notice of your right to file a lawsuit under ERISA Section 502(a).

XV. COBRA CONTINUATION COVERAGE OPTION

Under certain circumstances, coverage for you and your Eligible Dependents can be temporarily continued, at your expense, after it would normally end. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides you with the right to this continuation coverage.

COBRA provides you and your Eligible Dependents with the opportunity to continue the same or similar coverage in the Plan even if you have suffered an event which would usually terminate your coverage under this Plan. You may continue the health care benefits you received under the Plan as a Participant except Life Insurance, Accidental Death and Dismemberment . You pay the full cost of the continued coverage plus a small administrative charge.

Eligibility for COBRA Continuation Coverage

All Eligible Participants and their Eligible Dependents may be entitled to continue their coverage under the Plan if they suffer a "qualifying event." COBRA continuation coverage applies to each individual under the Plan. Additionally if you, the Eligible Employee, have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have the financial responsibility) while COBRA continuation coverage is in effect, you may add such child to your coverage. You must notify the Fund Office, in writing, of the birth or placement in order to have this child added to your coverage.

Children born, adopted or placed for adoption, as described above, have the same COBRA rights as your spouse and dependent(s) who where covered by the Plan before the event that triggered COBRA continuation coverage, and their continued coverage depends upon the timely and uninterrupted payment of the premiums on their behalf.

Definition of "Qualifying Event"

If coverage ends for one of the following reasons or "qualifying events," the COBRA continuation coverage will be available to any covered person whose coverage would otherwise stop due to one of the following events:

(1) your termination from work or reduction of work hours, including retirement, but not including termination due to gross misconduct;
(2) your death;
(3) your divorce or legal separation;
(4) your dependent child no longer qualifies for dependent coverage under the terms of the Plan; or
(5) you become entitled to Medicare after the date of your election to maintain COBRA continuation coverage.

Your Obligations

Under the law, you and your Dependents have the responsibility to notify the Fund Office about a divorce, legal separation or a child losing Dependent status under the Plan. Such notification MUST take place immediately after any of these three qualifying events. If you and/or your Dependents do not report the event to the Fund Office within sixty (60) days of the date the qualifying event occurred, COBRA continuation coverage will not be provided.

It is the responsibility of you and your employer to notify the Fund Office regarding a death, termination of employment, reduction in hours, or Medicare entitlement.

It is advisable, however, for the Spouse of a deceased Participant to contact the Fund Office as soon as possible after the Participant's death so that COBRA continuation coverage will be offered to the Surviving Spouse and Dependents at the earliest possible date.

It is also extremely important that you and your Dependents notify the Fund Office immediately about any changes in your address, so that if COBRA continuation coverage becomes available to you or your Dependents, the Fund Office will be able to forward the Notice to the correct address.

Once the Fund Office has notice of a qualifying event, the Fund Office will notify you and each of your Dependents individually of the right to elect COBRA continuation coverage and provide you with the amount of the premium required to elect this coverage. You and each of your Dependents individually will have the right to make this election within sixty (60) days after the date on the election notice. If you and your Dependents do not notify the Fund Office that you wish to elect the COBRA continuation coverage and remit the premium within this sixty (60) day period, your coverage under the Plan will be terminated and you will no longer have the ability to elect COBRA continuation coverage.

18 month COBRA Continuation Coverage

If you are no longer an Eligible Employee because of a reduction in work hours, termination or retirement, you will be eligible to maintain COBRA Continuation Coverage for up to eighteen (18) months.

29 Month COBRA Continuation Coverage

If your coverage ends due to one of the above "qualifying events" and, at the time of the event, or within the first sixty (60) days of COBRA Continuation Coverage, you or your Eligible Dependent is determined to be totally and permanently disabled by the Social Security Administration (SSA), COBRA Continuation Coverage for the disabled person will be offered for an additional eleven (11) month period, or a total of twenty-nine (29) months. This option seeks to offer the disabled person coverage until Medicare coverage becomes effective. Coverage for the additional eleven (11) months may be at a higher cost, as set by the Trustees.

