Summary Plan Description

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Effective March 1, 2012

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

Lino Cressotti, Chairman
Brian Cavey
Robert McCourt

Employer Trustees

R. Steve Shegogue, Secretary
Alan "Skip" Stortzum
Rick Schmid

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Life Insurance and AD&D
AIG Benefit Solutions
Tampa Solutions Center
3501 Frontage Road
Tampa, Florida 33607-1704
Policy # 492F94

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

(866) 282-8503 – Customer Care

www.caremark.com

PPO
CareFirst BlueCross BlueShield
P.O. Box 10104
Fairfax, VA 22038-8004
MD, DC or Northern Va: 1-800-235-5160
All Other Areas: 1-888-444-8115

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TABLE OF CONTENTS

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, as necessary to hear appeals and oversee the operation of the Fund. The Board of Trustees, in turn, 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 report on forms provided monthly 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 safety and investment return 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 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 12 - 17 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 Employer to make contributions to this Fund on his 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 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 which 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.

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), except that for periods prior to July 1, 2014, a child age 19 or older will not be covered if he or she is eligible for employer-sponsored coverage or for coverage under his or her spouses' employer-sponsored plan.
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 or separation. You are required to notify the Fund immediately if you become divorced or legally separated. If you fail to notify the Fund, and your former spouse uses services that are covered by the Fund, that 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 19, 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 23 and 30.

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	Max - 26 wks
Mechanics – 1st 4 Weeks	$350
5th Through 26th Weeks	$380
Apprentices – 1st 4 Weeks	$220
5th Through 26th Weeks	$250
Supplemental Workers Compensation Benefit	Max - 52 wks
Maryland	$75
Virginia	$115
West Virginia	$50
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 $4000	
Percentage Paid by Plan	100%
Percentage Paid by Employee	0%
$4,000 to $8,000	
Percentage Paid by Plan	80%
Percentage Paid by Employee	20%
Maximum Benefit Paid by Annual Plan - Calendar Year	$8,000
LIFETIME PLAN	
Deductible	ANNUAL PLAN
Paid by Plan (Percentage of UCR)	100%
MAXIMUM ANNUAL BENEFIT	
July 1, 2011 – June 30, 2012	$750,000
July 1, 2012 – June 30, 2013	$1,250,000
July 1, 2013 – June 30, 2014	$2,000,000
July 1, 2014 and thereafter	Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, pages 38 and 39. Otherwise, all percentages are of Usual, Customary and Reasonable (UCR) charges. *See,* page 43.

Prescription, Dental, Vision and Hearing Aid Benefits are as provided beginning on pages 55, 58, 62 and 64.

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 32) or to those participants and Dependents covered by the newly organized employee/newly indentured apprentice schedule of benefits. *See,* page 26.

EMPLOYEES IN HA MAT 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 Annual Benefit	
July 1, 2011 – June 30, 2012	$750,000
July 1, 2012 – June 30, 2013	$1,250,000
July 1, 2013 – June 30, 2014	$2,000,000
July 1, 2014 and thereafter	Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, page 38. Otherwise, all percentages are percentages of PPO or UCR charges.

Prescription Drug and Hearing Aid Benefits are as provided on pages 55 and 64.

Dental Benefits (*see,* page 58), Vision Benefits (*see,* page 62), Weekly Accident and Sickness Benefits (*see,* page 41), Annual Physical Benefits (*see,* page 43) and the Death Benefits and Accidental Death and Dismemberment Benefits (*see*, page 64) 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.

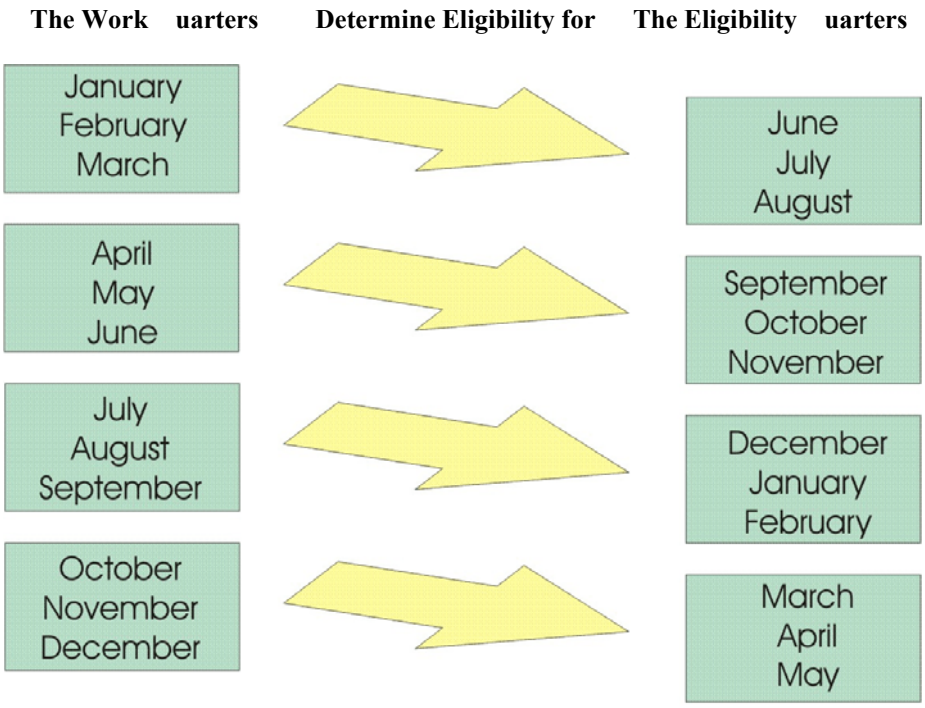
During the *ork uarter* you establish your *eligibility* for benefits in a later time period, known as an *Eligibility uarter*. A Work Quarter is a period of three months for which contributions are made to the Fund on your behalf. The hours for each Work Quarter are the hours worked in the payroll periods which 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 uarters 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.

