Summary Plan Description

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Effective May 1, 2019

Summary Plan Description

This newly-revised booklet is intended to explain your medical, dental, vision, prescription, death and dismemberment benefits and loss-of-time (Accident and Sickness Benefits) in non-technical language. It is also intended to give you an understanding of how the Fund is operated for your benefit. As indicated in the descriptions of benefits below, some benefits under the Fund are provided pursuant to Contracts of Insurance. With respect to those benefits, those Contracts constitute the Plan Document, and, those benefits (including any applicable claims and other procedures), are provided pursuant to the terms of those Contracts of Insurance, which constitute the Plan Document. The remaining benefits provided by the Fund are provided pursuant to this Summary Plan Description which, with respect to those benefits, serves as the Plan Document.

Board of Trustees

The Plan Administrator is the Board of Trustees of the Asbestos Workers Local 24 Medical Fund:

Union Trustees	Employer Trustees
Brian Cavey, Secretary	Kevin Orchard, Chairman
Jonathan Potter	Scott Grant
Robert McCourt	R. Steve Shegogue

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Washington, DC 20036

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Life Insurance and AD&D

Symetra
50 Congress Street
Suite 620
Boston, MA 02109
Policy # 2400005600

Prescription Drug Provider
CVS/Caremark

Address for Mail Order Pharmacy:
Caremark
P.O. Box 94467
Palatine, IL 60094-4467

Address to Submit Paper Claims:
CVS/Caremark Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196

1.866.282.8503 – Customer Care

www.caremark.com

PPO

Cigna Healthcare
P.O. Box 188004
Chattanooga, TN 37422
1.800.244.4695

Utilization Review/Large Case Management

Cigna Care Allies
Two Liberty Place
1601 Chestnut Street
Philadelphia, PA 19192
1.800.768.4695

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INTRODUCTION

The Asbestos Workers Local 24 Medical Fund ("Fund") offers you and your family protection when there is a need for:

- Medical Care (including hospitalization and physician's care)
- Prescription Benefits
- Dental Care; and
- Vision Care.

The Fund also provides benefits to you or your beneficiaries in the event of your:

- Death; or
- Loss-of-time because of a short-term disability.

Administration and History

The Fund became effective December 1, 2004, when the Heat and Frost Insulators and Allied Workers Local 24 ("Local 24") and its signatory Employers separated from the National Asbestos Workers Medical Fund ("National Fund"). The Fund is jointly administered by a Board of Trustees. Half of the Trustees are designated by the Employers and half are designated by Local 24, as required by the Labor Management Relations Act of 1947 (known as the "LMRA" or "Taft-Hartley Act"). The Trustees meet at least quarterly, to oversee the operation of the Fund and to review appeals. The Board of Trustees also employs the services of a professional benefits administration firm (also known as an "administrative agent") to handle the day-to-day operation of the Plan. The administrative agent is Carday Associates, Inc.

Healthcare Reform

The Trustees believe this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care 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 any 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 protections 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 the address and phone number shown above. 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.

Financing Your Benefits

The Fund is maintained pursuant to collective bargaining agreements between the Employers and Local 24. These agreements require that Employers contribute for every hour you work. This is the primary source of income to the Fund–contributions required for hours worked by active Employees. Each Employer who contributes to the Fund submits a monthly report on forms provided by the Fund. Participants and beneficiaries may receive from the Board of Trustees, upon written request, information as to whether a particular employer participates in the Plan and, if the employer does participate, the employer's address.

The money in the Fund is held in trust and invested by the Trustees. Earnings from investments are an additional source of income to the Fund for benefits. It is the Trustees' responsibility to invest the money in a way that keeps a reasonable balance between investment return and investment risk while ensuring that sufficient cash is available to pay day-to-day claims. The money in the Fund is invested and paid out for the exclusive benefit of Employees participating in the Plan and their Dependents.

The benefits provided through the Fund are primarily "self-funded." This means that your Employer's contributions are made directly to the Fund and benefit payments to you or your beneficiaries are made directly from the Fund. There is no insurance company in between to collect premiums and pay your medical benefits. This procedure helps keep costs down and enables the Fund to provide more benefits for the money. It also means that all of us are part of a self-sufficient group. This places responsibility upon all of us, both Trustees and Employees, to spend the Fund's money for benefits with the same or greater care and cost consciousness we would use in spending our own money.

Change of Eligibility Rules and Benefits

Over time, it may be necessary to change the eligibility rules and the benefits provided by the Medical Fund. The Trustees have the right to modify, amend, suspend or terminate the Plan in whole or in part at any time in accordance with the Agreement and Declaration of Trust of the Asbestos Workers Local 24 Medical Fund. Whenever the eligibility rules provide that certain policies (such as self-payment rates, benefits provided, etc.) are set by the Trustees, these policies will be on file at the Fund Office. If you have any questions about these policies, contact the Fund Office.

General Information

- The Plan is maintained pursuant to one or more collective bargaining agreements and a copy of any such agreement may be obtained by Employees and their eligible Dependents upon written request to the Fund Office. Any Employee or Dependent making a request for the above must pay the Plan's reasonable costs of furnishing these materials. Information about the charge that would be made to provide copies of the above described materials shall be provided upon request to the Fund Office.

  The above described materials are available for examination at no charge by Employees and Dependents at all times at the Fund Office, and within 10 calendar days after written request to the Fund Office at the office of Local 24 and at each Employer establishment at which at least 50 Employees covered under the Plan are customarily working.

- The Plan's requirements concerning eligibility for participating and for benefits are set forth in the following pages, which explain in detail the rules for becoming eligible for benefits as well as maintaining continuing eligibility.

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

  a. Failure to satisfy the eligibility requirements of this Plan by:
     1. not working or receiving credit for sufficient hours for which your Employer makes contributions to the Fund,

2. disability in excess of the periods of time for which credit is given under the Plan, or
3. failure to pay timely any sums that may be required to continue eligibility during periods of disability, when employment is not available, or sufficient credit is not given.

b. Engaging in non-covered employment.
c. Failure to file necessary forms required in support of a claim.
d. Failure to file claims within the time limit specified in this Plan.
e. Work for a non-participating employer in the insulation industry within the geographic jurisdiction of the International Association of Heat and Frost Insulators and Asbestos Workers, unless such work is pursuant to a written agreement between a participating Local Union and yourself, a copy of which is provided to the Fund.

ELIGIBILITY

Who Can Become Eligible

Employees

All Employees for whom the Fund has received Employer contributions for hours worked may become eligible for benefits in accordance with the Plan rules. The Employee must satisfy certain eligibility requirements relating to contributions for hours of work which are described on pages 16-19 of this Plan Booklet.

In this Plan Booklet we use different terms to refer to categories of Employees who are affected by Plan rules. These terms are explained below:

An **"Employee"** is an individual who is covered by a Collective Bargaining Agreement or a participation agreement that requires his or her Employer to make contributions to this Fund on his or her behalf. Contributions on an Employee's behalf are made for hours paid or worked in accordance with the applicable Collective Bargaining Agreement or participation agreement at an hourly rate established by the Trustees for an Option of Coverage offered by the Fund. (See special rules for Employees of Companies Owned By Relatives, Non-Bargaining Unit Staff Employees of Incorporated Employers and for Employees with an Ownership Interest in an Employer below.)

An **"Eligible Employee"** is an Employee who has satisfied the conditions for eligibility for benefits from this Fund as described in this Plan Booklet and who is currently eligible for benefits.

An **"Active Eligible Employee"** is an Eligible Employee whose eligibility is based entirely or partly on contributions made by his or her Employer for hours worked.

Therefore, Employees who are eligible under the Plan based completely on self-payment including COBRA self-payment, and Employees who are eligible because hours are credited during periods of disability are "Eligible Employees" but are not "Active Eligible Employees."

A **"Retiree"** is an Employee who has qualified for and is receiving Retiree benefits.

An Employee is a Retiree on the effective date of his Retiree coverage.

Employees of Employers Owned By Relatives

Special rules apply to companies owned by relatives of an Employee.

- Any Employer owned by a spouse, child, parent, brother or sister of an Employee contributes on the actual hours worked by the Employee in employment for which contributions are required to be made to this Fund under a Collective Bargaining Agreement or participation agreement.

- If the Employer contributes on fewer than 40 hours per week for the relative-Employee, the Employer must keep records for at least four years that document the total hours worked by the relative-Employee for the Employer, the hours for which contributions are required to be made to this Fund, and a description of the different types and amount of work performed by the relative-Employee (including both work for which contributions are required and any other work).

- If the Employer does not keep records that document the hours and work performed by the relative-Employee, refuses to permit an audit by the Fund or provides false information to the Fund, the Employer must contribute a minimum of 40 hours per week for the relative-Employee. This requirement may be applied retroactively.

- If the relative-Employee loses coverage, the relative-Employee may self-pay under the rules regulating self-payments.

Employees with an Ownership Interest in an Employer

These rules apply to an Employee with some ownership interest in an active, incorporated Employer if that Employer contributes on behalf of Employees covered by a Collective Bargaining Agreement with a participating Local Union.

- In the case of an Employee with an ownership interest in the Employer who is not actively involved in the management of the Employer, who performs work covered by the Collective Bargaining Agreement and who is paid by the hour, the Employer is not required to sign a participation agreement covering that Employee and contributes to this Fund in accordance with the Collective Bargaining Agreement covering the Employee.

- In the case of an Employee with an ownership interest in the Employer who is actively involved in the management of the Employer or who is salaried, in order for that Employee to participate in this Fund, the Employer must sign a participation agreement, must contribute on the Employee's behalf on the basis of 40 hours per week and must remain current in his contributions for Employees covered by the Collective Bargaining Agreement.

Non-Bargaining Unit Employees of Incorporated Employers

The Fund will allow participation of non-bargaining unit staff of incorporated participating employers. A summary of the rules are as follows:

- The contribution rate paid must be the same rate as that of the contributing employer.

- Initial eligibility will begin when other coverage terminates, or according to the Newly Organized Group & Newly Indentured Apprentice rules - whichever is later.

- Employers must contribute on all hours worked for hourly employees; however, at least forty (40) hours per week must be contributed on all staff employees for the first six months of an employee's participation. Employers must contribute on a minimum of forty (40) hours per week for salaried employees.

- Employees will be eligible under the Newly Organized Group & Newly Indentured Apprentice rules until they gain eligibility under the Fund.

- All full time staff employees must participate, unless covered by other coverage. Those covered by other coverage may opt back into this Plan when the other coverage terminates, upon proof of termination of the other coverage.

- The Fund reserves the right to terminate any employer's staff participation.

- The Employer must provide the Fund with a list of all employees showing which employees will and will not participate, and the reasons for non-participation.

- Employees who terminate employment with the Participating Employer are not considered "available for work" and accordingly are not permitted to self-pay for continued coverage under the regular self-payment rules. Affected individuals may seek coverage under the Alternative Self-Payment Rules (COBRA) described on page 23.

Dependents

Once you become eligible as an Employee, some of your Dependents may also become eligible for benefits through the Fund. Covered Dependents include:

1. Your Spouse.
2. Your children until they reach age twenty-six (26).
3. Your unmarried dependent child or dependent children over age 25 who become disabled at any age, if the disabling condition commenced while he or she was covered by this Plan. The child must remain continuously disabled, unmarried, financially dependent on you and unemployed. You must remain eligible and you must submit to the Fund Office a "Disabled Dependent Certification Form" with supporting medical evidence. The form must be submitted annually.

If you become divorced or legally separated, your former spouse is no longer covered as of the effective date of your divorce. You are required to notify the Fund immediately if you become divorced. If you fail to notify the Fund, any use of plan benefits by your former spouse will be considered an act of fraud, and you and your spouse will be responsible for repaying the Fund for any benefits so provided. Furthermore, as provided on page 23, you and your former spouse have sixty (60) days from the date your divorce becomes effective to notify the Fund Office in order to self-pay for continued coverage under the Fund's COBRA self-payment rules.

Each Covered Dependent must be listed on a "Benefit Enrollment Form" signed by the Employee and filed with the Fund Office. Each change in Dependent enrollment after

the initial enrollment must be submitted with evidence or proof of Dependent status satisfactory to the Trustees.

As used in the Plan, the term **"Dependent child"** or **"Dependent children"** means:

1. The Employee's natural, adopted, step and foster children.
2. Any other child who depends upon the Employee for support and who lives with the Employee in a regular parent-child relationship. The ability of the Employee to claim a child as an exemption for income tax purposes is evidence of dependency.

A "foster child" is a child placed with the Employee by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction.

The term "Dependent" shall not include any child who is no longer living with the Employee and with respect to whom the Employee's parental or guardianship rights have been terminated.

The Fund Office may investigate the status of any Dependent. The Fund Office may require copies of court orders, property settlement agreements, birth certificates, paternity determinations, guardianship orders, adoption papers, tax returns or any other document or information related to the determination of an individual's status as a Dependent. An individual will not be considered a Dependent child if it appears that the primary purpose of the child's living arrangement with the Employee is to obtain coverage from this Plan. Grandchildren of Employees are excluded from coverage in the Fund unless that child is legally adopted or in the legal custody of the Employee.

The Plan is required to recognize Qualified Medical Child Support Orders or QMSCOs. A QMSCO requires health plans to recognize State court orders that the Plan finds to be a QMSCO, as defined by federal law and will require the Plan to provide health benefit coverage for an eligible employee's dependent children under the age of 18, even if the eligible employee does not have custody of the child.

Disabled Employees, Retirees, and Surviving Spouses

Under certain conditions, disabled Employees, Retirees and surviving Spouses may also be eligible for benefits through the Medical Fund. For more information, see the sections beginning on pages 27 and 33.

BENEFITS FOR WORKING EMPLOYEES

COMPREHENSIVE PLAN SCHEDULE OF BENEFITS

ELIGIBLE EMPLOYEES (No Dependents)	
Death Benefit	$15,000
Accidental Death & Dismemberment	$65,000
Weekly Accident & Sickness Mechanics – 1st 4 Weeks 5th Through 26th Weeks Apprentices – 1st 4 Weeks 5th Through 26th Weeks	Max - 26 wks $350 $380 $220 $250
Annual Physical, up to (Active Employees only)	1 Per Year
ELIGIBLE EMPLOYEES AND DEPENDENTS	
ANNUAL PLAN	
Deductible (Per Individual)	$200
Maximum family deductible expense	$500
Basic Benefit (100% of UCR up to)	$4,000
Major Medical Benefit: Up to $4,000: Percentage Paid by Plan Percentage Paid by Employee Next $8,000: Percentage Paid by Plan Percentage Paid by Employee Maximum Benefit Paid by Annual Plan - Calendar Year	 100% 0% 80% 20% $10,400
LIFETIME PLAN	
Deductible	ANNUAL PLAN
Paid by Plan (Percentage of UCR)	100%
MAXIMUM ANNUAL BENEFIT	Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, page 41. Otherwise, all percentages are of Usual, Customary and Reasonable (UCR) charges. *See,* page 48.

Prescription, Dental, Vision and Hearing Aid Benefits are as provided beginning on pages 58, 63, 67 and 68.

A co-pay of $100 will be applied if you or your Dependents use the services of an emergency room. This co-pay will be waived only if the visit to the emergency room was for a life threatening illness, the visit to the emergency room was for an injury that

requires immediate medical attention or the patient is admitted to the hospital directly from the emergency room. The $100 co-pay will not be applied to your deductible.

Benefits under the Comprehensive Schedule are not available to those participants and Dependents covered by the HazMat Worker Benefit Plan, the retiree schedule of benefits (*see*, page 35) or to those participants and Dependents covered by the newly organized employee/newly indentured apprentice schedule of benefits. *See,* page 30.

EMPLOYEES IN HAZMAT WORKERS PLAN

HazMat Workers' Plan Schedule of Benefits

ELIGIBLE EMPLOYEES AND DEPENDENTS	
Deductible (Per Individual)	$250
Maximum family deductible expense	$600
Basic Benefit (100% of UCR up to)	$4,000
Major Medical Benefit (Up to $250,000 Lifetime):	
Percentage Paid by Plan	80%
Percentage Paid by Employee	20%
Major Medical Benefit (After $250,000 Lifetime):	
Percentage Paid by Plan	50%
Percentage Paid by Employee	50%
Maximum Paid by Employee (annual)	
Individual	$6,500
Family	$13,000
Maximum Annual Benefit	Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, page 41. Otherwise, all percentages are percentages of PPO or UCR charges.

Prescription Drug and Hearing Aid Benefits are as provided on pages 58 and 68.

Dental Benefits (*see,* page 63), Vision Benefits (*see,* page 67), Weekly Accident and Sickness Benefits (*see,* page 45), Annual Physical Benefits (*see,* page 47) and the Death Benefits and Accidental Death and Dismemberment Benefits (*see*, page 69) are not provided under the HazMat Workers Plan. To find out if you are covered under the HazMat Schedule of Benefits, contact the Fund Office.

How You Become Eligible for Benefits

The Medical Fund is designed to pay benefits based on a "Quarters System" that determines your eligibility to receive benefits. The Fund has two kinds of quarters that affect your benefits. They are:

- Work Quarters; and
- Eligibility Quarters.

It is important for you to understand the difference between these two concepts and how they are related to each other.