Please notify the Fund Office of the SSA determination of disability within sixty (60) days of the determination and before the end of the first eighteen (18) months of coverage. Otherwise, you will **not** be eligible for the additional eleven (11) months of coverage.

36-Month COBRA Continuation Coverage

Your Eligible Dependents may elect to purchase COBRA Continuation Coverage for up to thirty-six (36) months. Your dependents are entitled to elect COBRA Continuation Coverage which may last for up to thirty-six (36) months for any of the following "qualifying events:"

(1) your death;
(2) your spouse and you are divorced or legally separated;

(3) your dependent child no longer qualifies as a dependent under the terms of the Plan.

Your COBRA Continuation Coverage Terminates

COBRA Continuation Coverage may end for any of the following reasons:

(1) you or your dependent(s) become covered under another group health plan which is substantially the same as this Plan as an employee, dependent or spouse. However, coverage will continue if you or an Eligible Dependent has an existing health problem for which coverage is excluded under the other group health plan;
(2) the required premium is not paid at the time specified by the Trustees;
(3) the Fund terminates as a health coverage provider;
(4) you or your dependent(s) reach the maximum COBRA Continuation Coverage period allowed as provided above;
(5) you or your dependent(s) become eligible for Medicare after the date of your election to maintain COBRA Continuation Coverage.

When your coverage ends under this Plan, you will be provided with a certification of your length of coverage as required by the existing federal laws. This certificate may help to reduce or eliminate any pre-existing limitations under your new group medical plan.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

(Effective November 1, 2005)

INTRODUCTION

This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budge Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Office of the Administrative Manager.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Yours hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
(5) The parents divorced or legally separated from your spouse; or
(6) The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy filed with respect to one or more of the contractors who are signatories to the collective bargaining agreement with the Union and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Administrative Manager has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Office of the Administrative Manager of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Administrative Manager within sixty (60) days after the qualifying event occurs. You must provide this notice to the Fund's Office of the Administrative Manager.

How is COBRA coverage provided?

Once the Office of the Administrative Manager 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 spouse, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, is a covered employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

If you or anyone in your family covered under this Plan is determined by the Social Security Administration to be disabled and you notify the Office of the Administrative Manager in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage.

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Office of the Administrative Manager. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, ~~the~~ covered employee's Spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other Participants or Beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights, under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to eighteen (18) months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medical entitlement. This Notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

(1) any required premium is not paid in full;
(2) a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
(3) a covered employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage; or
(4) the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of the Administrative Manager of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected

continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Office of the Administrative Manager of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have cause the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Office of the Administrative Manager within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the direction on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the rights to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 (or in the case of an extension on continuation coverage due to a disability, 150 percent) percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for continuation coverage for each option is described in this Notice.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center

toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for COBRA continuation coverage be made?

First payment for COBRA continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your payment is correct. You may contact the Office of the Administrative Manager to confirm the correct amount of your first payment. Your first payment for COBRA continuation coverage should be sent to:

Office of The Administrative Manager
International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund
c/o BeneSys
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Periodic payments for COBRA continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. The amount due for each coverage period for each qualified beneficiary is shown in this Notice. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for COBRA continuation coverage should be sent to:

Office of the Administrative Manager
International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund
c/o BeneSys
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of its grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your Summary Plan Description or from the Office of the Administrative Manager. If you have any questions concerning the information in this Notice, your rights to coverage, or if you want a copy of your Summary Plan Description, you should contact the Office of the Administrative Manager; International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund, c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515, (800) 435-2388.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

XVI. FAMILY MEDICAL LEAVE ACT OF 1993

THE FAMILY AND MEDICAL LEAVE ACT (FMLA) was enacted on February 5, 1993. FMLA is generally effective on February 5, 1994. FMLA requires your Employer to provide you with up to 12 weeks of unpaid leave during any 12-month period for specified family and medical reasons, if you are eligible. During this period, your Employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing Employer for at least 12 months and for at least 1,250 hours during the 12-month period before the leave begins. Generally, your Employer is obligated to provide Family and Medical leave only if your employer employs 50 or more employees each working day during each of 20 or more work weeks during the current or preceding calendar year.