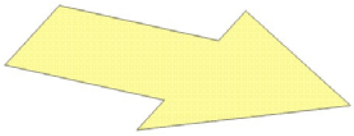
Initial Eligibility

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. *he 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 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 which 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 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 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 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 get it back again 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. *he payment is due within 1 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.
- You must remain a resident in Local 24's area. (Exception: If you find it necessary to accept employment in a non-participating local area you may pay contributions until recalled to your Home Local Union area for available employment. Failure to return will cause contributions to be refused.)
- 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 uarter.*
- You may also make payment of contributions under the following condition, provided you are in compliance with the above rules. In the event you have not had at least 800 hours reported and paid for you by your Employer during two consecutive Work Quarters, but you have had at least 500 hours during such period, you may elect to pay the difference between hours worked 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 16) or under these alternative "COBRA" rules. Also, if you are a new Retiree who is eligible for Retiree Health Benefits (*see,* page 30), 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 23 and for Retirees on page 35.

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 7); 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 30 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.

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 Hospitali ed 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 9 and 26, 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 Local Union 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 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, Employment Standards Administration.

EMPLOYEES IN NEWLY ORGANI ED GROUPS AND NEWLY INDENTURED APPRENTICES

COMPREHENSIVE PLAN SCHEDULE OF BENEFITS FOR EMPLOYEES IN NEWLY ORGANI ED 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 July 1, 2011 – June 30, 2012 July 1, 2012 – June 30, 2013 July 1, 2013 – June 30, 2014 July 1, 2014 and thereafter	 $750,000 $1,250,000 $2,000,000 Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, page 38. Otherwise, all percentages are percentages of PPO or UCR charges.

Prescription Drug, Dental, Vision and Hearing Aid Benefits are as provided on pages 55, 58, 62 and 64.

The Weekly Accident and Sickness Benefits (*see,* page 41), Annual Physical Benefits (*see,* page 43) and the Death Benefits and Accidental Death and Dismemberment Benefits (*see*, page 64) 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 43) when you meet the regular Initial Eligibility Rules of the Plan as described on page 13.

Which Employees ualify 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 maintained 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 13, 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 13, 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 13.

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.

Preexisting Condition Exclusion

If your benefits are provided under this Section, the Fund will not cover preexisting conditions for a period of up to one year. This means that if you have a medical condition before earning eligibility under this Section, you might have to wait a certain period of time before the Fund will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before the first day of the month in which you first work (and your employer contributes for) sufficient hours to earn eligibility under this Section. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from the first day of the month in which you first work (and your employer contributes for) sufficient hours to earn eligibility under this Section. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should provide the Fund Office with a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact the Fund Office if you need help demonstrating creditable coverage, or if you have any other questions about the preexisting condition exclusion and creditable 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 13, 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 16 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 13. The only exception is if you lose eligibility because of service in the Armed Forces (*see,* page 16).

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 16, the coverage continuation rules for disabled employees described on page 22, and the surviving Dependent coverage rules described on page 23 do not apply. However, the Alternative Self-Payment Rules (COBRA) described on page 19 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. *he rustees 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. Both Retirees eligible for Medicare and those not eligible for Medicare can qualify for this benefit.
The amount of the Death Benefit for retirees is $5,500. However, if you become Totally and Permanently Disabled, as determined by the Social Security Administration, while you are 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 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 69. (Note that you are *not* required 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.