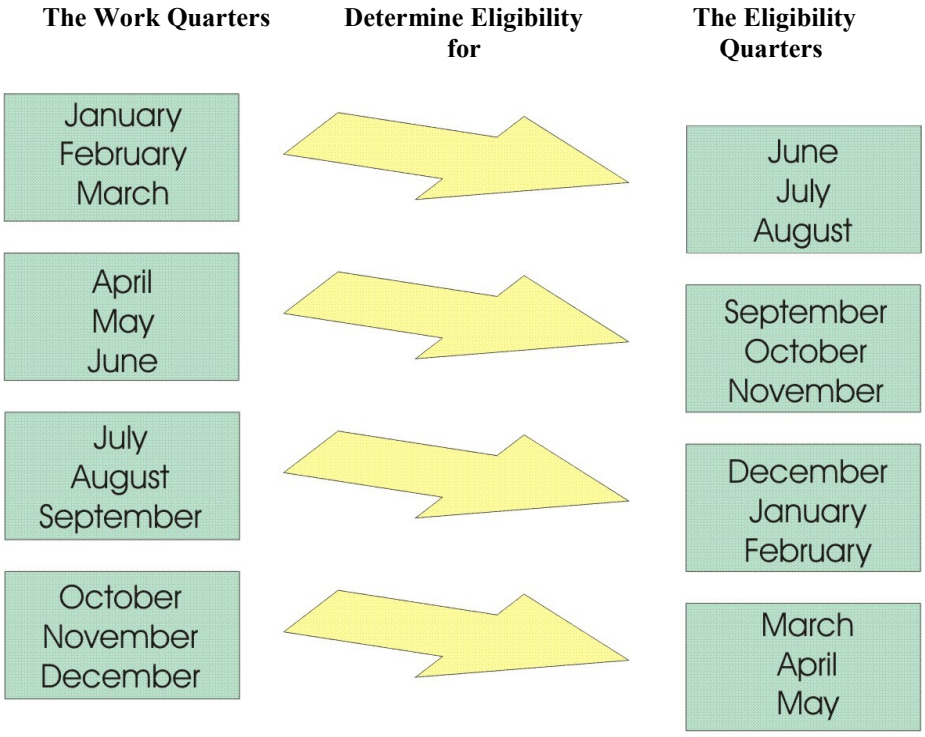
During the *Work Quarter* you establish your *eligibility* for benefits in a later time period, known as an *Eligibility Quarter*. A Work Quarter is a period of three months for which contributions are made to the Fund on your behalf. The hours for each Work Quarter are the hours worked in the payroll periods that ended in the Work Quarter for which the payments are made. An Eligibility Quarter is the minimum period of time you are eligible for benefits based on the contributions made for an earlier Work Quarter.

How Eligibility Quarters Are Earned

You earn credit for an Eligibility Quarter when:

- The Fund *receives* contributions from your Employers on your behalf for 400 or more hours for the preceding Work Quarter.

You can also earn credit for hours if you are receiving Loss-of-Time benefits from the Fund or if you verify to the Administrative Agent, in writing, that you are receiving Workers' Compensation benefits. In these cases you receive credit for up to 31 hours of contributions each week you are disabled up to a maximum period of 24 months per period of disability, so long as you continue to furnish medical evidence of your continued disability.



The following section will explain how the Quarters System works for your initial eligibility for benefits and continued eligibility for benefits.

Initial Eligibility

To become initially eligible you must have 800 hours reported and paid for you by your Employer in the two immediately preceding Work Quarters. You may self-pay the difference between the hours contributed and 800 hours required for initial eligibility if 500 or more hours are reported and paid for you by your Employer. *The initial period of eligibility is five months*.

In addition, if your Employer has filed bankruptcy and has not contributed to the Fund on your behalf, you may self-pay for the number of hours you worked for that Employer for which contributions were due in order to gain initial eligibility. You must verify the hours through pay stubs or other documentation and the self-payment must be

received in the Fund Office no later than 30 days after you learned that you were able to make the self-payment under this rule.

Example of Initial Eligibility for Benefits

Assume Mike started working as an Allied Worker on April 1 and that he worked 800 hours in April through September. The Work Quarter that he started working is April, May, and June. If the Fund received Employer contributions for these hours, Mike satisfies the eligibility requirements and earns initial eligibility which would ordinarily commence December 1. However, for initial eligibility the first Eligibility Quarter includes the two (2) months immediately preceding the Eligibility Quarter in which eligibility would ordinarily commence so that the first period only for any newly eligible employee is five (5) months. This means Mike is covered for benefits by the Fund effective October 1 through the end of February.

Work 800 Hours Over the Following Months	**Earns**	**Eligibility in Months**
April May June July August September	→	October November December January February

Benefit Enrollment Form

When you have met the initial eligibility requirements, you must fill out a Benefit Enrollment Form. The information required by the Form, including the Social Security Number for you and your Dependents, is needed by the Fund Office to provide your benefits to you. Without this information, no benefits will be processed by the Fund Office. This form also includes your beneficiary designation for the death benefits provided by the Fund.

Also, you must notify and submit proof to the Fund Office of any changes that affect your Benefit Enrollment Form information. These changes include:

- Changes in marital status;
- Names and birth dates of newborn children;
- Any changes of address;
- Change in beneficiary; and
- Death of Dependent.

If a Dependent is not listed on the most current Benefit Enrollment Form on file at the Fund Office, benefits will not be paid on that Dependent until the Fund Office receives a new correct and updated Form along with documentation of the Dependent's status.

Continuing Your Eligibility

Once you have earned your *initial eligibility,* you will continue to earn *three-month* periods of eligibility called Eligibility Quarters. You will stay eligible as long as you work at least 400 hours per Work Quarter and the Fund receives Employer contributions for those hours. If you drop below 400 hours in a Work Quarter, you can still be eligible if at least 800 hours of Employer contributions have been made for you in the last *two* Work Quarters.

How You Can Lose Eligibility

This Plan is designed to provide benefits for all eligible Employees and their covered Dependents. However, you should be aware of the circumstances that could result in a loss of eligibility. It is possible for you and your Dependents to lose eligibility if:

- Fewer than 400 hours of Employer contributions are received by the Fund for a Work Quarter on your behalf.
- Fewer than 800 hours of Employer contributions are received by the Fund for the preceding two Work Quarters on your behalf.
- You work for a non-participating employer in the insulation industry within the geographic jurisdiction of the International Association of Heat and Frost Insulators and Allied Workers. (In this case, your eligibility will terminate immediately, unless such work is pursuant to a written agreement between a participating Local Union and yourself, a copy of which is provided to the Fund.)

- You fail to make required self-payments on time.
- You are absent from work as the result of service in the U.S. Armed Forces. (See below on how to regain your status once discharged.)
- There is a Plan amendment that affects eligibility.

Lost Your Eligibility? How To Get It Back

If for any reason you lose your eligibility for benefits, you can restore eligibility on the first day of an Eligibility Quarter following completion of any Work Quarter for which your Employer reported and paid a minimum of 400 hours on your behalf. However, if you are not eligible for four (4) consecutive Eligibility Quarters, you must satisfy the requirements for Initial Eligibility to once again become eligible.

Veterans Rights

Your rights to health coverage from the Plan during and following any periods of military service are governed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In order to prevent unnecessary disruptions in your health coverage, you should notify the Fund Office before you leave work. If you are off work for no more than 30 days, your and your family's coverage will not be affected. If your period off work is greater than 30 days and your total time off work from all separate periods of military service is less than five years, in general, it will resume upon your return to employment, as long as you return to work within the period provided by law (generally within 14 days if your period of service is no more than 180 days, and 90 days for longer periods of service). You should be aware that this is only a very general statement of your rights. For more information on your rights as a member of the Armed Forces, contact the Fund Office or the local office of the Veterans' Employment and Training Service of the Department of Labor.

What Happens if You Don't Have Enough Hours ...Self-Payments

If you have fewer than 400 hours reported and paid to the Fund for you by your Employer for a Work Quarter (or fewer than 800 hours in the last <u>two</u> Work Quarters), *you will lose your eligibility for benefits*, unless you make a personal payment to the Fund to keep your eligibility. These personal payments are called "self-payments." Self-payment amounts depend on the number of hours that you were short of the minimum and also on the self-payment rate which is set periodically by the Trustees.

You will not receive credit for any hours you have worked unless contributions for those hours at the correct rate are received by the Fund Office. You will be required to Self-pay to continue your eligibility and will receive a full refund when your delinquent Employer makes the contributions on your behalf. If there are any unreported hours and/or unpaid contributions that require you to make a Self-payment, you should immediately report this to the delinquent Employer, the Fund Office and the Local 24 Business Manager. You should insist on prompt payment of all delinquent contributions owed on your behalf.

You may make self-payments to continue your eligibility for up to 24 months, as long as you are immediately available for work as an Allied Worker for a participating Employer. If you work for a non-participating employer in the insulation industry within the geographic jurisdiction of the International Association of Heat and Frost Insulators and Allied Workers, your eligibility will be terminated and you will not be allowed to make self-payments, unless such work is pursuant to a written agreement between a participating Local Union and yourself, a copy of which is provided to the Fund.

Self-Payment Notice

During the months of February, May, August and November of each year, those Employees whose hours are not sufficient to continue eligibility will receive a Self-Payment Notice. This report contains the name of the Employer(s) for whom you worked, the month(s) worked and the number of hours reported and contributed to the Fund on your behalf for the most recent Work Quarter. If you do not agree with the hours reported, use the reverse side to indicate what the hours should be and return it to the Fund Office with your payment. The amount due is stated on the center of the report. Before returning the notice and payment to the Fund Office, be sure to sign it at the bottom. *The payment is due within 15 days from the date of the notice or your medical coverage will be terminated*.

More About Self-Payments

Self-payments will allow you to keep your eligibility if you don't have enough Employer contribution hours. Self-payments are limited in nature and there are rules that apply to them. This section will cover these rules and also explain how self-payments are calculated.

The Rules

- You may make self-payments to preserve your eligibility only if you are immediately available for full-time employment as an Allied Worker with a participating Employer in Local 24's jurisdiction. Former employees who participated as a Non-Bargaining Unit Employee of an Incorporated Employer are not considered "available for work" and are not permitted to self-pay for continued coverage under the regular self-payment rules. Such employees may, however, utilize Alternative Self-Payment Rules (COBRA) described on page 23.
- You must remain a resident in Local 24's area. (Exception: If you find it necessary to accept employment in another asbestos workers union's jurisdiction, you may pay contributions until recalled to your Home Local Union area for available employment. Failure to return will cause contributions to be refused. See also page 28 for rules concerning other health funds with which this Fund has a reciprocity agreement)
- The maximum period for self-payment is 24 months.
- Self-payments must be made on time – this means within 15 days of the date of your Self-Payment Notice. The Fund Office mails these notices quarterly. Notices are mailed in February, May, August and November.
- If you *don't get* a Self-Payment Notice by the 15th day of the first month of the Eligibility Quarter, *it is your responsibility* to contact the Fund Office. This must be done by the end of the month or *you will lose eligibility from the first day of the Eligibility Quarter.*
- You may also make payment of contributions under the following condition, provided you are in compliance with the above rules. In the event you had at least 500 but less than 800 hours reported and paid for you by your Employer during two consecutive Work Quarters, you may elect to pay the difference between hours reported and paid and 800 hours, at the contribution rate in effect in the area in which you are working, to become eligible the first day of the next applicable five month benefit period for initial eligibility.
- After an Employee has made self-payments to the Fund for one year (four (4) consecutive Quarters), where no hours are reported by an employer signatory to a Collective Bargaining Agreement, the amount of the self-payment will be based on 520 hours per Work Quarter. The amount of the self-payment will continue to be based upon 520 hours per Work Quarter and at the rate set by the Board of Trustees until 400 hours of work have been performed in covered employment in one Work Quarter for which the Fund has received contributions.
- The contribution rate on which your self-payment is calculated is the rate in effect under this Plan on the last day of the eligibility quarter.

- A new retiree may self-pay for active or retiree coverage for the first self-payment after retirement.

Alternative Self-Payment Rules (COBRA)

If you or your Dependents lose eligibility because your contribution hours are insufficient, you may continue coverage under the regular self-payment rules (page 20) or under these alternative "COBRA" rules. Also, if you are a new Retiree who is eligible for Retiree Health Benefits (*see,* page 33), you may elect either Retiree Benefits or to continue your coverage under these COBRA provisions of the Plan. Under the COBRA rules you and/or your Dependents may continue health coverage by making self-payments. You must choose whether you want to continue coverage under the regular self-payment rules described above (or the Retiree Benefits provisions, if applicable) or these alternative COBRA rules. You may not switch back and forth. The rules, premiums and time periods of coverage for regular self-payment and COBRA self-payment differ, so you should decide which will better meet your needs.

In addition, your Spouse and Dependent children, including a child born or placed for adoption after your COBRA coverage has commenced, may continue coverage under the COBRA rules after your death or after you and your Spouse are divorced.

The COBRA rules are an alternative to the regular Plan rules for continuing eligibility of surviving family members after the Employee's or Retiree's death. The COBRA rules and the regular Plan rules for widow(er)s coverage differ, so both sets of rules should be reviewed. The regular Plan rules for surviving dependents of eligible employees begins on page 27 and for Retirees on page 38.

Under the COBRA rules, you and/or your Dependents may choose to continue either:

- Medical benefits only ("Core Benefits"); or
- Medical benefits plus dental and/or vision benefits ("Core plus Non-core Benefits").

You are responsible for paying the full cost of COBRA coverage once all the coverage under this Plan ends. The COBRA rates are established by the Trustees and can change from time to time.

COBRA coverage does not include death benefits, accidental death and dismemberment benefits or Weekly Accident and Sickness Benefits.

COBRA Rules for Active and Retired Employees

As an Employee, you have the right to elect COBRA coverage for yourself and/or your Spouse and/or your eligible Dependent children. Coverage can be continued for up to 18 months from the date you would lose coverage under the Plan because you terminate employment covered by this Plan (for reasons other than gross misconduct) or you do not have sufficient hours of covered employment for which contributions are received by the Fund to continue your eligibility.

Under certain circumstances a disabled person and his or her family may extend COBRA coverage for up to a total of 29 months following the date you would lose eligibility under the Plan because of the termination of your employment or a reduction in your hours reported. To qualify for the additional 11 months of coverage, the disabled person must have a determination of disability from the Social Security Administration effective within 60 days of the termination of employment or reduction in hours. The determination from Social Security must be filed with the Fund Office within 60 days of the date the determination is made. The extended COBRA coverage applies to the disabled individual and all covered non-disabled family members.

If an individual receives extended COBRA coverage because of a disability, you must also notify the Fund Office within 30 days of a final determination by Social Security that you are no longer disabled. COBRA coverage ends if Medicare coverage begins before the 29-month period expires or if the disabled person recovers from the disability and you have already received 18 months of COBRA coverage.

COBRA Rules for Retirees

As a Retired Employee, you have the right to buy COBRA coverage for yourself and/or your Spouse and/or your eligible Dependents for up to 18 months, if coverage would otherwise end because you are not eligible for Retiree coverage or if you do not elect Retiree coverage.

COBRA Rules for Dependents

If you choose not to purchase COBRA coverage for yourself, and/or your Spouse and/or Dependent children can separately purchase COBRA coverage for themselves by making the election and the required monthly premium payments. The coverage can be continued for up to 18 months (29 months, if you are disabled) if coverage would otherwise end because of the termination of your employment or the reduction in your hours reported to the Fund. Additionally, your Spouse and Dependent children can elect to continue their coverage for up to 36 months if their coverage would otherwise end because of:

- your death;
- your divorce;
- your child's loss of status as a "Dependent" under the Plan (*see,* page 12); or
- your entitlement to Medicare benefits.

Generally, the maximum period of COBRA coverage for Dependents is 36 months from the date your Spouse or Dependent child would otherwise lose eligibility under the Plan due to one of the events listed above even if two or more of these events occur.

Also, see page 33 for the Plan provisions that permit continuation of Retiree coverage for the Spouse and Dependent children of Retired Employees.

Notification Requirement for COBRA

You or your Spouse or Dependent children must notify the Fund Office in writing within 60 days of a divorce or legal separation or your child's loss of Dependent status under the Plan. Your Dependents should notify the Fund Office in writing within 60 days of your death. Your Employer must notify the Fund Office within 60 days of your death or your eligibility for Medicare benefits. The Fund Office will determine when your eligibility under the Plan would end due to the termination of your employment or the reduction in your hours for which contributions are received by the Fund. Following the receipt of a notice or after your loss of eligibility due to termination of your employment or reduction in hours of contributions is determined, the Fund Office will notify you and your Dependents of your and your Dependents' right to purchase COBRA coverage and the cost of this coverage. You will also be provided information concerning the cost to continue your coverage under the regular self-payment rules of the Plan.

Election of COBRA Coverage

To elect COBRA coverage, you and/or your Spouse and/or your eligible Dependent must complete an election form provided by the Fund Office and submit it to the Fund Office within 60 days after the date your regular coverage ends or the date you receive notice of your right to elect COBRA coverage.

The election periods for the plan's regular self-payment differ from the election period for COBRA self-payment. Please make certain that you make your regular self-payment by the date required by those rules if you wish to elect regular self-payment instead of COBRA self-payment.

Termination of COBRA Coverage

COBRA coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- All health benefits offered by the Fund terminate;
- You, your Spouse or eligible Dependent who has elected COBRA coverage do not make the required payments to the Fund on time;
- You, your Spouse or eligible Dependent becomes entitled to benefits under Medicare; or
- You become covered by another group health plan unless that replacement plan limits coverage due to preexisting conditions, and the preexisting condition limitation actually applies to you after your coverage under this Plan is taken into account.

You do not need to be immediately available for work in covered employment to continue coverage under the COBRA self-payment rules.