During the FMLA leave, your Employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility.

A covered Employer must grant an eligible Participant up to a total of 12 work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

(1) For the birth of a child or placement of a child for adoption or foster care;

(2) To care for an immediate family member (spouse, child or parent) with a serious health condition; and

(3) To take medical leave when the Eligible Employee is unable to work because of a serious health condition.

Arrangements will need to be made for the Eligible Employee to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, the Eligible Employee must be restored to his or her original job or to an equivalent job. In addition, the Eligible Employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave.

Please contact the Fund Office if you have any questions regarding your options under the FMLA.

Repayment of Contributions to Employer
If you take a leave under the FMLA and you fail to return to your Employer for any reason after such absence, under the Act your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your Employer, you should return to work at the end of your leave of absence under the FMLA.

XVII. NOTICE OF PRIVACY PR

SECTION 1: PURPOSE OF THIS NOTICE AND EFFECTIVE DATE

Effective Date. The effective date of this Notice is April 14, 2003,

This Notice is required by law. The International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI).
- Your rights to privacy with respect to your PHI.
- The Fund's duties with respect to your PHI.
- Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and
- The person or office you should contact for further information about the Fund's privacy practices.

SECTION 2: YOUR PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Fund May Disclose Your PHI

The Fund Sponsor has amended its Fund Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

- *At your request.* If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.

- *As required by an agency of the government.* The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

- *For treatment, payment or health care operations.* The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out: treatment, payment, or health care operations.

When the Disclosure of Your PHI Requires Your Written Authorization

The Fund must generally obtain your written authorization before it will use or disclose psychotherapy notes about you from your psychotherapist. However the Fund may use and disclose such notes when needed to defend itself against litigation filed by you.

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The Fund must generally obtain your written authorization before it will use or disclose psychotherapy notes about you from your psychotherapist. However the Fund may use and disclose such notes when needed to defend itself against litigation filed by you.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1. When required by law.

2. Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. Domestic violence or abuse situations. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4. Health oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensures or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

6. Law enforcement health purposes. When required for law enforcement purposes (for example, to report certain types of wounds).

7. Law enforcement emergency purposes. For law enforcement purposes including:

a. Identifying or locating a suspect, fugitive, material witness or missing person, and

b. Disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. Determining cause of death or organ donation. When required to be given to a coroner or medical examiner to identify a deceased person to determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent.

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

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

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

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claim or for other reasons regarding the administration of the Fund. The "Plan Sponsor" of this Fund is the International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Fund Board of Trustees.

SECTION 3: YOUR INDIVIDUAL PRIVACY RIGHTS

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:
1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

In addition, the Fund will accommodate an individual's reasonable request to receive communication of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

The Fund must provide the requested information within thirty (30) days if the information is maintained on site or within sixty (60) days if the information is maintained offsite. A single thirty (30) day extension is allowed if the Fund in unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

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

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI. This accounting period starts as of April 14, 2003 and allows you to request an accounting for up to six (6) years of disclosures after that date. The maximum period of time you can request is six (6) year. Please contact the Fund Office for a complete listing of the contents of an accounting. You should request a copy of the Fund's Accounting for Disclosure Policy.

The Fund has sixty (60) days to provide the accounting. The Fund is allowed an additional thirty (30) days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

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

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

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

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider spouse's covered under the Fund as the personal representative for each other. Additionally, the Fund will consider a covered parent, guardian, or other person acting *in loco parentis* as the personal representative of any dependent covered by the Fund unless applicable law requires otherwise. A parent may act on an individual's behalf, including requesting access to their PHI. Covered dependents, including your spouse may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice. Additionally, the Fund will automatically consider any person designated under a Power of Attorney which is on file with the Fund as a personal representative.