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 $4,000 - $8,000 Percentage Paid by Plan Percentage Paid by Retiree Maximum Major Medical Benefit Paid by Plan - Calendar Year	 100% 0% 80% 20% $8,000
LIFETIME PLAN	
Deductible	ANNUAL PLAN
Paid by Plan (Percentage of UCR)	100%
MAXIMUM ANNUAL BENEFIT July 1, 2011 – June 30, 2012 July 1, 2012 – June 30, 2013 July 1, 2013 – June 30, 2014 July 1, 2014 and thereafter	 $750,000 $1,250,000 $2,000,000 Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, page 38. Otherwise, all percentages are percentages of Usual, Customary and Reasonable (UCR) charges. *See,* page 43.

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 maternity, Weekly Accident and Sickness Benefits and Annual Physical Benefits. The Plan provides Prescription Drug, Dental, Vision and Hearing Aid Benefits as described on pages 55, 58, 62 and 64.

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 36.

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 of an Eligible Employee who dies while he 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 he had stopped working on the date of his 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. 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,* p. 17. 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 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 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 will become eligible for the reduced premium upon reaching age 55, provided he 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 35.)

PREFERRED PROVIDER ORGANI ATION (PPO)

The Fund has implemented a regional PPO through CareFirst PPO which covers most areas of the Fund. The Trustees have selected the CareFirst PPO as a way to help hold the line on medical costs. A PPO is a network of physicians and Hospitals who 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, CareFirst may be contacted at the following toll-free numbers:

CareFirst BlueCross BlueShield
P.O. Box 10104
Fairfax, VA 22038-8004
Maryland, DC or Northern Virginia: 1-800-235-5160
All Other Areas: 1-888-444-8115

Current provider information is also accessible through the CareFirst website on the Internet at: http://www.carefirst.com. This website has a list of providers. You also have the right to request and receive, free of charge, a paper copy of this list.

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 CareFirst PPO Service Area; or
3. When you or your Dependent require medical service while traveling outside the CareFirst 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 CareFirst 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 contract with CareFirst PPO. To determine whether a provider participates, contact CareFirst PPO member services at the number listed earlier in this book. The CareFirst PPO participating providers may be revised as necessary.

2. PPO Service Area - The postal zip code areas identified by Alliance as being in the Alliance Service area. If your residence is more than 25 miles from the CareFirst PPO Service Area, you will not be penalized for using a non-participating provider; if you do live within 25 miles of the CareFirst 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.

VOLUNTARY PRE-CERTIFICATION/ UTILI ATION REVIEW

The Board has retained American Health Holdings to provide Voluntary Precertification/Utilization Review and Case Management services. The services provided by American Health Holdings 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 American Health Holdings 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).

American Health Holdings 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 American Health Holdings is 800-641-5566.

Case Management

You do not need to do anything to initiate this program. If you are treated for any of a number of different conditions, such as diabetes, certain types of cancer, chemical dependency, and many more, you may be selected American Health Holdings 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.

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 70).

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 9.

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 separated by less than two (2) weeks of active work on full time will be considered one period of disability unless the subsequent disability is due to an injury or illness entirely unrelated to the causes of the previous disability.

WORKERS COMPENSATION SUPPLEMENT

The Workers' Compensation Supplement is available to participants when a job related injury occurs within the jurisdiction of Local 24. The weekly benefit is $75 for those participants receiving Maryland Workers' Compensation benefits, $115 for those receiving Virginia Workers' Compensation benefits, and $50 for those receiving West Virginia Workers' Compensation benefits. This benefit will last as long as the Workers' Compensation benefits, but in no event longer than fifty-two (52) weeks per lifetime. There is no benefit supplement for those receiving Workers' Compensation from the District of Columbia. In the event of a contested Workers' Compensation case, participants may qualify for a $100 weekly benefit until the case is decided. If Workers' Compensation finally pays, you must reimburse the Fund what you would not have received if Workers' Compensation had paid timely.

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. However, maternity benefits are available only for Eligible Employees and their Spouses.

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 Medicode 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 for other than alcohol and chemical dependency disorders as follows:

100% of UCR up to	$ 4,000
80% of UCR up to	$ 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 of Free Standing Ambulatory Surgical Association 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 only to you or your Spouse (while you are eligible).

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.

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. Injury, illness or disease for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.
2. Eye glasses, eye re-fractions, and the fitting of eye glasses.
3. Injuries caused by declared or undeclared war.
4. Plastic surgery except when the operation is performed to correct deformities resulting from injury or sickness or such congenital defects which interfere with function; however expenses for treatment of medical complications arising from cosmetic treatment will be covered.
5. Charges for medical 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.
6. An expense which would not be incurred except for the existence of insurance.
7. Services rendered without charge.
8. Charges for medical 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.
9. Dental services, including dental x-rays, except for accidental injuries, osseous surgery and TMJ treatment subject to the limits of the Plan.
10. 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 Health Care Financing Administration; and
    e. It is not furnished in connection with medical or other research.
11. Services, treatment, drugs and supplies which are experimental or investigational in nature, including any services, treatment drugs or supplies which 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.