Continuing Your Eligibility While Totally Disabled

Periods of proven disability while you are eligible will not be counted as periods of unemployment up to a maximum period of twenty-four (24) months per period of disability. If you are disabled and unable to work at your own occupation, you will be credited with up to thirty-one (31) hours of employment for each week disabled, so long as you furnish medical evidence of your continued disability, (including Workers' Compensation) to the satisfaction of the Trustees. Successive periods of disability will be considered a single period of disability unless you return to work long enough to earn at least one quarter of eligibility prior to your subsequent period of disability.

An Employee who has been credited with the maximum period of 24 months per period of disability will be permitted to self-pay the required contribution to remain eligible for one additional year (Four (4) Eligibility Quarters) so long as such Employee remains so disabled.

Eligibility will be determined in accordance with the Fund rules.

Treatment of Claim if Hospitalized When Eligibility Terminates

In the event you lose eligibility for any reason as an Employee or Retiree when you or one of your Dependents is confined to a hospital, the Fund will pay for the hospital expenses only, in accordance with the Schedule of Benefits (*see,* pages 14 and 30, respectively), until the earlier of the date you or your Dependent is discharged from the hospital or 30 days following the date your eligibility terminated.

CONTINUING ELIGIBILITY FOR YOUR DEPENDENTS AFTER YOUR DEATH

Dependents of Eligible Employee

If you should die while you are an Eligible Employee, the eligibility of your Dependents will terminate on the last day of the Eligibility Quarter on which your eligibility would have normally terminated as if you had stopped working on the date of your death.

The eligibility for your widow(er) and Dependent children may continue following your death as an Eligible Employee beyond the period described above provided the widow(er) elects to continue coverage, makes timely payment of the appropriate amount and satisfies the following rules.

1. To be eligible for widow(er) coverage, the individual must:
    a. Be a widow(er) of an Eligible Employee;
    b. Have been married to the Employee for at least one year prior to death;
    c. Have no other group health benefits coverage; and
    d. Pay the applicable contribution rate multiplied by 400 hours per quarter. After payment of four (4) quarters at 400 hours; the payment is based on 520 hours.
2. The widow(er) must make payment prior to eligibility terminating.

3. The Widow(er) must sign an initial certification of eligibility and must sign such a certification annually thereafter.
4. The eligibility of the widow(er) and Dependent children will terminate at the earlier of:
    a. Remarriage of the widow(er), or
    b. The widow(er)s eligibility for Medicare, or other group health benefits.

The Dependent child(ren) of an Eligible Employee who dies may continue to be entitled to benefits without regard to the continued coverage of a widow(er) if payments are made on their behalf for as long as they would have been eligible if the Employee had not died. If the children became Dependents of the Employee as a result of a marriage less than one year prior to the death of the Employee, the benefits of such Dependent child(ren) will terminate as provided above.

Continuing Eligibility While Working Out of Area ... Reciprocity

There may be occasions when you find yourself working in the geographical jurisdiction of another local union that does not participate in this Fund. This Fund has made arrangements with certain other local union funds whereby credits that you earn in their jurisdiction will be transferred to this Fund. A list of those locals is available from the Fund Office upon request.

Continuing Your Eligibility During Family and Medical Leave

The Family and Medical Leave Act ("FMLA") of 1993 entitles employees eligible under the Act to take up to 12 weeks of unpaid job-protected leave each year for the employee's own illness, or to care for a seriously ill child, spouse or parent. In addition, the FMLA provides leave for the birth or placement of a child with the employee in the case of adoption or foster care.

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the employer and who have provided at least 1,250 hours of service to the employer. An employee at a work site at which there are fewer than 50 employees is not eligible for FMLA leave unless the total number of employees within a 75 mile radius of that employee equals or is greater than 50. Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your employer's responsibility to report the period of your absence.

Employers covered by the FMLA are required to maintain medical coverage for employees on FMLA leave whenever such coverage was provided before the leave was taken, and on the same terms as if the employee had continued to work. This means that your Employer will be required to continue making contributions to the Medical Fund on your behalf while you are on FMLA leave. If you have reason to believe that your Employer has not made the required contributions during your leave, you should contact the Fund Office immediately and submit any documentation in support of your eligibility, *i.e*, pay stubs, medical certifications, *etc.* This will enable the Fund to collect the contributions owed by your Employer for you during your FMLA leave. In addition, if you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. Government, Department of Labor.

EMPLOYEES IN NEWLY ORGANIZED GROUPS AND NEWLY INDENTURED APPRENTICES

COMPREHENSIVE PLAN SCHEDULE OF BENEFITS FOR EMPLOYEES IN NEWLY ORGANIZED GROUPS AND NEWLY INDENTURED APPRENTICES

ELIGIBLE EMPLOYEES AND DEPENDENTS	
Deductible (Per Individual)	$250
Maximum family deductible expense	$600
Basic Benefit (100% of UCR up to)	$4,000
Major Medical Benefit: Percentage Paid by Plan Percentage Paid by Employee	 80% 20%
Maximum Major Medical Benefit Paid by Annual Plan-Calendar Year	$10,000
Supplemental Major Medical Benefit (Payable after Basic and Major Medical Benefits are Exhausted): -Percentage Paid by Plan -Percent paid by Employee	 50% 50%
Maximum Annual Benefit	Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, page 41. Otherwise, all percentages are percentages of PPO or UCR charges.

Dental Benefits (*see* page 63), Vision Benefits (*see* page 67). Weekly Accident and Sickness Benefits (*see,* page 45), Annual Physical Benefits (*see,* page 47) and the Death Benefits and Accidental Death and Dismemberment Benefits (*see*, page 69) do not apply during the limited period covered by the special rules described in this Section. You will become eligible for these benefits and the Lifetime Plan of the Comprehensive Plan Schedule of Benefits (*see,* page 47) when you meet the regular Initial Eligibility Rules of the Plan as described on page 17.

Which Employees Qualify for These Special Rules?

The Asbestos Workers Local 24 Medical Fund has established special eligibility rules for "Employees in Newly Organized Groups and Newly Indentured Apprentices"—the

"NOG" Plan. Employees who qualify for these special rules are individuals who are not participants in the Plan. They may be current employees of a newly organized company that signs a Collective Bargaining Agreement with Local Union No. 24 or newly organized employees represented by Local Union No. 24 who are then employed by an Employer already contributing to the Fund. A Newly Indentured Apprentice will be an Employee who enrolls in an apprenticeship program sponsored by Local Union No. 24, who has contributions made on his behalf and who has never before been eligible for benefits from the Fund. The purpose of these special eligibility rules is to encourage the addition of new participants to the Plan. These special eligibility rules are not available for current employees represented by an Allied Workers Local Union or other regular applicants for representation by Local Union No. 24.

To What Period Do These Special Rules Apply?

This Section describes the eligibility requirements and benefits that are applicable to Employees in Newly Organized Groups and Newly Indentured Apprentices for a limited period before an Employee establishes eligibility under the regular Initial Eligibility Rules of the Plan. During this limited period, the Sections below should be substituted for the Sections of the Summary Plan Description with the same title. All other provisions of the Summary Plan Description apply to Employees in Newly Organized Groups and Newly Indentured Apprentices during this limited period.
After an Employee in a Newly Organized Group and Newly Indentured Apprentices meets the regular Initial Eligibility Rules of the Plan as described on page 17, all of the rules and benefits of the Plan apply as described in that booklet and these special rules are no longer applicable. In addition, if an Employee in a Newly Organized Group or a Newly Indentured Apprentice does not meet the regular Initial Eligibility Rules of the Plan as described on page 17, within nine (9) months of employment or loses eligibility under the special Continuing Eligibility Rules described in this section, these special rules are no longer applicable. In either circumstance, the Employee can then become eligible for benefits only by meeting the regular Initial Eligibility Rules of the Plan as described on page 17.

Initial Eligibility

If you are an Employee in a Newly Organized Group or are a Newly Indentured Apprentice, you will become eligible for benefits on the first day of the month following the completion of at least 135 Hours in the immediately preceding calendar month for which the Fund receives contributions. The contributions for the first month of coverage and the names of the new Employees covered under this provision must be received in the Fund Office prior to the first day of the first month of coverage.

Continuing Your Eligibility

Once you have earned your initial eligibility, you will stay eligible under these special rules as long as you work at least 135 Hours per month and the Fund receives contributions for those Hours. Each month for which you work at least 135 Hours per month and the Fund receives contributions for those Hours, will provide eligibility for two months, those months being the two months following the month worked. For example if Bob worked and had contributions for 135 hours in May, he would remain eligible for June and July.

After you meet the regular Initial Eligibility Rules of the Plan, as described on page 17, all of the rules and benefits of the Plan apply as described in that booklet and the special rules described in this section are no longer applicable to you.

How You Can Lose Eligibility

This Plan is designed to provide needed benefits for all eligible Employees and their covered Dependents. However, you should be aware of the circumstances that could result in a loss of eligibility. It is possible for you and your Dependents to lose eligibility if:

- Fewer than 135 hours of Employer contributions are received by the Fund for a month on your behalf.
- You work for a non-participating employer in the insulation industry within the geographic jurisdiction of the International Association of Heat and Frost Insulators and Allied Workers. (In this case, your eligibility will terminate immediately unless such work is pursuant to a written agreement which is provided to the Fund.)
- You are absent from work as the result of service in the U.S. Armed Forces. (See page 20 on how to regain your status once discharged.)
- There is a Plan amendment that affects eligibility.

Lost Your Eligibility? How To Get It Back

If for any reason you lose your eligibility for benefits during the limited period covered by the special rules described in this section, you can then become eligible for benefits only by meeting the regular Initial Eligibility Rules of the Plan as described beginning on page 17. The only exception is if you lose eligibility because of service in the Armed Forces (*see,* page 20).

Special Rules for Loss of Benefits

If you lose your eligibility for benefits during the limited period covered by the special rules described in this section as the result of insufficient hours, disability or death, the Self-Payment Rules described on page 20, the coverage continuation rules for disabled employees described on page 26, and the surviving Dependent coverage rules described on page 27 do not apply. However, the Alternative Self-Payment Rules (COBRA) described on page 23 does apply.

CONTINUING YOUR ELIGIBLITY WHILE YOU'RE RETIRED

The Fund provides benefits to retirees and their eligible Dependents, as described below. The rates charged to Retirees are set by the Trustees, and are available from the Fund Office. *The Trustees may change rates and change or discontinue benefits for Retirees at any time.*

Death Benefits

You are eligible for Retiree Death Benefits at no cost to you if you were eligible under the Medical Plan on the date of your retirement, and you are entitled to receive a pension from the Asbestos Workers Local 24 Pension Fund; however, you are not eligible for the Retiree Death Benefit if you decline Retiree coverage under the Medical Plan unless you have submitted a Retiree Coverage Suspension Election form. Both Retirees eligible for Medicare and those not eligible for Medicare can qualify for this benefit. The amount of the Retiree Death Benefit is $5,500. However, if you became Totally and Permanently Disabled prior to November 1, 2015, as determined by the Social Security Administration, while you were an Eligible Employee and before age 60, your Death Benefit will be continued as an Eligible Employee. You must obtain an application from the Fund Office, complete the application, have it certified by Local 24 and submit it to the Fund Office.

Medical Benefits

If you are receiving a pension other than a deferred pension or a disability pension from a plan sponsored by Local Union No. 24, you may continue your eligibility if you meet certain conditions. If you are receiving a disability pension from a plan sponsored by Local Union No. 24, you must be permanently and totally disabled based on either your receipt of a Social Security Disability Award or your being found by the Board of Trustees of the Pension Fund to be permanently disabled because of an asbestos-related disease. To continue eligibility while retired, you either 1) must be eligible under this

Fund at the time of your retirement (and not employed in the insulation industry by a non-contributing employer during this period unless such work is pursuant to a written agreement between Local Union No. 24 and yourself, a copy of which is provided to the Fund) or 2) must have worked for the International Association of Heat and Frost Insulators and Allied Workers, the AFL-CIO, a Building Trades Council, or if approved by the Board of Trustees, a related organization whose purpose is to promote the unionized insulation industry from the time you were last eligible under this Fund until retirement. If you meet these conditions, you can continue your eligibility as a Retiree by making self-payments. The amount of the self-payment and the benefits provided to Retirees are set by the Trustees. You do not have to be available for work.

If you are an Employee with Ownership Interests in an Employer who was covered by the Special Participation Agreement for Employees with Ownership Interests and was actively working and participating in the Fund at the time of retirement, you may continue your eligibility while retired if you meet the requirements stated above. However, you may satisfy the pension requirement if you are receiving a pension other than a deferred pension from Local Union No. 24 or from the pension plan of an Employer signatory to a Collective Bargaining Agreement with Local Union No. 24 or a retirement benefit from the Social Security Administration.

For Retirees covered by Medicare, your claims are coordinated with Medicare Parts A and B. This means that the Fund's payment will be made as if you have both Medicare Part A and Part B benefits and Medicare has paid first whether you have signed up for these Medicare benefits or not. See Coordination with Medicare on page 75. (Note that the Fund does *not* require you to sign up for Part D (Prescription Drug Coverage)).

If you begin to receive Weekly Accident and Sickness Benefits and then retire (either by receiving a Pension from the Asbestos Workers Local 24 Pension Fund or Social Security Retirement Benefits or both) your Weekly Accident and Sickness Benefits will terminate as of the effective date of the Pension Benefit or the Social Security Benefit, whichever is first.

Plan of Health Benefits For Retirees

Comprehensive Major Medical Benefit for Covered Expenses	
ANNUAL PLAN	
Deductible (Per Individual)	$200
Maximum family deductible expense	$500
Basic Benefit (100% or UCR up to)	$4,000
Major Medical Benefit: Up to $4,000: Percentage Paid by Plan Percentage Paid by Retiree Next $8,000: Percentage Paid by Plan Percentage Paid by Retiree Maximum Major Medical Benefit Paid by Plan - Calendar Year	 100% 0% 80% 20% $10,400
LIFETIME PLAN	
Deductible	ANNUAL PLAN
Paid by Plan (Percentage of UCR)	100%
MAXIMUM ANNUAL BENEFIT	Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, page 41. Otherwise, all percentages are percentages of Usual, Customary and Reasonable (UCR) charges. *See,* page 48.

A co-pay of $100 will be applied if you or your Dependents use the services of an emergency room. This co-pay will be waived only if the visit to the emergency room was for a life threatening illness, the visit to the emergency room was for an injury that requires immediate medical attention or the patient is admitted to the hospital directly from the emergency room. The $100 co-pay will not be applied to your deductible.

The Plan for Retirees excludes Weekly Accident and Sickness Benefits and Annual Physical Benefits. The Plan provides Prescription Drug, Dental, Vision and Hearing Aid Benefits as described on pages 58, 63, 67 and 68.

People Covered By Retiree Benefits

Retiree Benefits will be provided as described above to eligible Retirees and eligible Dependents of Retirees and to a widow(er) to whom the Retiree has been married for at least one year prior to the death of the Retiree, provided there is no group health benefits coverage on the widow(er). The eligibility of a widow(er) will terminate upon remarriage. *See,* page 39.

Dependent children of a deceased Retiree may continue to be entitled to benefits if payments are made on their behalf for as long as they would have been eligible if the Retiree had not died. If the Dependent children are not natural born children of the Retiree, but became Dependents of the Retiree as a result of a marriage less than one year prior to the death of the Retiree, the benefits of such Dependent children will terminate at the death of the Retiree.

The widow(er) of an Eligible Employee who dies while he (or she) is eligible for benefits from this Plan and could have retired immediately on other than a deferred pension from the Asbestos Workers Local 24 Pension Fund is eligible for Retiree coverage.

Application

An application for Retiree Benefits must be filed with proper payment within 60 days following termination of eligibility as an Eligible Employee. If the application is being filed by the widow(er) of a deceased active Employee, the application must be filed with proper payment within 60 days following the date the deceased Employee's active eligibility would have terminated if the Employee had stopped working on the date of death. An application is not accepted until approved by the Board of Trustees.

If you do not select Retiree coverage for yourself at the time of your retirement, you may not select it later.

If a widow(er) does not select Retiree coverage at the time he or she first becomes eligible, the widow(er) may not select it later. However, if you are receiving Retiree Benefits, you may add Dependents upon your remarriage or within 60 days after the birth of your Dependent child, after the placement of a Dependent child with you for adoption, or after termination of your Dependent(s) (or Widow(er)s) eligibility under another group health benefits plan.

Payment for Retiree Benefits

Payment to the Fund for Retiree Benefits must be made ***quarterly in advance*** by:

- The Retiree;
- An eligible widow(er); and/or
- Someone on behalf of eligible Dependent children.

You may elect to have your payment for Retiree Benefits deducted from your pension check from the Asbestos Workers Local 24 Pension Fund. In this case, your quarterly premium will be deducted from your pension and paid in monthly installments.

Termination of Retiree Benefits

Your coverage for Retiree Benefits will terminate if payment for benefits is not made on a timely basis.

If you return to employment covered by this Fund, Employer contributions will be made on your behalf under the terms of the applicable Collective Bargaining Agreement or participation agreement. Your coverage as a Retiree will terminate when you become eligible as an Active Eligible Employee or when you are employed in the insulation industry within the geographic jurisdiction of the International Association of Heat and Frost Insulators and Allied Workers by a non-participating employer, unless such work is pursuant to a written agreement between Local Union No. 24 and yourself, a copy of which is provided to the Fund. If you gain eligibility as an Active Eligible Employee you will receive benefits as an Active Eligible Employee and you are not required to make payments for Retiree Benefits.