You or your spouse may elect not to have one another as your personal representative. You or your spouse must fill out an Opt-Out of Personal Representation Form and submit the form to the Privacy Official. Your covered dependent children also have the right to submit an Opt-Out Form if they do not wish to have one or both of their parents as their deemed personal representative. All requests are reviewed by the Privacy Official who may deny the requests, especially those based upon State law restrictions.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

SECTION 4: THE FUND'S DUTIES

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the covered participant and dependents.

Any revised version of this notice will be distributed within sixty (60) days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

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

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

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.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

SECTION 5: YOUR RIGHT TO FILE A COMPLAINT WITH THE FUND OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Fund Privacy Official at the address provided in Section 3.

You may also file a complaint with:

Secretary of the U.S. Department of Health and
Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

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

SECTION 6: IF YOU NEED MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address provided in Section 3.

SECTION 7: CONCLUSION

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

XVIII. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

XIX. MENTAL HEALTH PARITY ACT

Effective June 1, 2010, the Plan may not impose any limitations on mental health and/or substance abuse benefits that violate the requirements of ERISA §712.

XX. MICHELLE'S LAW

Effective June 1, 2010, the Plan will comply with Michelle's Law with respect to the loss of full-time student status due to a medically necessary leave of absence for up to one year

XXI. GENETIC INFORMATION NONDISCRIMINATION ACT

This section of the Plan is intended to implement the requirements of the Genetic Information Nondiscrimination Act of 2008 ("GINA").

"Genetic Information" means, with respect to any individual, information about:

1. such individual's genetic tests;
2. the genetic tests of family members of such individual; and
3. the manifestation of a disease or disorder in family members of such individual.

Pursuant to the GINA, the Plan:

1. may not adjust premium or contribution amounts on the basis of genetic information;
2. shall not request or require an individual or a family member of such individual to undergo a genetic test;
3. shall not request, require or purchase genetic information for "underwriting purposes," as that term is defined in ERISA 733;
4. shall not request, require or purchase genetic information with respect to any individual prior to such individual's enrollment under the Plan or coverage in connection with such enrollment; and
5. no use or disclosure of genetic information may be made for insurance underwriting purposes.

Notwithstanding the foregoing, the Plan may use genetic information as otherwise allowed by GINA.

XXII. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can be found under health care coverage. If you may be affected by this law, ask your Administrator for further details.

XXIII. GENERAL PROVISIONS

SECTION 1: RECOVERY OF OVERPAYMENT

If the Plan Administrator ascertains that an Eligible Person has received an erroneous overpayment of a benefit, the Plan Administrator shall immediately notify such Eligible Person in writing, explaining the nature of the erroneous overpayment, and requesting return of the amount of such overpayment. If the initial request for restitution is not successful, the Plan Administrator shall renew the demand in writing upon the Eligible Person and may take other reasonable actions to obtain reimbursement of the erroneous overpayment.

If reasonable steps taken to obtain repayment of the overpayment have been unsuccessful, the Plan Administrator may treat the overpayment of benefits as an advance payment of benefits due to the Eligible Person and offset the amount of such overpayment against any Plan benefits due or which may become due to the Eligible Person until the full amount of the overpayment has been repaid to the Plan.

SECTION 2: VALIDITY OF PLAN AND PLAN PROVISIONS

This Welfare Plan is established in the State of Ohio and all questions pertaining to the validity and construction of this Plan and the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Ohio, except as preempted by Federal law. Where all or part of a Plan provision is declared invalid, any remaining balance of such provision will remain valid.

SECTION 3: CONSTRUCTION BY TRUSTEES

Under the Plan of Benefits and Trust Agreement creating the Plan, the Trustees have the sole and exclusive authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement, the Plan document or any other rules, regulations, procedures or administrative rules adopted by the Trustees. Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for and amount of benefits, shall be resolved by the Board of Trustees. Decisions of the Trustees or, where appropriate, decisions of those acting for the Trustees in such matters, are final, binding and conclusive on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the further intention of the parties to the Trust that such a decision is to be upheld unless it is determined to be arbitrary and capricious.

Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties.