When you stop working in employment covered by this Fund, you will continue as an Active Eligible Employee until your active eligibility terminates under the provisions of the Plan. *See,* page 19. At that time you may reinstate your coverage as a Retiree if you are receiving a pension from the Asbestos Workers Local 24 Pension Fund, but you must do so immediately. You may not make self-payments to continue your active eligibility. However, if your Retiree Benefits terminate for any reason, except during periods in which you establish active eligibility, you may not reinstate those Retiree Benefits at a later date.

Suspension of Benefits to Participate in a Medicare HMO

Qualified Retirees and Dependents who are eligible for Medicare may elect to suspend Retiree coverage through the Fund in order to participate in a Medicare Advantage plan, which has a contract with the Center for Medicare and Medicaid Services (CMS) to provide Medicare services. Suspended Retiree coverage can be reinstated in the future, should you or your Dependent decide to terminate the Medicare Advantage coverage.

In order to qualify for future reinstatement of Retiree coverage through the Fund, you must file a Retiree Coverage Suspension Election form (available from the Fund Office) with the Fund Office prior to enrollment in the Medicare Advantage plan. In addition, you will be required to provide evidence that you or your Dependent were continuously covered under a Medicare Advantage plan during the full suspension period.

Suspension of Benefits When Retiree Has Other Coverage

Qualified Retirees, Spouses and/or Dependents who are covered by other coverage may elect a one-time option to suspend Retiree coverage through the Fund in order to participate in the other coverage. Suspended Retiree, Spouse and/or Dependent coverage can be reinstated in the future, should you, your Spouse and/or Dependent decide to terminate the other coverage.

In order to qualify for future reinstatement of Retiree coverage through the Fund, you must file a Retiree Coverage Suspension Election form (available from the Fund Office) with the Fund Office prior to suspending Retiree coverage, *and* you must notify the Fund no later than 60 days after your other coverage has ended. In addition, you will be required to provide evidence that you, your Spouse and/or Dependent were continuously covered under other coverage during the full suspension period.

Continuing Eligibility for Your Dependents After Your Death

If you should die while you are a Retiree, the eligibility of your Dependents who are covered by your Retiree Benefits at the time of your death will terminate on the last day of the quarter for which a payment has been made for coverage for that Dependent. Your widow(er) may continue coverage provided (1) he or she has been married to you for at least one year immediately prior to your death, (2) there is no other group health benefits coverage on the widow(er) (except Medicare) and (3) the qualified widow(er) makes the applicable payment as determined by the Trustees. If your widow(er) is not

eligible to continue coverage because he or she had other group health benefits coverage at the time of your death, he or she can elect to have Retiree Benefits reinstated when the other coverage terminates, provided application for reinstatement is made within 60 days after termination of the other coverage. The coverage on a widow(er) will terminate if the widow(er) remarries or fails to make the required payment to continue Retiree Benefits on a timely basis.

Dependent children of a deceased Retiree may continue to be entitled to benefits if payments are made on their behalf for as long as they would have been eligible if the Retiree had not died. If the Dependent children are not natural born children of the Retiree, but became Dependents of the Retiree as a result of a marriage less than one year prior to the death of the Retiree, the benefits of such Dependent children will terminate at the death of the Retiree.

Eligibility for Reduced Retiree Premiums

Pursuant to their collective bargaining agreements with Local 24, certain employers contributing to the Plan pay an additional monthly contribution to partially subsidize retiree benefits, known as the "Retired Employees' Separate Account" or "RESA" contribution. If the former employer of a retiree pays this additional contribution, he, as well as his or her Spouse (or surviving Spouse), will be eligible for a reduced premium if the following requirements are met:

1. The Employee must be eligible for Retiree benefits from this Fund.
2. The Employee's home local must be Local 24 and he or she must be a member in good standing of Local 24. For purposes of this Section, "member in good standing" means any Employee who has satisfied all financial obligations to the Local.
3. The Employee must have pension eligibility from the Asbestos Workers Local 24 Pension Fund. An Employee with Ownership Interests in an Employer satisfies the requirements of this paragraph if the Employee:
    a. Is covered by a Special Participation Agreement for Employees with Ownership Interests;
    b. Has pension eligibility from the Asbestos Workers Local 24 Pension Fund, the pension plan of an Employer signatory to the Collective Bargaining Agreement in Local 24's area or for a retirement benefit from the Social Security Administration; and
    c. Was actively working and participating in the Fund immediately prior to retirement.

4. The Employee must have a combined fifteen (15) years of participation in this Fund and in the National Asbestos Workers Medical Fund in Local 24's area prior to December 1, 2004.
5. The Employee must have a combined twelve (12) years of eligibility in this Fund and in the National Asbestos Workers Medical Fund in Local 24's area prior to December 1, 2004.
6. Local 24 may include an Eligible Employee who is totally and permanently disabled and receiving a Social Security Disability Benefit even though that Employee does not meet the requirements of other eligibility guidelines indicated herein.
7. Contributions (including the RESA contribution) must have been made on the Employee's behalf into the Fund for thirty-six (36) out of the sixty (60) months, immediately preceding the Employee's pension effective date. Local 24 may waive this requirement, provided that any such waiver applies uniformly to all premium subsidy participants from the Local and the waiver remains in effect for at least one year.
8. The employee has reached age 55. If a Retiree is not eligible for this benefit solely for failure to meet this condition, he or she will become eligible for the reduced premium upon reaching age 55, provided he or she has maintained his coverage by paying the required premium.

Additional rules may be adopted as necessary from time to time.

Suspension of Reduced Premium Upon Return to Work

Participants receiving Retiree Benefits who return to work for contributing Employers in jobs not covered by the Plan must pay the full retiree premium for continued coverage while they are working. Alternatively, if they have other coverage (including any coverage provided by their Employers), they can temporarily suspend their retiree coverage using the Plan's existing optional Suspension of Benefits provisions (see, page 38.)

PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund provides benefits through a national PPO provided by Cigna Healthcare ("Cigna"), which covers all areas of the Fund. The Trustees have selected Cigna as a way to help control medical costs while continuing to provide a wide selection of providers and services. A PPO is a network of physicians and Hospitals that have an agreement with the Fund to charge Employees and Dependents a "preferred" or negotiated rate. If you have questions about the PPO or want to determine if there is a PPO provider in your area, Cigna may be contacted as follows:

Cigna Healthcare
P.O. Box 188004
Chattanooga, TN 37422

Current provider information is also accessible through the Cigna website at: https://www.cignasharedadministration.com/ or by calling 1.800.768.4695. You also have the right to request and receive, free of charge, a paper copy of this list. If your preferred provider is not listed in the Cigna PPO network, you can contact the Fund Office for a request form; after receipt of the form, Cigna will attempt to contact the provider to add the provider to its PPO network.

If you do not use a Participating PPO Provider, your benefits will be paid at 50% of the amount the Fund would have paid if you used a PPO provider, unless one of the following applies:

1. In a Medical Emergency where selection of a provider is not an option;
2. If you reside more than 25 miles from the Cigna PPO Service Area; or
3. When you or your Dependent require medical service while traveling outside the Cigna PPO Service Area.
4. When an eligible employee receives benefits under the Annual Physical benefit.

In the event exception No. 1 or No. 3 above applies to you, you are responsible for notifying the Fund Office within two business days or the penalty will be applied. The Fund Office will identify those living outside the Cigna PPO Service area by zip code.

PPO Definitions:

1. Participating PPO Provider - Those Hospitals, skilled Nursing Facilities, outpatient therapy facilities, physicians, or other providers of health care services under a PPO contract with Cigna. To determine whether a provider participates, contact Cigna member services at the number listed earlier in this book. The list of providers participating in the Cigna PPO may be revised as necessary.

2. PPO Service Area - The postal zip code areas identified by Cigna as being in the Cigna's Service area. If your residence is more than 25 miles from the Cigna PPO Service Area, you will not be penalized for using a non-participating provider; if you do live within 25 miles of the Cigna PPO Service Area and use a non-participating provider, benefits will be paid at 50% of the normal schedule (unless exception 1 or 3 applies and you have notified the Fund Office in advance of claim submission).

3. Medical Emergency - A serious health-threatening or disabling condition manifested by severe symptoms occurring suddenly and unexpectedly, which could reasonably be expected to result in serious physical impairment or loss of life or limb if not treated immediately.

Remember, there is a 50% penalty if you do not use a PPO Provider unless one of the exceptions listed above applies.

PRE-CERTIFICATION/ UTILIZATION REVIEW

The Board has retained Cigna Care Allies to provide Voluntary Precertification/Utilization Review and Case Management services (see below, on page 43, for a description of certain outpatient procedures that require preauthorization). The services provided by Cigna Care Allies have two parts: Voluntary Precertification/Utilization review and Case Management. Both of these programs are designed to help ensure that you get the most appropriate and cost-effective medical treatment. The ultimate goal of these programs is to help to ensure the best medical outcomes while at the same time saving you and the Plan from inappropriate or unnecessary expenditures.

To take advantage of this program, either you or your medical provider (your hospital, your doctor, etc.) should call Cigna Care Allies when:

- A hospital admission is necessary.
- Inpatient or outpatient elective surgery is to be performed.
- A pregnancy has been physician-confirmed.
- An emergency hospital admission has occurred (within 24-48 hours).

Cigna Care Allies will then assign your own dedicated nurse case manager, who can:

- Coordinate your medical care with your doctor and other medical care providers to make sure that you get the best and most appropriate treatment.
- Help you navigate the health care system.
- Provide you with information about your specific condition and prescribed course of treatment.
- Track your recovery progress.
- Assist with follow-up care arrangements like physical therapy or home health services, as needed.

The toll-free number for Cigna Care Allies is 1.800.768.4695.

Case Management

You do not need to do anything to initiate this program. If you are treated for any number of different conditions, such as diabetes, certain types of cancer, chemical dependency, you may be selected by Cigna Care Allies for Case Management services. If your case meets their criteria, a nurse manager will be assigned to you and to your family to help to make sure that you get the services that you need.

Outpatient Services Pre-Authorization Through Cigna

Pre-Authorization for the following outpatient services ("Outpatient Pre-Authorization"), when covered by the Fund, is required for the following procedures:

- Diagnostic Radiology – MRI, PET, CT, nuclear cardiology
- Certain Outpatient surgical procedures
- Injectable Medications
- Durable Medical Equipment
- Ear Devices
- Erectile Dysfunction

- Gastric Bypass
- Home Health Care (Home Nursing Care)
- Home Infusion Therapy (Intravenous, enteral, parenteral)
- Oral Pharynx
- Orthotics and Prosthetics
- Potential Experimental/Investigational/Unproven Treatments
- Speech Therapy
- Spinal Procedures
- Therapeutic Radiology
- Transplants
- Sleep Management

Participation in this Program is designed to help Participants and Beneficiaries access the right care, at the right time, in the right setting. With pre-authorization, you will find out in advance whether the service is covered, which can help you lower costs and avoid unnecessary procedures.

Who is responsible for getting Outpatient Pre-Authorization?

Your referring physician should request the Pre-Authorization.

- If your referring physician is in-network, they should handle this for you.
- If your physician is out-of-network, you must ask the physician to call Cigna and request the Pre-Authorization. You can also call Cigna yourself to ensure the process is started. Remember that you will be assessed higher cost-sharing rates for using an out-of-network provider.

Things to note:

1. Outpatient Pre-Authorizations that are requested by someone other than the referring physician may be denied due to lack of clinical information.

2. Make sure your Pre-Authorization was approved prior to having the service performed. (The provider may request that you pay for the service in full if the provider has not obtained an authorization prior to the service.)

3. Cigna may contact you if the procedure for which you are seeking authorization can be performed at a lower cost at a facility that will save you out-of-pocket expense. (For example: If you are scheduled to have an MRI done at a hospital, Cigna may request that you have the MRI performed at a non-hospital facility to save you money.)

4. Outpatient Pre-Authorization is not required for Retired Participants who are eligible for Medicare.

What to do if your request is denied:

- If you receive a denial for an Outpatient Pre-Authorization, your doctor should contact Cigna to determine why it was denied. In many cases, the denial can be approved once additional information is obtained from your doctor.

- If your Outpatient Pre-Authorization is denied, your doctor can request a peer-to-peer review with a Cigna Medical Director. If the denial is upheld once the peer-to-peer review is complete, you have the right to file an appeal with Cigna. If the appeal with Cigna is denied, you also have the right to request a second-level Appeal with the Board of Trustees.

Pre-Authorization contact information:

For Inpatient and Pre-certification of Outpatient Procedures, call: 1.800.768.4695

For Outpatient Pre-certification of CT Scans, MRI and PET Scans call: 1.866.249.3808

WEEKLY ACCIDENT AND SICKNESS BENEFITS FOR ACTIVE ELIGIBLE EMPLOYEES – OFF THE JOB ILLNESS OR INJURY

General

The Weekly Accident and Sickness Benefit is payable to you while you are totally and continually disabled by a non-occupational injury or illness that prevents you from working at your occupation and for which benefits are not payable under a Workers' Compensation Law or a pension plan, or while you are unable to work at your occupation because of being an organ donor for which benefits are provided from this Fund.

It is not necessary to be confined to your home to collect benefits, but you must be under the care of and be seen by a legally qualified Physician during the period of disability.

A legally qualified Physician must certify on the attending Physician claim form the dates you have been totally disabled and unable to work. The Employee must complete the reverse side of this form in detail.

When you are totally disabled and prevented from working due to an occupational illness or injury you must also periodically furnish the Fund with a Physician's claim form certifying to your continued disability in order to maintain eligibility for other illnesses or injuries. If Workers' Compensation has denied your initial claim for benefits of an illness or injury that may be work related, the Fund will pay Weekly Accident and Sickness Benefits. These benefits are subject to the subrogation provisions of the Plan (see "Benefits Paid Where A Third Party May Be Liable" on page 76).

This benefit is only available to Active Eligible Employees; it is not available to Dependents of Active Eligible Employees or to Retirees and their Dependents. Any Employee who begins receiving Weekly Accident and Sickness Benefits and then withdraws from the labor market, either by receiving a pension or Social Security Retirement Benefit or both, will have the Weekly Accident and Sickness Benefit terminated as of the effective date of the pension benefit or the Social Security Retirement Benefit, whichever begins first.

The Weekly Accident and Sickness Benefit is subject to FICA (Social Security) Taxes during the first six months of unemployment.
You may request that Federal Taxes be withheld from your Weekly Accident and Sickness Benefit check provided that you submit a properly executed IRS form to the Fund Office and comply with IRS rules for such withholding. Contact the Fund Office if you have any questions or desire further information.

Amount of Benefit

The weekly benefit rate is shown in the table on page 14.

Period of Coverage

Your Weekly Accident and Sickness Benefit will begin on the first day if your disability resulted from an accident or on the eighth day if your disability resulted from an illness. Benefits are payable for a maximum of twenty-six (26) weeks of disability. Payment will be made for as many separate and distinct periods of disability as may occur. Successive periods of disability will be considered one period of disability unless you

return to work long enough to earn at least one quarter of eligibility prior to your subsequent period of disability.

WORKERS' COMPENSATION SUPPLEMENT

Effective May 1, 2019, the Fund no longer provides a Workers' Compensation Supplement benefit.

ANNUAL PHYSICAL

This benefit provides reimbursement for charges in connection with a complete physical examination once each calendar year. The amount of reimbursement will be limited to the usual, reasonable and customary charges. Benefits will not be provided for services that are not recommended under standard medical protocols.

COMPREHENSIVE MEDICAL BENEFITS

Who Is Covered

All Employees and Retirees who have satisfied the eligibility requirements of the Fund and their eligible Dependents are covered for Comprehensive Medical Benefits as shown on the applicable Schedule of Benefits. Comprehensive Medical Benefits include the benefits under both the Annual and Lifetime Plans.

The Comprehensive Medical Benefits plan is designed to provide coverage for medical care that is necessary for the treatment of injury or sickness. Therefore, elective medical treatment that is not medically necessary, such as for elective cosmetic surgery will not be covered. If you have any questions whether a certain treatment or procedure is covered, please contact the Fund Office.

Amount of Coverage

Usual, Customary and Reasonable (UCR)

Benefits are paid based on "Usual, Customary and Reasonable" (UCR) charges for services and supplies. There is no flat dollar limitation for a specific procedure except in the few instances described later. Usual, Customary and Reasonable charges are determined by taking into consideration:

- the fee charged by a majority of the applicable health care providers (Physicians, Hospitals, etc.), for the medical procedure performed in the specific geographical area where the care was provided; and
- complications or special circumstances that arose, if any.

The Fund pays benefits at the FAIR Health 70th percentile to make this determination.

When the charge is higher than the Usual, Customary and Reasonable amount, you will be informed through the explanation of benefits accompanying the payment. The difference between the benefit paid by the Fund and the amount charged is your responsibility. This does not mean that the Fund is saying that your Physician is "overcharging." Medical fees vary and there are no minimum or maximum fee schedules maintained by doctors.

If you should require surgery, it is recommended that you ask your Physician to submit the surgical procedure numbers and his fee to the Fund Office in advance of the surgery. We will then advise you if the Physician's fee is greater than the Usual, Customary and Reasonable amount which this Fund will pay. This way you are aware, in advance, if there are any amounts that exceed the "Usual, Customary and Reasonable" amounts for which you will be responsible.

Deductible

The amount of the Deductible is stated in the Comprehensive Plan Schedule of Benefits for Eligible Employees or Retirees as applicable. This is the first amount of eligible expenses incurred during each calendar year which must be paid by you.

The Deductible applies separately to you and each eligible Dependent except that no more than the maximum family Deductible as stated in the Comprehensive Plan Schedule of Benefits will apply to any one family during each calendar year.

A new Deductible will apply each calendar year. However, if during one calendar year, you or your Dependents do not satisfy the Deductible, medical expenses incurred during the last three months of that calendar year which would have been applied toward the Deductible may instead be applied toward the Deductible for the next calendar year.

The Deductible is waived for an expense if coordination of benefits applies and the other plan is the Primary Plan. However, the waiver of the Deductible in connection with a particular claim does not mean that the requirement for a Deductible is satisfied for the calendar year.

Amount

Annual Plan

In general, after you have paid the Deductible, the Comprehensive Medical Benefits will be paid each calendar year as shown in the Schedule of Benefits as follows:

100% of UCR up to the first:	$ 4,000
80% of UCR up to the next:	$ 8,000

Lifetime Plan

Each calendar year, if you incur covered expenses in excess of the Annual Plan, unless the benefit has a maximum benefit amount (*e.g.*, treatment for TMJ), then 100% of the Usual, Customary and Reasonable charges up to the applicable annual maximum benefit will be paid. If a participant loses eligibility and again becomes a participant, any amounts originally applied to that year's maximum benefit will remain.

What Is Covered

Hospital Charges

Comprehensive Medical Benefits covers Hospital charges for *semi-private room and board* and covered inpatient services for as long as hospitalization is medically required. Hospital charges for private room and board will be covered when it is medically necessary to isolate the patient to prevent contagion of that patient or others.

Definition of Hospital

When we use the word "Hospital" we mean an establishment that provides and charges for facilities for major surgical procedures and medical diagnosis and treatment of bed patients under the supervision of one or more licensed Staff Physicians available at all times and 24 hour-a-day care by registered or graduate nurses, Licensed Birthing Centers, and institutions for alcohol rehabilitation or physical rehabilitation that are approved by (1) the Joint Commission on Accreditation of Hospitals, (2) by the Accreditation Association for Ambulatory Health Care and licensed by appropriate regulatory authorities.

Ambulatory Surgical Centers and drug and alcohol rehabilitation facilities that do not meet the above requirement will be considered as Hospitals provided they are (a) licensed by the State or (b) approved by Medicare, or (c) in the event not approved by Medicare, they are recognized for payment by major insurance companies which provide health benefits.

A Skilled Nursing and Rehabilitation Facility will be considered a "Hospital", provided treatment follows at least 3 days of in-hospital care and begins within 30 days of hospital discharge. Treatment in a skilled nursing facility is limited to 45 days unless the Fund's medical consultant or case management agent determines that the alternative to extended treatment at the facility will be more costly to the Fund. **Institutions that are primarily nursing homes, rest homes, convalescent homes or homes for the aged are not Hospitals.**

Definition of Physician

"Physician" includes: a duly licensed doctor of medicine (MD) or a duly licensed doctor of Osteopathy (DO); a duly licensed dentist for dental X-Rays and dental treatment where such services are covered; a duly licensed Podiatrist (Chiropodist) (DSC) for purposes of conditions of the feet; a duly licensed Chiropractor practicing within the scope of his license; a duly licensed Psychologist (Ph.D.) within limits specified in the Plan; a duly licensed social worker, if such services are referred by a psychiatrist or psychologist; and a certified nurse midwife.

Covered Items

The Fund covers charges for these items if they are ordered by a Physician while you (or your Dependent) are admitted, and are billed by and payable to the Hospital:

- general nursing service, sterile tray service, and meals;
- use of artificial heart and kidney machines;
- operating, delivery, recovery, cystoscopic and treatment rooms, and equipment;
- recognized drugs and medicine and take-home medications;
- dressings, ordinary splints, casts, braces, trusses and crutches;
- all diagnostic services and laboratory services, including, but not limited to laboratory examinations, x-ray examinations, electrocardiograms, basal metabolism tests, physical therapy (furnished and billed by the Hospital), oxygen and its administration, anesthetics and its administration, administration of blood and blood plasma, intravenous injections and solutions, x-ray and radium therapy, radioactive isotope therapy, chemotherapy; and
- other medically necessary services, supplies and equipment related to the illness or injury.

Intensive Care

The Fund will pay benefits while you or your eligible Dependent is confined to an intensive care unit. We define "intensive care unit" to be a special area of a Hospital that is reserved for critically ill patients needing constant observation and that provides (1) personal care by specialized registered nurses on a 24-hour basis; (2) special equipment and supplies which are available and on standby; and (3) care not available in other units of the Hospital.

Maternity and Obstetrical Benefits

Maternity and obstetrical benefits are available to you, your Spouse and Dependents (while you are eligible). Benefits for a baby born to a dependent are not covered unless the baby otherwise qualifies as your Dependent.

Complications arising during pregnancy that result in surgery, treatment, or Hospital service are also covered by the program.

Under the "Newborns' and Mothers' Health Protection Act," this Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, this law generally does not prohibit the mother's or newborn's attending provider (e.g. physician, nurse-midwife, or physician assistant), after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act of 1998

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and coinsurance.

Outpatient and Out-of-Hospital Care (Including Emergency First Aid)

You and your eligible Dependents are covered for care you receive out of the Hospital or from a Hospital as an out-patient. In other words, this means you have protection against expenses for sudden and serious medical problems. Coverage includes:

- emergency room fee if rendered within 72 hours after a non-occupational injury or medical emergency. A co-pay of $100 will be applied if you or your Dependents use the services of an emergency room. This co-pay will be waived only if the visit to the emergency room was for a life threatening illness, the visit to the emergency room was for an injury that requires immediate medical attention or the patient is admitted to the hospital directly from the emergency room. The $100 co-pay will not be applied to your deductible;
- hospital charges other than the emergency room fee recommended by the physician for surgical treatment and for emergency first aid; and
- surgical charges; and
- ambulance service to a local Hospital.

Other charges for out-of-Hospital services and supplies that are covered by the program as long as they are recommended by your Physician include:

- treatment by a Physician or surgeon;
- services of a graduate or licensed nurse or a physiotherapist (excluding a member of your immediate family or person ordinarily living in your home);
- medically necessary FDA-approved prescribed drugs and medicines available only by prescription;
- dressings, ordinary splints, casts, braces and crutches;
- laboratory examination, pap smear tests, x-ray examinations, x-ray, radium or cobalt treatment, chemotherapy, anesthetic and its administration, blood and blood plasma, oxygen and its administration, artificial limbs and eyes, rental of wheelchair, Hospital bed or iron lung, and other prescribed durable medical equipment.

  See above, on page 43, for a list of outpatient services for which preauthorization by Cigna is required.

Surgical Benefits

Comprehensive Medical Benefits cover most surgical procedures when recommended by a Physician or surgeon legally licensed to practice medicine, including usual pre- and post-operative care. The Fund will pay surgical benefits to surgeons (including assistant surgeons at not more than 25% of the surgeon's fee, when medically necessary), and Physicians, based on actual fees charged as long as fees are Usual, Customary and Reasonable. Benefits are paid whether covered surgery is performed in or outside a Hospital.

If there are multiple surgical procedures performed through the same incision, whether related or not, 100% of the Usual, Customary and Reasonable charge will be considered for the greater procedure and 50% of the Usual, Customary and Reasonable charge will be considered for each lesser procedure during the same operative session.

Mental Health and Alcohol and Chemical Dependency

Comprehensive Medical Benefits cover in-patient and outpatient treatment for mental health disorders and alcoholism and chemical dependency in the same manner, and is subject to the same limitations, as other medical treatments.

Medical Benefits for Dental Treatment

Medical Benefits for dental treatment are limited to expenses necessary for the repair of accidental injury to sound natural teeth, provided that primary attention must be rendered within seventy-two (72) hours following the accident, the repair is initiated within 6 months after the accident causing the injury and the accident occurs while covered by the Plan. Benefits for such dental treatment are further limited to expenses incurred during the 24-month period immediately following the accident.

Medical Benefits will also be provided for osseous surgery.

Hospice Care

Hospice care is a covered expense and payable in accordance with general Plan provisions as follows:

- Medical treatment and services to the claimant are covered.
- An institution that meets the Plan definition of a "Hospital" is covered when the claimant is in an in-patient program.
- Charges for counseling and bereavement services rendered to family members are not covered.
- Charges for pastoral and dietary services are not covered.
- Charges for psychological counseling or social services provided to the claimant are not covered.
- Benefits are payable under the provisions of the Plan provided benefits are for a terminally ill patient with a prognosis of no more than six (6) months to live. Additional six (6) month benefit periods are covered if the patient remains alive and submits a Physician's certification.

Benefits Paid After Employee's or Dependent's Death

Benefits, other than Death Benefits, payable after an individual's death that have not been assigned are payable to the Employee or, if the Employee is deceased, the Employee's Spouse. If both Employee and Spouse are deceased these benefits are payable to the individual's estate.

Items Not Covered By the Medical Plan

Comprehensive Medical Benefits provide coverage for most Hospital expenses you can expect to incur. You should be aware, however, that the program does not cover the expenses, disabilities, or types of care listed below:

1. All services, supplies, conditions, and situations listed under General Exclusions on page 72 of this SPD.
2. Eye glasses, eye refractions, and the fitting of eye glasses.
3. Plastic surgery except when the operation is performed to correct deformities resulting from injury or sickness or congenital defects that interfere with function; however, expenses for treatment of medical complications arising from cosmetic treatment will be covered.
4. Dental services, including dental x-rays, except for accidental injuries, osseous surgery and TMJ treatment subject to the limits of the Plan.
5. Charges for any service or supply that is not medically necessary for the treatment of the patient's illness or injury. For purposes of this Plan, a treatment is "medically necessary" if it meets all of the following criteria:
   a. It is required and appropriate for care of the illness or injury;
   b. It is given in accordance with generally accepted principles of medical practice in the United States and has been accepted by the American Medical Association;
   c. It is not deemed to be experimental, educational or investigational in nature by any appropriate technological assessment body established by any state or federal government;
   d. It is approved for reimbursement by the Centers for Medicare & Medicaid Services; and
   e. It is not furnished in connection with medical or other research.
6. Charges in excess of the Usual, Customary and Reasonable Charge as defined in this Plan.
7. Charges for a Dependent for any medical expense for which the Dependent is entitled to benefits as an Employee or former Employee under this Plan.
8. Charges for education, training, and bed and board while you or your Dependent are confined in an institution that is primarily a school, or other institution for training, a place of rest, a convalescent home, a place for the aged or a nursing home.
9. Charges in excess of the most prevalent semi-private Hospital rate except as specifically provided by this Plan.
10. Charges for reversals of tubal ligations and vasectomies.
11. Radial keratotomy, lasix or other laser eye surgery.

12. Acupuncture, unless performed by a Physician.
13. Occupational therapy or rehabilitation, except following illness or injury.
14. Services provided or paid for by any other group health plan sponsored by an employer.
15. Charges for dietary control.
16. Non-legend drugs.
17. Vitamins (except prescription prenatal vitamins), minerals, dietary supplements, dietary drugs, etc.
18. Medications that can be legally purchased over the counter without a prescription, even if prescribed by a doctor.
19. Therapeutic devices or appliances.
20. Hypodermic needles or syringes (except those associates with insulin injections).
21. Any medication to promote hair growth.
22. Genetically engineered drugs.
23. Anabolic steroids.
24. Diet Aids.
25. Fluoride.

Limited Benefits

In addition to the limits stated elsewhere in the Plan, the following benefits have specific limitations:

1. Charges for gastric bypass surgery for morbid obesity, if eligible for payment, will be paid as any other covered surgery, provided it is recommended for payment by the Fund's Medical Consultant.
2. All benefits paid with a diagnosis of "Temporo-Mandibular Joint dysfunction" (TMJ) will be paid under the following rules, but no more than $1,000 per lifetime will be paid on behalf of any one Employee of this Fund with the diagnosis of TMJ. The following items will be considered within the $1,000 lifetime maximum:
    a. Consultation and office visits to dentists and medical doctors;
    b. X-rays and lab;
    c. Appliances and adjustments to appliances;
    d. Behavior modification (usually bio-feedback training) -- only when clinical evaluation indicates;
    e. Surgery;
    f. Orthodontia (only covered if payable under the limits of the dental coverage as well as the $1,000 lifetime maximum for all claims received with a diagnosis of TMJ).

3. Claim payments involving transplants are paid as follows:
    a. If only the donor is eligible under this Plan no benefits will be paid, unless no other plan or program will cover these expenses.
    b. If only the recipient is eligible under this Plan, the Plan provides benefits for both donor and recipient under recipient's benefits and limits.
    c. If both donor and recipient are eligible under this Plan, the Plan provides benefits for each under their respective benefits and limits.
4. Wheelchair benefits are limited to rental for up to 90 days, or purchase no more often than once per five (5) years and at the Usual, Customary and Reasonable level.
5. Benefits for replacement or repair of prosthetic devices are limited to once per five (5) years, unless outgrown, at the Usual, Customary and Reasonable level.
6. Nicoderm/Habitrol Patches will be covered under a one (1) time course of treatment.
7. One (1) flu shot per calendar year.
8. One (1) lifetime pneumonia shot.
9. One (1) lifetime shingles vaccine.
10. Immunizations are covered for Dependent children through the age of 14.
11. Usual, Customary and Reasonable charges per mammography examination for low dose mammographic examinations as follows:
    - For women from age 35 through 39: one mammogram
    - For women from age 40 through 49: one mammogram every other year
    - For women age 50 and over: one mammogram each year
12. Medically necessary services for the Treatment of Infertility are covered for the member and Spouse within the normal provisions of the plan, with a lifetime family cap of $10,000 (including prescriptions). This benefit will not cover any procedures for reversal of voluntary sterilization or any procedure when the participant and/or Spouse has previously undergone voluntary sterilization.
13. Erectile dysfunction drugs are limited to six (6) pills per month. Coverage of daily-use Cialis is provided only with a diagnosis of benign prostatic hyperplasia (BPH) and must be pre-authorized by CVS/Caremark.
14. Smoking cessation products are limited to one (1) treatment per lifetime.
15. Annual physicals are limited to one per year, and only for services that are recommended under standard medical protocols (*see* page 47)
16. Hearing Aids, when medically necessary, including the equipment, associated professional fees, repairs and supplies (including batteries) will be covered up to a maximum benefit of $4,000 per person every three years.

17. Least Costly Alternative Treatment
    If the Trustees, upon the recommendation of a medical benefits consultant or advisor retained by them, determine that an otherwise non-covered service, procedure, treatment or equipment with respect to an individual Employee or Dependent is likely to achieve at least substantially the same results as a more costly covered service, procedure, treatment or equipment, then the Trustees, in their sole discretion, may elect to provide coverage for the less costly but otherwise non-covered expense in lieu of the more costly covered expense. In making any determination in accordance with this provision, the Trustees will be guided solely by the medical opinion of their medical benefits consultant or advisor. In addition, the availability of coverage for alternative treatment in accordance with this provision will be limited to those circumstances in which the likelihood of a cost saving to the Fund can be clearly identified. The Trustees may establish limits and review requirements with respect to each individual coverage determination.

    In the event that alternative treatment made available in accordance with this provision proves unsuccessful and it is necessary that, within twenty four (24) months from the last alternative treatment, further treatment be provided that would be deemed to be covered by this Fund, then the amount of benefits otherwise payable by the Fund for this treatment shall be reduced by the amount of benefits already paid by the Fund in accordance with this provision. Benefits that exceed Plan limits or maximums will not be paid under this provision.

18. HPV Vaccine (three-dose series) is covered for female and male participants up to age 26 and where medically indicated.

PRESCRIPTION DRUG BENEFIT

Prescription drug benefits are provided through a prescription drug card program with CVS/Caremark. Although you will be charged a co-payment based on whether the drug is generic or brand name, you and your Dependents will be reimbursed by the Plan up to $400 annually for these prescription drug co-pays.

Co-Payments

The copayments vary, depending on whether you choose to receive a generic, brand-name formulary, or brand-name non-formulary drug. Your copayment is for up to a 30-day supply, unless your prescription is for a maintenance drug filled either through mail order or at a CVS.

	Copayment—30-day Supply	Copayment—90-day Supply (Mail Order or CVS)*
Generic	$0	$0
Brand-Name Formulary	$20	$45
Brand-Name Covered Non-Formulary	$35	$75
Brand Name Non-Covered Non-Formulary	Full Cost	Full Cost

When you present your card with your prescription for a Federal Food and Drug Administration (FDA)-approved medication at a participating pharmacy, you will be asked to pay only the copayment, and the Fund will be billed for the rest. You may then submit your receipt for your copayment to the Fund Office for reimbursement on the same Direct Prescription Reimbursement Form previously used for prescription benefits.

Participating Pharmacies

You must fill your prescriptions at a pharmacy that participates in the Prescription Drug Program. Except as provided under the Maintenance Prescription Drug Program, you are not limited to CVS stores, as the vast majority of chains and independent pharmacies also participate in the CVS/Caremark program.

Generic and Brand-Name Drugs

A brand-name drug is a drug sold under a trade name, and is often protected by a patent that prohibits other companies from manufacturing it until the patent expires. A generic drug is an FDA-approved drug with chemically identical active ingredients to the brand name drug and becomes available once the patent for the brand name drug has expired. It is typically much less expensive than its brand-name equivalent.

*See page 60 for an explanation of the Maintenance Prescription Drug Program, which provides a 90-day supply for a reduced copayment.