SECTION 4: LEGAL ACTIONS

No action at law or in equity shall be brought to recover any benefits provided under this Plan before the expiration of one hundred twenty (120) days after written proof of loss has been furnished nor shall any such action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

XXIV. STATEMENT OF YOUR RIGHTS UNDER ERISA

ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the International Association of Heat and Frost Insulators & Allied Workers Local #3 Health and Welfare Plan. The Trustees of your Plan, in consultation with their professional advisors, have

reviewed these standards carefully and have taken steps necessary to assure full compliance with ERISA.

ERISA requires that Plan Participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedures to follow when

filing a claim for benefits. This information has already been presented in the preceding pages of this SPD.

ERISA also requires that Participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan.

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

(A) ERISA provides that all Plan Participants and Beneficiaries shall be entitled to:

(1) Examine, without charge, at the Fund Office and at other specific locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Pension and Welfare Benefit Administration.

(2) Obtain, upon written request to the Administrative Manager or Board of Trustees, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrative Manager may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of this Summary Annual Report.

(4) Obtain a complete list of employers sponsoring the Plan upon written request to the Administrative Manager which list is available for examination by Participants and Beneficiaries.

(5) In addition, Participants and Beneficiaries may obtain from the Administrative Manager, upon written request, information as to whether a particular employer or employee organization is a sponsor to the Plan and if the employer or employee organization is a plan sponsor, the sponsor's address.

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.

(B) In addition to creating right for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

(C) 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 pension benefit to which you may be entitled, or exercising your rights under ERISA.

(D) If you have a claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. The Plan's Claims Procedures are furnished automatically without charge as a separate document. If you have a claim for benefits which is denied, in whole or in part, you may file suit in a state or federal court after you exhaust your appeal rights.

(E) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in Federal court. In such a case, the court may require the Plan Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Manager. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state of Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(F) If you have any questions about your Plan, you should contact the Plan Administrative Manager or the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trustees, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor or the Pension and Welfare Benefits Administration, whose offices are located at:

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street, Suite 556
Washington, DC 20006
Tel: (202) 254-7013

Or

U.S. Department of Labor
Employee Benefits Security Administration
1885 Dixie Highway, Suite 210
Ft. Wright, Kentucky 41011-2664
Tel: (606) 578-4680

Or

Division of Technical Assistance and Inquiries
Employee Benefits Security 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.

XXV. NON-DISCRIMINATORY HEALTH PLAN

International Association of Heat and Frost Insulators & Allied Workers Local No. 3 ("the Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact by mail or phone at:

BeneSys, Inc.
33 Fitch Avenue
Austintown, Ohio 44515
(330) 779-8855

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Grievance Coordinator:

BeneSys
33 Fitch Avenue
Austintown, Ohio 44515
(330) 779-8855

You can file a grievance in person at the Health Plan office or by mail, fax, or email. If you need help filing a grievance the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you need help or speak a non-English language, call 1 (800) 435-2388 and you will be connected to an interpreter who will assist you at no cost.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 435-2388

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 435-2388

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 435-2388

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 435-2388

PAUNAWA: Kung nagsasalita ka ng Tagalog, may mga libreng serbisyo para sa tulong sa wika na maaari mong gamitin. Tumawag sa 1 (800) 435-2388

BH'MH'E! ECINebircBOpdre ra p/ccKovuBwce, TO BaMAxryn*i6ecnnarhfee yaicrn nepeeqqa. 3BQae no Hamepy 1 (800) 435-2388

ATANSYON Si w pale Kreyòl, gen sèvis èd pou lang gratis ki disponib pou ou. Rele 1 (800) 435-2388

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (800) 435-2388

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1 (800) 435-2388

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Dzwoń pod numer 1 (800) 435-2388

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Call 1 (800) 435-2388

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1 (800) 435-2388

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie uns an unter 1 (800) 435-2388

توجه: اگر به زبان فارسی صحبت می کنید، خدمات یاری رسانی زبانی، بطور رایگان، در دسترس شما می باشد. با شماره 1 1 800(435-2388)