Formulary Drugs

CVS/Caremark uses an independent Pharmacy and Therapeutics (P&T) Committee to create a list of drugs that have been demonstrated to be the most cost-effective available to treat particular disorders. A drug that is on this list is said to be a formulary or preferred drug. A non-formulary or non-preferred drug is one that is not on the list. The copayment for brand-name drugs will be higher if you and your physician choose a non-formulary drug rather than a formulary drug. ***Certain non-formulary brand name drugs are not covered by CVS/Caremark.*** In order to use your prescription card to receive these drugs, ***you must use CVS/Caremark's preauthorization program.*** For more information, contact CVS/Caremark at 1.866.282.8503 or through the CVS/Caremark website on the Internet at www.caremark.com, or call the Fund Office.

Covered Prescription Drug Expenses

Benefits are payable for medically necessary FDA-approved drugs that are available only by prescription, sometimes referred to as legend-type drugs. Medication that you can buy "over the counter" such as aspirin or antacids are not legend-type drugs and are not covered under the prescription drug program. Medically necessary means that the drug must be prescribed in order to treat an illness, injury, disease or condition.

Maintenance Drug Program

When filling prescriptions for maintenance drugs, you are permitted to receive up to a 90-day supply for a reduced copayment, provided you utilize either the Caremark mail order facility or a local CVS Pharmacy. "Maintenance drugs" are drugs that are prescribed for a long period of time and are necessary to sustain good health. Examples are drugs used to treat high blood pressure, high cholesterol, diabetes and arthritis. You will be permitted two retail fills (two 30-day fills at a local non-CVS pharmacy) of your maintenance medication. After the second 30-day fill you must get additional refills either through mail order at a local CVS Pharmacy.

Medical/Prescription Drug Identification Card

When you or one of your eligible dependents need to have a prescription filled, you must present your identification card to the participating pharmacist along with the prescription. Remember, the card may be used only on behalf of persons covered under the program. Unauthorized or fraudulent use of your card to obtain prescription drugs will result in immediate cancellation of your prescription drug benefit.

Advanced Control Specialty Formulary

The Fund utilizes the CVS/Caremark Advanced Control Specialty Formulary (ACSF). Under ACSF, certain specialty generics and specialty brand therapies will be excluded by the Plan unless prior authorization is obtained from CVS/Caremark for use of the medications. In addition, ACSF excludes certain non-preferred specialty drugs. The list of exclusions and/or preferred products may change quarterly. You can access the formulary at:
http://www.caremark.com/portal/asset/Advanced_Control_Specialty_Preferred_Drug_List.pdf

All specialty medications undergo clinical review for medical necessity through the CVS Caremark Specialty Guideline Management program. CVS/Caremark provides review of medical necessity for excluded medications. If approved, then the drug will be covered under the normal rules of the Plan. If CVS/Caremark does not provide approval via prior authorization, your prescription for the drug will not be covered under the Plan rules at all. If you agree to use the alternate medication, rather than the excluded drug, the alternate medication will be covered under the normal rules of the Plan.

Transform Diabetes Care Program

This Program helps members control diabetes to reduce clinical complications through personalized outreach and delivery of diabetes medications and supplies through CVS/Caremark. Using the CVS/Caremark network, members can simplify fulfillment of medications; reduce costs with more affordable prescription benefits; stay engaged with therapy through convenient channels; and receive improved coordination of care in consultation with their physicians.

Opioid Utilization Management

The Fund participates in the Opioid Utilization Management Program through CVS/ Caremark. Opioid Utilization Management provides for review of opioid medications, prior authorization by CVS/Caremark for specific prescribed controlled substances and quantity limits based on Center for Disease (CDC) guidelines for controlled substances.

Dispense as Written Penalties

Many brand name prescription drugs have a generic equivalent that has the same chemical components as the brand name drug and are just as effective. Generic drugs,

however, are less expensive alternatives to the brand name drug. If a Participant or Dependent presents a prescription for a brand name drug that has a generic equivalent, the participating pharmacy will substitute the generic equivalent for the brand name drug, unless the prescribing physician specifically requires that the brand name be dispensed instead of the generic drug. This is a program provided by CVS/Caremark known as "dispense as written". Unless your physician specifically requires that the brand name drug be dispensed, the Fund will only pay for the generic price, and you will be responsible for the remainder. Substitution of the generic drug will provide both the Plan and the Participant a savings on the cost of the medication. If the physician does specifically require that the brand name drug be dispensed instead of the approved generic, an appeal must be submitted in order to bypass this penalty.

If your physician indicates that generic substitution is suitable and you request the brand instead of the generic equivalent, you will also be required to pay the difference between the cost of the generic and the brand medication.

CVS MinuteClinic Savings

CVS/Caremark MinuteClinics offer family health care services, including treatment for basic and acute illnesses; vaccinations; sports, camp and administrative physicals; and health condition monitoring. Services are provided seven days a week by family nurse practitioners and physician assistants at more than 815 locations in 28 states. For more information about locations and hours of operation, please visit https://www.cvs.com/minuteclinic.

Limitations and Exclusions

Specific prescription expenses that are not covered or are limited in coverage are:

- All services, supplies, conditions, and situations listed under General Exclusions on page 72 of this SPD.
- Medications that can be legally purchased over the counter without a prescription, even if prescribed by a doctor.
- Drugs with over-the-counter equivalents are not covered. Examples include Proton Pump Inhibitors (PPI) and Non-Sedating Antihistamines (NSAs).
- Charges for dietary control. (See "Vitamins" below)
- Non-legend drugs.
- Vitamins (except prescription prenatal vitamins), minerals, dietary supplements, dietary drugs, etc.
- Hypodermic needles or syringes (except those associated with insulin injections).

- Any medication to promote hair growth.
- Anabolic steroids.
- Diet Aids.
- Nicoderm/Habitrol Patches will be covered under a one (1) time course of treatment. Smoking cessation products are limited to one (1) treatment per lifetime.
- Medically necessary services for the Treatment of Infertility are covered for the member and Spouse within the normal provisions of the plan with a lifetime family cap of $10,000 (including prescriptions). This benefit will not cover any procedures for reversal of voluntary sterilization or any procedure when the participant and/or Spouse has previously undergone voluntary sterilization.
- Erectile dysfunction drugs are limited to six (6) pills per month. Coverage of daily-use Cialis is provided only with a diagnosis of benign prostatic hyperplasia (BPH) and must be pre-authorized by CVS/Caremark.

DENTAL BENEFITS

Who is Covered

The Fund provides coverage for dental care for Eligible Employees*, their Dependents and Eligible Retirees and their Dependents.

What Is Covered

Benefits are provided at the rate of 80% of the Usual, Customary and Reasonable charge. The annual calendar year maximum is $2,000.00 per Employee, Retiree and covered Dependent, except that there is no annual calendar year maximum benefit for dependent children age 18 or younger.

Usual, Customary and Reasonable charges are determined by taking into consideration:

- the fee charged by a majority of dentists for the services or supplies in the geographic area where the care was provided; and
- complications or special circumstances that arose, if any.

Where more than one dental procedure can be used, dental benefits will be provided for the least costly satisfactory treatment. When the charge is higher than the Usual,

*Dental benefits are not provided to Employees, or their dependents, who receive NOG Coverage (*see* page 30) or HazMat Coverage (*see* page 15*).*

Customary and Reasonable charge, you will be informed through the explanation of benefits. The difference between the Fund's benefit and the amount charged is your responsibility.

Covered Items

1. Two oral examinations during a calendar year, applicable to each specialty listed: General Dentist, Endodontist, Oral Surgeon, Orthodontist, Pedodontist, Periodontist, Prosthodontist and Public Health Dentist.
2. X-ray coverage involving periapical, occlusal and extra oral x-rays as required, and bite-wing x-rays twice per year. (Complete mouth or panoramic x-rays may be made once in a three consecutive year period.)
3. Oral prophylaxis (cleaning of teeth) twice a year.
4. Emergency treatment for the relief of pain.
5. Fillings or restorations consisting of amalgam, silicate, acrylic or composite material once per calendar year per tooth surface.
6. One recementation during a calendar year for any given crown, bridge, facing or inlay.
7. One consultation by any one dentist consultant (other than the attending dentist) during the calendar year.
8. Simple extractions (not involving cutting of tissue or bone).
9. One topical fluoride application (used to reduce susceptibility to decay) during a calendar year for individuals under age 16.
10. One of the following repairs of the same removable denture during a calendar year:
    a. Repair broken full or partial denture, no teeth damaged.
    b. Repair broken full or partial denture and replace broken teeth.
    c. Replace broken tooth on denture, no other repairs.
    d. Adding teeth to partial denture to replace extracted teeth.
    e. Re-attach or replace damaged clasps on denture.
11. Endodontia (root canal treatments and fillings; removal of pulp; and amputation of root tip).
12. Pulp capping; placement of mediated material to protect the nerve.
13. Space maintainers to preserve space created by prematurely lost primary (baby) teeth.
14. Gold inlays and onlays -- not part of a bridge.
15. Crowns (including cast gold, porcelain, acrylic, stainless steel, porcelain-faced, and temporary crowns) not part of a bridge. Benefits for the same tooth are not available any more frequently than once in a five consecutive calendar year period. (Crowns posterior to the first molar position are limited to gold crown allowance.)
16. Gold foil restoration.

17. Oral surgery, limited to:
    a. Biopsy and examination of oral tissue.
    b. Treatment of dislocated or fractured jaw.
    c. Removal of tumors and cysts; treatment of abscesses.
    d. Surgical extraction of erupted teeth.
    e. Extraction of impacted teeth.
    f. Removal of abnormal bony growths (tori).
18. Radiograph (special x-ray) temporo-mandibular joint, single film.
19. Models for diagnostic purposes.
20. Some of the more frequently performed surgical procedures are:
    a. Extraction of retained root tips
    b. Tooth replantation
    c. Surgical preparation of bony tissues for dentures (alveoli-plasty)
    d. Removal of foreign bodies
    e. Repair of traumatic wounds
    f. Removal of abnormal oral tissue growth (hyperplastic tissue)
    g. Excision of inflammatory lesions
    h. Other oral surgical procedures approved by the Fund.
21. Dentures, removable, full and partial.
22. Bridges, except that benefits are not provided for:
    a. Any denture or bridge replacement made less than five (5) years after a denture or bridge placement or replacement which was covered under this Plan.
    b. Any denture or bridge replacement made necessary by reason of the loss or theft of a denture or bridge.
    c. Replacement of an existing denture or bridge which could have been repaired.
    d. Precious metals used in preparing any denture including any increased charge occasioned by the use thereof.
    e. Bridges or partial dentures for any individual under the age of 16 years.
    f. Veneer crowns, including porcelain fused to metal, when applied to any tooth posterior to the first molar position. (Gold crown allowance is made.)
    If, in the construction of a denture or bridge, the Employee, Dependent or the dentist decides on personalized restoration or to employ special techniques as opposed to standard procedures, the benefits provided under the Plan will be limited to the standard procedures for prosthetic services as determined by the Fund Office.
23. Removable or fixed prosthesis (temporary) when used for replacement of bicuspid and anterior teeth; however, benefits are limited to wrought wire clasps and acrylic bases for removable prostheses and molded plastic duplications cemented to abutting teeth for fixed prostheses (no Treatment Plan required).

24. Relining or rebasing of denture (no Treatment Plan required).
    a. For existing dentures:
        i. If performed in laboratory, limited to one relining per denture during three consecutive calendar year period.
        ii. If performed in office, limited to once per denture per calendar year.

        In any case, benefits shall not be available for more than one relining per denture in any calendar year period.
    b. Immediate denture (the placement following extraction of natural teeth) limited to two relinings during the first two years following placement.
25. Periodontal examination (no Treatment Plan required). (Periodontics is the branch of dentistry concerned with the prevention, detection, and treatment of diseases of the tissues and bones supporting the teeth.)
26. Gingival curettage, the removal of diseased tissue (no Treatment Plan required).
27. Gingivectomy (removal of gum tissue) or gingivoplasty (recontouring and re-attachment of gum tissue).
28. Osseous surgery (related to the bone) as a result of a periodontal condition, including flap entry and closure.
29. Treatment of acute infection and oral lesions (no Treatment Plan required).
30. Orthodontics, limited to a lifetime payment of $1,500.00. (This benefit is not in addition to the otherwise applicable annual calendar maximum, if any.)
31. Sealants - limited to one application per tooth, once every five years.

Items Not Covered by the Plan

There are some specific exclusions and limitations on your dental coverage. Among the items excluded are charges for:

- All services, supplies, conditions, and situations listed under General Exclusions on page 72 of this SPD.
- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, Trustee or similar person or group.
- Dental services for cosmetic or aesthetic purposes.
- Dental services furnished or available to an Employee or Dependent, in whole or in part, under any law of the United States (including but not limited to Medicare), the District of Columbia, or any State or political subdivision thereof, or for which the Employee or Dependent would have no legal obligation to pay in the absence of this or any similar coverage, nor to the extent the Employee or Dependent is entitled to receive benefits for dental services from any health or dental benefit plans.

- Precious metals, including any increased charge occasioned by the use thereof.
- Dental services which are not necessary for the diagnosis or treatment of any dental disease, defect or injury.
- Dental services rendered prior to the date Dental Benefits become effective, or dental services in process on the date the Dental Benefits become effective.
- Charges and fees for broken appointments.
- General Anesthesia, if not administered for a covered procedure *and* performed by a dentist.
- Injectable drugs not administered by a dentist for therapeutic purposes under this program.

VISION BENEFITS

The Fund provides coverage for vision care for Eligible Employees, their Dependents and Eligible Retirees and their Dependents[*].

Benefit Schedule of Allowances

Covered vision benefits include professional fees, materials, lenses, frames, and contact lenses. The maximum allowance for all benefits is $250 per Employee, Retiree and covered Dependent per calendar year, except that coverage for dependent children age 18 and under are not subject to an annual maximum benefit. Professional fees, materials, frames, lenses, and contact lenses are available once each calendar year, if necessary.

Benefits Covered

- Vision survey
- Vision analysis
- Materials, Lenses and Frames

[*] Vision benefits are not provided to Employees, or their dependents, who receive NOG Coverage (*see* page 30) or HazMat Coverage (*see* page 15*).*

Exclusions

The following services and materials are not covered under this Plan:

- All services, supplies, conditions, and situations listed under General Exclusions on page 72 of this SPD.
- Examinations or materials provided more frequently than medically indicated.
- Non-prescription glasses or other lenses.
- Special procedures such as orthoptics, vision training, subnormal vision aids, aniseikonia, etc.
- Replacement of broken lenses and/or frames, unless the Employee or Dependent is eligible for benefits again and then in lieu of new glasses.
- Medical or surgical treatment of the eyes (this may already be covered under existing medical and surgical benefits, and any Eligible Employee or his or her Dependents found to be in need of such treatment should check other benefits available under another portion of the Plan).
- Vision services received from a vision or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, Trustee or similar person or group.
- Vision services furnished or available to an Employee, Retiree or Dependent, in whole or in part, under any law of the United States (including but not limited to Medicare), the District of Columbia, or any State or political subdivision thereof, or for which the Employee or Dependent would have no legal obligation to pay in the absence of this or any similar coverage, nor to the extent the Employee or Dependent is entitled to receive benefits for vision services from any health or vision benefits plan.
- Vision services rendered prior to the date the Vision Benefits become effective, or vision services in process on the date the Vision Benefits become effective.
- Charges and fees for broken appointments.

HEARING AID BENEFIT

The Fund will provide coverage for medically necessary hearing aids, including the equipment, associated professional fees, repairs and supplies (including batteries) up to a maximum benefit of $4,000 per person every three years.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Life insurance and accidental death and dismemberment benefits are provided by Symetra Life Insurance Company ("Symetra").

Who is Covered

All Active Eligible Employees and Retirees who have satisfied the eligibility requirements are covered by the basic life insurance benefit. All Active Eligible Employees are also provided the accidental death and dismemberment benefit. Non-bargaining unit staff of incorporated participating employers who opt-out of benefits due to other coverage are not eligible for basic life and dismemberment benefits during the period for which they have opted out of benefits. See page 33 for a description of the eligibility requirements for Retiree Death Benefits.

Life Insurance and Accidental Death and Dismemberment Benefits

In the event of your death while you are covered by the life insurance benefit, your designated beneficiary will receive the basic life insurance benefit. If you are an Active Eligible Employee and your death is caused by an accident on or off the job, Symetra will pay an additional accidental death benefit. In order for the accidental death and dismemberment benefit to be payable, losses must occur within 365 days of the accident.

Basic Life Insurance Benefit	**Benefit**
Basic Death Benefit	
Active Eligible Employees	$15,000
Retirees	$ 5,500
Accidental Death and Dismemberment	
Active Eligible Employees	$65,000*

* Active Employees only.

Dismemberment Benefits[*]

If you sustain an injury that results in any of the following losses within 365 days of the date of the accident, Symetra will pay your amount of principal sum, or a portion of such principal sum as shown below. Symetra will not pay more than the principal sum to any one person for all losses due to the same accident.

Accidental Loss	Benefit
Loss of life	$65,000
Loss of both hands, both feet or sight of both eyes	$65,000
Loss of one hand and one foot	$65,000
Loss of speech and hearing in both ears	$65,000
Loss of either hand or foot and sight of one eye	$65,000
Loss of movement of both upper and lower limbs (quadriplegia)	$65,000
Loss of movement of both lower limbs (paraplegia)	$48,750
Loss of movement of three limbs (triplegia)	$48,750
Loss of movement of the upper and lower limbs of one side of the body (hemiplegia)	$32,500
Loss of either hand or foot	$32,500
Loss of sight of one eye	$32,500
Loss of speech or hearing in both ears	$32,500
Loss of movement of one limb (uniplegia)	$16,250
Loss of thumb and index finger of either hand	$16,250

Loss means, with regard to:

1. Hands and feet: actual severance through or above wrists or ankle joints;
2. Sight, speech and hearing: entire and irrecoverable loss thereof;
3. Thumb and index finger: actual severance through or above the metacarpophalangeal joints;
4. Movement: complete and irreversible paralysis of such limbs;

Beneficiary

You may designate or change a beneficiary by filing with the Fund Office a written request on a form satisfactory to Symetra. Only satisfactory forms sent to the Fund

[*] Active Employees only.

Office prior to your death will be accepted. Beneficiary designations will become effective as of the date you signed and dated the form, even if you have died since.

You may change your beneficiary at any time. In no event may a beneficiary be changed by a power of attorney. To change beneficiaries, contact the Fund Office. The Fund Office will provide you the form necessary to make the change.

If your marital or dependent status changes, you may want to review your beneficiary designation. *Remember, it is your responsibility to keep your beneficiary designation current.*

If any designated beneficiary dies before you, that beneficiary's right to the death benefit also terminates. If there is no designated beneficiary on file, your death benefit will be paid to the following, in order, if living:

1. the executors or administrators of your estate
2. your surviving Spouse
3. if your spouse does not survive you, your children in equal shares
4. if no child survives you, your parents in equal shares

Exclusions

The accidental death and dismemberment benefit does not cover any loss caused or contributed by:

- war or act of war, whether declared or not.
- intentionally self-inflicted injury.
- suicide or attempted suicide, whether sane or insane
- injury sustained while on full-time active duty as a member of the armed forces (land, air, water) of any country or international authority
- commission of or attempted commission of a felony by the insured
- the intoxication of or influence of any narcotic by the insured

Intoxication means the blood alcohol content, the results of any other means of testing blood alcohol level or the results of other means of testing other substances that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

Please contact the Fund Office is you would additional information about the life insurance and dismemberment benefits provided through Symetra.

Total and Permanent Disability

The Plan also provides that Employees who become Totally and Permanently Disabled, as determined by the Social Security Administration, while they are otherwise Eligible Employees and before age 60 will be provided with the Retiree Death Benefit. Effective for determination on or after November 1, 2015, Eligible Employees who become Totally and Permanently Disabled as determined by the Social Security Administration will be provided with the Retiree Death Benefit so long as they are otherwise eligible for the Death Benefit, regardless of their age at the time of disability. The Fund Office should be advised immediately of such disability. You should submit proof of disability to the Fund Office within three months after total disability has lasted nine months. A Social Security Administration Disability Award Certificate must be furnished the Fund Office within the first twenty-four (24) months of disability. Proofs of continuing disability must be furnished each year thereafter.

GENERAL EXCLUSIONS

The Fund provides coverage for most medical, dental and vision expenses as well as death and dismemberment benefits and Weekly Accident and Sickness benefits. Various sections of the Plan list expenses not covered by that section. In addition, the following situations, expenses, disabilities and types of care are not covered by any provisions of the Fund:

- Injury, illness or disease for which benefits are available in whole or in part, under any Workers' Compensation or similar law whether or not such benefits are claimed or received.
- Charges for treatment of intentionally self-inflicted injury (other than charges for treatments where the self-inflicted injury is the result of mental illness) or injury sustained in the act of committing a crime.
- Illness, injury or disability due to declared or undeclared war or any act of war or armed aggression.
- Loss incurred while in military service.
- Charges for services or supplies furnished in a government hospital or institution or by a federal, state or local government agency or program unless required by law or unless you would have to pay for the service or supplies if you did not have this coverage.
- Any expense that would not be incurred if you did not have health benefits.

- Services rendered for which the patient incurs no charge.
- Charges for services or supplies furnished by an individual who ordinarily resides in the patient's home or is related to the patient by blood or marriage.
- Charges for custodial care.
- Services or supplies not specifically listed as covered by the Plan.
- Charges in excess of the limits provided by the Plan.
- Services, treatment, drugs and supplies that are experimental or investigational in nature, including any services, treatment drugs or supplies that are not recognized as acceptable medical practice or any items requiring Governmental approval for which approval was not granted or in existence at the time the services were rendered

COORDINATION OF BENEFITS

Your Dependents' medical, dental and vision benefits will be coordinated with other group health plans, or prepaid group health care plans, so that all plans together pay no more than 100% of the health care costs. Here's how benefits will be coordinated:

- The plan covering a person as an Employee will pay benefits first (Primary Plan), except where costs of benefits are covered under an auto insurance policy, including a no-fault auto insurance policy. In such a case, the auto insurance policy shall be the Primary Plan, and the plan covering a person as an employee shall be secondary.
- When both parents' plans cover a person as a dependent child, the plan of the parent whose birthday is earlier in the year will pay benefits first (Primary Plan). For example, if the mother's birthday is March 3rd, and the father's birthday is August 20th, the mother's plan will pay benefits first because her birthday is earlier than his. This is called the "birthday" rule.
- If one plan does not follow the birthday rule, then if both parents' plans cover the person as a dependent child, the father's plan will pay benefits first (Primary Plan).
- When a determination cannot be made, the plan that covered the person for the longer time will pay benefits first (Primary Plan).
- When the parents are divorced or separated the order is:
    1. The plan of the parent with custody pays benefits first. (Primary Plan) The plan of the parent without custody pays benefits second.

2. If the parent with custody has remarried, the order is:
    a. the plan of the parent with custody,
    b. the plan of the step-parent,
    c. the plan of the parent without custody.

   If there is a QMSCO which states that one of the parents is responsible for the child's health care expenses, the plan of that parent will pay first. (Primary Plan) That order will supersede any order given in 1 or 2.

- If a person is covered under more than one plan as an Employee, the plan he or she was covered under longer pays first. (Primary Plan).
- A group plan that covers a person as an Eligible Employee or a Dependent of an Eligible Employee will pay benefits first. (Primary Plan) A group plan that covers a person as a retired Employee or Dependent of a retired Employee will pay benefits second.

The Fund will pay benefits as stated above when this Plan is the Primary Plan. When the Fund is the Secondary Plan, the Fund will apply the Plan rules to the balance after payment by the other Plan and will pay benefits so that no more than 100% of covered charges under this Fund will be paid.

Coordination with HMO

If your Dependent is covered by an HMO but the HMO does not cover an expense because your Dependent did not go to an HMO provider, this Fund will pay the claim as if the HMO coverage was in force. Since an HMO typically covers all of the costs of treatment, this will usually mean that this Fund will not pay benefits to your Dependent.

Coordination with PPOs

If your Dependent is covered by a group plan that provides lower benefits if services are not provided by a PPO Physician or Hospital, this Fund will coordinate with the actual amount paid by the other plan.

Coordination When Husband and Wife Are Covered by This Fund

If you and your Spouse are both covered by this Fund as Eligible Employees, the Deductible is waived and the Coordination rules described above are applied to each claim.

Coordination With Medicare

Eligible Employees and Their Spouses

At age 65 you become eligible for Medicare benefits. As long as you continue to work and have enough hours or make the required self-payments, you continue to be covered by the Fund's medical benefits as an Active Eligible Employee or Eligible Employee. Medical Benefits provided by the Fund will be your primary coverage (and your Spouse's, if he or she is also eligible for Medicare); Medicare benefits will be secondary. You will have the benefit of two coverages. As long as you remain eligible due to hours worked or Employee self-payments, you should continue to submit your claims to the Fund. After payment by the Fund, you can submit any remaining expenses to Medicare for possible payment.

Active disabled Employees (as defined in Federal Regulations) also receive primary coverage from the Fund and secondary coverage from Medicare as described above.

Retirees and Their Spouses

If you are a Retiree, an inactive disabled Employee or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible and Medicare will be your primary coverage. You will have to satisfy the applicable Deductible whether or not the medical services provided are covered by Medicare.
Medicare has three parts -- Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Insurance (Part D). Part A covers inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Part B covers doctors' services, outpatient Hospital services and other medical supplies and is optional. You must pay a monthly premium for Part B. ***(The Fund will pay benefits as if you have both Medicare Part A and Part B benefits -- whether you are signed up for them or not.) To have adequate coverage, you and your Spouse must sign up for both Medicare Part A and Part B when eligible. The Fund does not require you to enroll in Medicare Part D (Prescription Drug Insurance).***

Your claims and your Spouse's claims (if also eligible for Medicare) should be submitted to Medicare first. After Medicare pays the claim, submit a copy of the bill along with the Medicare explanation of benefits to the Fund Office.

The Fund's benefit payment will coordinate with Medicare's payment. For covered expenses, the Fund will figure its benefit based on the total expense and then subtract the Medicare benefit and consider the balance under the provisions of the Plan. For these expenses, the Fund "carves out" Medicare's payment. However, Federal law limits the amount a provider (Hospital, Physician, etc.) can charge above the Medicare payment. The Fund cannot pay the provider more than that amount and the provider cannot legally bill you more than that amount.

BENEFITS PAID WHERE A THIRD PARTY MAY BE LIABLE

If your or your dependent's injury or illness was caused by the action or inaction of another person or party, that person or party, including tortfeasors, insured or uninsured motorists programs, workers compensation programs, or any other insurance programs or benefits plans, may be responsible for your hospital or medical bills. If that is the case and you or your dependent receives benefits from the Fund, you are required to reimburse the Fund for the benefits or subrogate your recovery rights to the Fund. Examples of such injuries include automobile accident injuries or personal injury suffered on the job or on another's property.

The repayment rules described in this section, which are also known as reimbursement and subrogation rules, are in place to assist you. Collecting payment for your or your dependent's medical expenses from another person or party may take a long time, and during that time, the Fund will provide you with covered benefits, but the Fund must be repaid from any recovery related to the injury or illness that you or your dependent may receive, whether through settlement, judgment, worker's compensation or any other insurance or benefits program. These rules also prevent a situation where you are compensated twice for the same injury or illness – once by the Fund when it pays your medical bills and a second time by the other person or party when it pays damages for your loss. The bottom line is that the repayment rules help to ensure that the Fund's assets are available to cover all of the participants and dependents.

The repayment rules require that, if you or your dependent recovers money from another person or party related to an illness or injury for which the Fund is paying or has paid benefits, you or your dependent must repay the Fund for the benefits it paid out on your or your dependent's behalf, up to the amount of the recovery. For example,

if the Fund pays out $15,000 in medical claims on your behalf, and you later recover $25,000 from the person who caused your injury, you must reimburse the Fund for the full $15,000 it paid in medical benefits on your behalf. In addition, if the amount that you or your dependent recover from the other person or party is less than the full amount of damages or expenses that you claim, the Fund's share of the recovery will not be reduced and will remain the full amount of the benefits that the Fund has paid on your or your dependent's behalf, unless the Board of Trustees agrees in writing to a reduced amount. In addition, the Fund has the right to seek reimbursement from the recovery or to deny the payment of future claims related to the illness or injury for any future claims related to the same illness or injury.

Under these rules, you or your dependent need to promptly inform the Fund of any potential recovery from another person or party, or the filing of any claim or legal action against another person or party, that is related to an injury or illness that may be covered by Fund benefits. You also must promptly provide the Fund with any information and documents that are related to the potential recovery, claim or legal action.

Under these rules, if you or your dependent have a potential recovery, claim or legal action against another person related to an injury or illness that the Fund covers, you and your dependent will be required to sign a form, called a Reimbursement and Subrogation Agreement, that acknowledges the Fund's right to be reimbursed and verifies that you will help the Fund secure its rights. If you have hired an attorney to help you in your efforts to collect from the other person or party, your attorney will be required to sign the form also. The form must be completed and signed by you and your dependent (and your attorney if you have one) before the Fund will make payments on your or your dependent's behalf. If you, your dependent or your attorney fails to sign the form, the Fund may withhold paying any claims relating to your or your dependent's injury or illness caused by the other person or party. Even if you or your dependent do not sign or return the Fund's forms, the Fund is entitled to recover in accordance with the repayment rules because, by accepting Fund benefits, you and your dependent are consenting to these repayment rules.

If you or your dependent brings a liability claim against the other person or party, benefits payable under the Fund, including anticipated future benefits, must be included in the liability claim. However, even if you fail to include such a claim, the Fund is still entitled to reimbursement under the repayment rules. When the claim is resolved, you, your dependent or your attorney (if your attorney is holding the monetary recovery) must hold the monetary recovery in constructive trust and promptly reimburse the Fund for the benefits provided related to the injury or illness, up to the amount of the monetary recovery. You, your dependent and your attorney (if your

attorney is holding the monetary recovery) shall be fiduciaries and trustees with respect to the monetary recovery. You and your dependent may not assign to any other party, including your attorney, any rights or causes of action that you or your dependent may have against another person or party related to the illness or injury for which the Fund is paying or has paid benefits, absent written consent of the Board of Trustees.

You and your dependent agree that the Fund has an equitable lien, an equitable lien by agreement and/or an irrevocable vested future interest upon, and will have a specific and first priority in, any recovery related to the injury or illness caused by the other person or party for which Fund benefits are payable, paid, or are payable in the future regardless of the manner in which the recovery is structured or worded. This is the case, regardless of whether you have been made whole by the settlement. The Fund's lien and/or irrevocable vested future interest extends to claims the Fund may pay in the future related to the illness or injury for which you or your dependent receive any recovery. The Fund's reimbursement will not be reduced by attorney's fees, absent consent of the Board of Trustees.

In addition to its right to reimbursement, the Fund is fully subrogated to any and all rights of recovery and causes of action that you or your dependent may have against any other liable person or party. Therefore, the Fund may make a claim, bring any action, or assert any right against such other person or party to recover any benefits paid on you or your dependent's behalf by the Fund. You and your dependent agree to cooperate with the Fund to effect the Fund's subrogation rights, including repaying the Fund for its costs and expenses. You and your dependent are legally obligated to avoid doing anything that would prejudice the Fund's rights of reimbursement and subrogation, including settling any claim or lawsuit without the written consent of the Board of Trustees.

The Fund's right to reimbursement and subrogation will not be affected, reduced or eliminated by the make whole doctrine, the comparative fault doctrine, the regulatory diligence doctrine, the collateral source rule, the attorney fund doctrine, the common fund doctrine, or any other defenses or doctrines that may affect the Fund's recovery.

Your or your dependent's failure to comply with the repayment rules and cooperate with the Fund to recover from another responsible party or person may result in your and your dependent's disqualification from receipt of future benefits from the Fund. In addition, the Fund may offset any future benefits otherwise payable to you or your dependent with interest of 6% per annum until the outstanding benefit amounts are repaid. If the Fund prevails in a lawsuit to enforce its Reimbursement and Subrogation Agreement and/or these rules, the Fund shall be entitled to recover benefits paid on

your or your dependent's behalf, together with interest at 6% per annum plus costs and expenses, including reasonable attorneys' fees. Any amount recovered in excess of the Fund's recovery will be payable to you and your dependent.

Right of Recovery

If you receive incorrect payments from the Fund through error or misrepresentation, you will be notified of the error and the Fund Office will first attempt to collect these amounts from any providers who may have received payment. If the Fund Office is unable to collect these amounts from providers within thirty (30) days, you must make immediate repayment to the Fund upon request.

If you do not make repayment to the Fund within 30 days after a request for repayment has been made, the following penalties will apply:

- Interest will be added to the amount due at the rate of 6% per annum; and
- All claims with respect to you and your immediate family presented to the Fund for payment will be applied to the amount of repayment due from you, until the erroneous amount is paid in full. This will apply even if your benefits have been assigned and coverage certified to a provider by the Fund Office.
- The Fund may file suit against you to collect the amount due including interest. In the event suit is filed, you will also owe court costs and attorney's fees.

CLAIMS AND APPEALS

1. Filing Initial Claims

a. Claim Forms
Claim forms are available from the Fund Office. You can either call or write the Fund Office for claim forms. Be sure to tell the Fund Office what kind of claim you will be filing because different forms are used for medical, dental, vision and Weekly Accident and Sickness claims. You should submit a separate form for each family member.

b. Time for Filing Claims
You should file a written claim with the Fund Office within 90 days of incurring covered charges. Late claims are more difficult for the Fund Office to process. If you do not file your claim within 18 months of the date of service, your claim will not be accepted. However, this limitation will not apply if your claim is first submitted to Workers' Compensation as provided on page 79 or with another health plan or insurance company within 18 months and is promptly submitted to this Plan following a final determination by the other plan or Workers' Compensation.

c. What to File With Your Claim
Attach to your claim form all the itemized bills for the individual. The itemized bills should show:

- Your (Employee's) name;
- Your (Employee's) Social Security number;
- The patient's name;
- The doctor's name;
- The dates of treatment or purchase of equipment or supplies;
- The type of services (doctor's office visit, Hospital, lab tests, etc.);
- The charge made for each service;
- The condition for which the charge was incurred (the diagnosis); and
- If due to an injury, indicate how, when and where the injury occurred.

d. PPO Claims
If you use a PPO Provider, the PPO Provider will file the claim for you. If you do not use a PPO Provider, or if you want the Fund to pay the doctor or Hospital directly: You and your medical provider must complete the claim form in accordance with the instructions provided, and it must be filed, along with any appropriate attachments, with the Fund Office. Claim forms are available from the Fund Office.

e. Procedure For Work-Related Claims
Step 1. The Fund Office will not pay any claim for benefits where it reasonably appears that the claim is in connection with an injury, illness or disease for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.
Step 2. The Fund Office will immediately notify the Employee or Dependent of its decision under Step 1 above and recommend to the Employee or Dependent that he take immediate steps to protect his right to file

a claim under the appropriate Workers' Compensation statute or similar law. The Fund Office shall also notify the Employee or Dependent of his right to appeal the denial of benefits.

Step 3. In appeal cases, the Board of Trustees, if it denies the appeal, will again recommend that the Employee or Dependent take steps to protect his rights under the appropriate Workers' Compensation statute or similar law.

Step 4. If the Employee or Dependent files his claim under the appropriate Workers' Compensation statute or similar law and the claim is finally denied, the Board of Trustees, upon request of the Employee or Dependent, will again review this claim to see if the claim is payable under the rules in Step 1.

If any monies are accepted as a settlement in a Workers' Compensation case, even if Workers' Compensation denies any liability, the Fund will consider the illness or injury at issue to be work related, and therefore will not consider such claims for payment.

If Workers' Compensation has denied your initial claim for benefits of an illness or injury that may be work related, the Fund will pay Weekly Accident and Sickness Benefits. These benefits are subject to the subrogation provisions of the Plan (see "Benefits Paid Where A Third Party May Be Liable" on page 76).

2. Action on Claims

a. Applicable Definitions

As described below, the notification procedures following an initial benefit determination differ depending on whether your claim involves "urgent care," is a "pre-service claim," or is a "post-service claim." These and other important terms are defined in this subsection.

i. Urgent Care Claim

This is a claim which (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or (2) in the opinion of a physician with knowledge of your medical condition would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a physician with knowledge of your medical condition determines that your claim is

one involving urgent care, the Plan will treat your claim as an urgent care claim.

ii. Pre-service Claim
This is any claim with respect to which the terms of the Plan condition receipt of a benefit, in whole or part, on approval of the benefit in advance of obtaining medical care.

iii. Post-service Claim
This is any claim for a benefit that is not a pre-service claim. In this type of claim, you request reimbursement after medical care has already been rendered.

iv. Concurrent Care Claim
This is any claim to extend the course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can be either an urgent care claim, a pre-service claim, or a post-service claim.

v. Incomplete Claims
A claim will be deemed incomplete if you do not provide enough information for the Plan to determine whether and to what extent your claim is covered by the Plan. This includes your failure to communicate to a person who ordinarily handles benefit matters for the Fund your name, your specific medical conditions or symptom, and the specific treatment or service for which you request payment of benefits.

b. Notification of Initial Benefit Determination

i. Urgent Care Claims
The Fund will notify you whether your claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim, unless your claim is incomplete. The Fund will notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. The Fund may notify you orally, unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Fund will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information, or the end of the period within which you must provide the information.

ii. Pre-service Claims
The Fund will notify you whether your claim is approved or denied within a reasonable time, but not later than 15 days after receipt of your claim.

This period may be extended by one 15-day period, if circumstances beyond the control of the Fund require additional time to process your claim. If an extension is needed, the Fund will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund expects to reach a decision. If the Fund needs an extension because you have submitted an incomplete claim, the Fund will notify you of this within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The Fund may notify you orally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Fund sends you the notification of the extension until the date you respond to the request for additional information.

iii. Post-service Claims

The Fund will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Fund require that additional time is needed to process your claim. If an extension is needed, the Fund will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the Fund expects to reach a decision. If the Fund needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Fund sends you the notification of the extension until the date you respond to the request for additional information.

iv. Concurrent Care Claims

If the Fund has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund will notify you of its determination within 24 hours after receiving your claim, provided that the Fund receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a pre-service or post-service claim.

v. Weekly Sickness and Accident Benefit Claims
The Fund will decide claims for accident and sickness benefits within a reasonable time but not later than 45 days from the date of the receipt of the claim. The initial 45-day period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund if the Fund Office notifies you of the extensions prior to the expirations of the initial 45-day and first 30-day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. You have 45 days after receiving the extension notice to provide additional information or complete a claim. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Fund sends you the notification of the extension until the date you respond to the request for additional information.

vi. Life and Accidental Death and Dismemberment Claims
If your claim for benefits is denied, in whole or in part, the Fund claims payment office will provide you with a written or electronic notice within a reasonable time but not more than 90 days after your claim is received by the Fund Office. This 90-day period may be extended for up to an additional 90 days if special circumstances require that additional time is needed to process your claim. If an extension is needed for the Fund to process your claim, you will be given written notice of the delay prior to the expiration of the 90-day period stating the reason(s) why the extension is necessary and the date by which the Fund expects to make a decision.

c. Notice of Denial of Claim for Benefits
If any claim for benefits described above is denied, in whole or in part, the Fund (or an individual or entity acting on behalf of the Fund) will provide you with a written or electronic notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied

on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning an urgent care claim, the notice will also describe the shortened time frames for reviewing urgent care claims. In addition, in the case of an urgent care claim the notice may be provided to you orally, within the time frames described above. You will be provided with a written notice within 3 days of oral notification.

d. Your Right to Appeal

i. General

If your claim is denied, in whole or in part, you may request the Board of Trustees to review your benefit denial. If your claim involves medical or other health benefits or for Weekly Sickness and Accident Benefits, your written appeal must be submitted within 180 days of receiving the denial notice. In the case of a concurrent care claim only, the Fund will notify you at a time sufficiently in advance of the reduction or termination of treatment, which may be a period that is less than 180 days, to allow you to appeal and obtain review before the benefit is reduced or terminated. If your claim is for Accidental Death and Dismemberment Benefits, your appeal must be submitted within *60 days* of the denial. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Plan Administrator will be final and binding.

Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Fund did not have this information in making the initial determination. This does not mean that

you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Fund policy, determination or action. The Board of Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The review on appeal shall be made by the Board of Trustees, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The Board of Trustees deciding the appeal shall give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained by the Plan in connection with the adverse determination will be identified upon request.

Also, in case of an urgent care claim, you may request review orally or in writing, and communications between you and the Fund may be made by telephone, facsimile, or other similar means.

ii. Notification of Decision on Appeal

(1) Timing of Notification

(a) Urgent Care Claim

The Fund will notify you of its decision of an urgent care claim as soon as possible, but no later than 72 hours after it receives your request for review.

(b) Pre-Service Claim

The Fund will notify you of its determination of a pre-service claim within a reasonable period of time, but not later than 30 days after it receives your request for review.

(c) Other Claims

In all other cases, the Board of Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in

time to be heard at that meeting. If special circumstances require a further extension of time for review for the Board of Trustees, a benefit determination will be rendered not later than the third Board of Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Board of Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Board of Trustees after review by the Board of Trustees, within 5 days of their decision.

iii. Content of Notification

The Fund will provide you with written or electronic notice of its determination on review. The notice will set forth the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination, a statement of your right to bring a civil action under 502(a) of ERISA, and any voluntary dispute resolution option. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

3. Board of Trustees' Decision on Appeal is Final and Binding

The decision of the Board of Trustees on review shall be final and binding upon all parties including any person claiming a benefit on your behalf. The Board of Trustees has full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Board of Trustees denies your appeal of a claim, and you decide to seek judicial

review, the Board of Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

The Board of Trustees has full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits.

If the Board of Trustees denies your appeal of a claim or challenged policy, and you decide to seek judicial review, the Board of Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

4. General Information on Claims and Appeals

a. You may designate a representative to act on your behalf in filing a claim or an appeal of a denial of a claim or other adverse determination. If the Fund Office or Board of Trustees is uncertain whether or not you have designated a representative, either may request that you put such designation in writing and may decline to communicate with a third party claiming to be a representative until such written designation is received.

b. Both in determining initial claims and in deciding appeals, the Fund will make all determinations in accordance with the Plan document, policies and rules and will apply the Plan provisions consistently, to the extent reasonable, with respect to similarly situated claimants.

c. Throughout the procedures set forth above, there are several time limits within which a claimant must file a claim or appeal and within which the Fund or the Board of Trustees must issue a decision on such claim or appeal. The Fund or the Board of Trustees may agree to extend the time limits within which the claimant must file and the claimant may agree to extend any time limit within which the Fund or the Board of Trustees must issue a decision. The agreement to extend a time limit must be knowing, explicit, and confirmed in writing before the time period in question expires.

OTHER INFORMATION

Facts You Should Know About Your Rights

As a participant in the Asbestos Workers Local 24 Medical Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan administrator's office and at other specified 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 Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people

who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If 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.

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, 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 Employee Benefits Security Administration.

The Trustees shall have the right to terminate, suspend, amend or modify the Plan in whole or in part at any time.

PRIVACY PRACTICES

This Section Describes How Medical Information about You May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it Carefully.

This Section describes how the Asbestos Workers Local 24 Medical Fund can use and disclose your Protected Health Information. Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Plan which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. In general, the Fund may not use or disclose your PHI unless you consent to or authorize the use or disclosure, or if the Privacy Rules specifically allow the use or disclosure.

Use or Disclosure of PHI

1. The Fund may use or disclose your PHI for treatment, payment or health care operations without your written authorization:

    - "Payment" generally means the activities of a Fund to collect premiums, to fulfill its coverage responsibilities, and to provide benefits under the Plan, and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing and collection, making claims for stop-loss insurance, determining medical necessity and performing utilization review. For example, the Fund will disclose the minimum necessary PHI to medical service providers for the purposes of payment.
    - "Health Care Operations" are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run its business and to support the core functions of treatment and payment. For example, the Fund may disclose the minimum necessary PHI to the Fund's attorney, auditor, actuary, and consultant(s) when these professionals perform services for the Fund that requires them to use PHI. Persons who perform services for the Fund are called "business associates." Federal law requires the Fund to have written contracts with its business associates before it shares PHI with them, and the disclosure of your PHI must be consistent with the Fund's contract with them. Other examples of business associates are the Fund's stop-loss insurance carrier,

claims repricing services, utilization review companies, prescription benefit managers, PPOs and HMOs.

- "Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. The Fund is not directly involved in treatment activities.

2. The Fund is permitted or required to use or disclose your PHI without your written authorization for the following purposes and in the following circumstances, as limited by law:

   - The Fund will use or disclose your PHI to the extent it is required by law to do so.
   - The Fund may disclose your PHI to a public health authority for certain public health activities, such as: (1) reporting of a disease or injury, or births and deaths, (2) conducting public health surveillance, investigations, or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality, safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an employer about a member of its workforce, for the purpose of workplace medical surveillance or the evaluation of work-related illness and injuries, but only to the extent the employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or State law requirements having a similar purpose.
   - The Fund may disclose your PHI to the appropriate government authority if the Fund reasonably believes that you are a victim of abuse, neglect or domestic violence.
   - The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law, including: (1) audits; (2) civil, administrative, or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative, or criminal proceedings or actions; and (6) other activities.

- The Fund may disclose your PHI in the course of any judicial or administrative proceeding in response to an order by a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process.
- The Fund may disclose your PHI for a law enforcement purpose to law enforcement officials. Such purposes include disclosures required by law, or in compliance with a court order or subpoena, grand jury subpoena, or administrative request.
- The Fund may disclose your PHI in response to a law enforcement official's request, for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- The Fund may disclose your PHI if you are the victim of a crime and you agree to the disclosure or, if the Fund is unable to obtain your consent because of incapacity or emergency, and law enforcement demonstrates a need for the disclosure and/or the Fund determines in its professional judgment that such disclosure is in your best interest.
- The Fund may disclose your PHI to law enforcement officials to inform them of your death, if the Fund believes your death may have resulted from criminal conduct.
- The Fund may disclose PHI to law enforcement officials that it believes is evidence that a crime occurred on the premises of the Fund.
- The Fund may disclose your PHI to a coroner or medical examiner for identification purposes. The Fund may disclose your PHI to a funeral director to carry out his or her duties upon your death or before and in reasonable anticipation of your death.
- The Fund may disclose your PHI to organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.
- The Fund may use or disclose your PHI for research purposes, if the Fund obtains one of the following: (1) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.
- The Fund may use or disclose your PHI to avoid a serious threat to the health or safety to you or others.

- The Fund may disclose your PHI if you are in the Armed Forces and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities.
- The Fund may disclose your PHI to a correctional institution where you are being held.
- The Fund may disclose your PHI in emergencies or after you provide verbal consent under certain circumstances.
- The Fund may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

3. The Fund may use or disclose your PHI to you, to your Personal Representative, to a third party (such as your Spouse) pursuant to an Authorization Form, and to the Board of Trustees of the Fund but only for the purposes and to the extent specified in the Plan:

   - The Fund will provide you with access to your PHI. *The Fund will first require you to complete and execute a "Request for Protected Health Information Form" and will provide you with access to PHI consistent with the Request Form, or as otherwise required by law.*
   - The Fund may provide your Personal Representative or Attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your Personal Representative or lawyer has authority under applicable law to act on your behalf.
   - Unless otherwise permitted by law, the Fund will not use or disclose your PHI to someone other than you unless you sign and execute an "Authorization Form." You can revoke an Authorization Form at any time by submitting a "Cancellation of Authorization Form" to the Fund. The Cancellation of Authorization Form revokes the Authorization Form on the date it is received by the Fund.
   - The Fund will disclose your PHI to the Fund's Board of Trustees only in accordance with the provisions of the Fund's Privacy Policy and the provisions of the Plan.

Individual Rights

You have certain important rights with respect to your PHI. You should contact the Fund's Privacy Officer, identified below, to exercise these rights.

- You have a right to request that the Fund restrict use or disclosure of your PHI to carry out payment or health care operations. The Fund is not required to agree to a requested restriction.
- You have a right to receive confidential communications about your PHI from the Fund by alternative means or at alternative locations, if you submit a written request to the Fund in which you clearly state that the disclosure of all or part of that information could endanger you.
- You have a right to inspect and copy your PHI that is maintained by the Fund in a "designated record set." A "designated record set" consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Fund in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Fund, or (2) decisions that the Fund makes about you. The Fund may charge a reasonable fee for the cost of copies.
- You have a right to amend your PHI that was created by the Fund and that is maintained by the Fund in a designated record set, if you submit a written request to the Fund in which you provide reasons for the amendment. If the Fund declines your request to amend your PHI, the Fund will tell you why within 60 days.
- You have a right to receive an accounting of disclosures of your PHI, with certain exceptions, if you submit a written request to the Fund. The Fund need not account for disclosures that were made more than six years before the date on which you submit your request, nor any disclosures that were made for treatment, payment or health care operations. We may charge a reasonable fee for covering costs to fulfill more than one request within a 12-month period.

Duties of the Fund

The Fund has the following obligations:

- The Fund is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. To obtain a copy of the Fund's entire Privacy Policy, you should contact the Fund's Privacy Officer, identified below.
- The Fund is required to abide by the terms of the Notice that is currently in effect.
- The Fund will provide a paper copy of this Notice to you upon request.
- The Fund will notify you if a breach of your PHI occurs, as required under HIPAA or other applicable law.

Changes to Notice

- The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains, regardless of whether the PHI was created or received by the Fund prior to issuing the revised Notice.
- Whenever there is a material change to the Fund's uses and disclosures of PHI, individual rights, the duties of the Fund, or other privacy practices stated in this Notice, the Fund will promptly revise and distribute the new Notice to participants and beneficiaries.

Contacts and Complaints

If you believe your privacy rights have been violated, you may file a written complaint with the Fund's Privacy Officer at the following address:

Privacy Officer
Asbestos Workers Local 24 Medical Fund
7130 Columbia Gateway Drive
Suite A
Columbia, MD 21046

You may also submit a complaint with the U.S. Secretary of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. The Fund will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for filing a complaint.

For More Information About Privacy

If you want more information about the Fund's policies and procedures regarding privacy of PHI, contact the Fund's Privacy Officer at the address above.

More Important Facts

Plan Sponsor and EIN

The Internal Revenue Service assigns an Employer Identification Number (EIN) to organizations sponsoring benefit plans. The Board of Trustees is the sponsor of our Plan. Its EIN is 77-0649935. The Plan Number (PN) is 501.

Type of Plan

Under federal law, the Medical Fund is a welfare benefit plan providing medical, dental, vision, disability and death benefits.

Recordkeeping Year

All records for this Plan are kept on a Plan Year basis. The Plan Year starts on July 1, and ends on June 30.

Legal Process

Service for legal process may be delivered to the:

Account Executive, Carday Associates, Inc.
7130 Columbia Gateway Drive
Suite A
Columbia, MD 21046

Service of legal process may also be made upon a Plan Trustee or the Plan Administrator.

For Further Information Contact:

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND
7130 Columbia Gateway Drive
Suite A
Columbia, MD 21046
410.872.9500

This booklet has been prepared for your use as a convenient reference.

Notice of Nondiscrimination and Accessibility

The Asbestos Workers Local 24 Medical Fund ("Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fund:

- 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 the Fund's civil rights coordinator, Amanda Christie, at the number or address below.

If you believe that the Fund 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: Amanda Christie, Civil Rights Coordinator, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046, 410.872.9500, 410.872.1275 (fax), achristie@cardayassociates.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Amanda Christie, 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, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-410.872.9500.

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 1-410.872.9500。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.410.872.9500 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.410.872.9500.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.410.872.9500.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.410.872.9500.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.410.872.9500.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ ነ.410.872.9500.

Dè dẹ nià kɛ dyédẹ́ gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dọ̀ po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá 1-410.872.9500

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1.410.872.9500.
AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1.410.872.9500.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں . 1.410.872.9500

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-410.872.9500 تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-410.872.9500.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-410.872.9500.

BOARD OF TRUSTEES

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