12. Charges in excess of the Usual, Customary and Reasonable Charge as defined in this Plan.
13. 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.
14. Charges for education, training, and bed and board while you or your Dependent are confined in an institution which 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.
15. Charges for custodial care.
16. Charges in excess of the most prevalent semi-private Hospital rate except as specifically provided by this Plan.
17. Charges for reversals of tubal ligations and vasectomies.
18. Transsexual surgery.
19. Radial keratotomy, lasix or other laser eye surgery.
20. Acupuncture, unless performed by a Physician.
21. Occupational therapy or rehabilitation, except following illness or injury.
22. Services provided or paid for by any other group health plan sponsored by an employer.
23. Charges for treatment of intentionally self-inflicted injury (other than those that result from mental illness), or injury sustained in the act of committing a crime.
24. Charges for dietary control.
25. Services or supplies not specifically listed as a covered service.
26. Non-legend drugs.
27. Vitamins (except prescription prenatal vitamins), minerals, dietary supplements, dietary drugs, etc.
28. Medications which can be legally purchased over the counter without a prescription, even if prescribed by a doctor.
29. Therapeutic devices or appliances.
30. Hypodermic needles or syringes (except those associates with insulin injections).
31. Any medication to promote hair growth.
32. Genetically engineered drugs.
33. Anabolic steroids.
34. Diet Aids.
35. Fluoride.
36. Charges in excess of the limits provided by the Plan.

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. Viagra (or similar drug) is limited to eight (8) pills per month.
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 43)
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 which 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 which exceed Plan limits or maximums will not be paid under this provision.

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.

*See page 57 for an explanation of the Maintenance Prescription Drug Program, which provides a 90-day supply for a reduced copayment.

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.

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. ***ertain non for ulary brand na e drugs are not covered by are ar*** In order to use your prescription card to receive these drugs, ***you ust use are ar s preauthori ation progra*** For more information, contact the CVS/Caremark at (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.

Limitations and Exclusions

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

- Medications that can be legally purchased over the counter without a prescription, even if prescribed by a doctor.
- 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.
- 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.
- Viagra (or similar erectile dysfunction drugs) is limited to eight (8) pills per month.

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 17 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.

[*]Dental benefits are not provided to Employees, or their dependents, who receive NOG Coverage (*see* page 26) or HazMat Coverage (*see* page 11*).*

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, 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:

- 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 which the Employee or Dependent incurs no charge.
- Dental services for which coverage is available to the Employee or Dependent, in whole or in part, under any Workers' Compensation Law or similar legislation whether or not the Employee Dependent claims compensation or receives benefits thereunder.
- 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.
- Services not specifically listed.
- 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

Vision benefits covered include professional fees, materials, lenses and frames. The maximum allowance for all benefits is $250 per Employee, Retiree and covered Dependent per calendar year, except that coverage for dependent children age 17 and under are not subject to an annual maximum benefit. Professional fees, materials and lenses are available once each calendar year, if necessary. Frames or contact lenses are available every other calendar year.

* Vision benefits are not provided to Employees, or their dependents, who receive NOG Coverage (*see* page 26) or HazMat Coverage (*see* page 11*).*

Benefits Covered

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

Exclusions

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

- 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 for which the Employee, Retiree or Dependent incurs no charge.
- Vision services for which coverage is available to the Employee, Retiree or Dependent, in whole or in part, under any Workers' Compensation Law or similar legislation whether or not the Employee or Dependent claims compensation or receives benefits thereunder.
- 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.
- Services not specifically listed.
- 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 ACCIDENAL DEATH AND DISMEMBERMENT BENEFITS

Who is Covered

All Eligible Employees and Retirees who have satisfied the eligibility requirements are covered by the basic death benefit. See page 30 for a description of the eligibility requirements for Retiree Death Benefits. All Eligible Employees are covered by the accidental death and dismemberment benefit program. These benefits are provided through a contract with AIG Benefit Solutions.

Amount of Death Benefits

In the event of your death while eligible for benefits from the Fund, your designated beneficiary will receive the basic death benefit. If you are an Eligible Employee and your death is caused by an accident on or off the job (and occurs within 90 days of the accident, or within one year of the accident if you are continuously hospitalized during that period as a result of the accident), the Fund will pay an additional accidental death benefit.

	Benefit
Basic Death Benefit Active Employees Retirees	 $15,000 $ 5,500
Accidental Death	$65,000*

* Active Employees only.

Dismemberment Benefits[*]

The following benefits are paid if you suffer an accidental loss *while on or off the ob* and within 90 days of the accident. Benefits are paid if the loss is after 90 days of the accident only if the delay was a result of medical efforts to save the member.

Accidental Loss	**Benefit**
Loss of both hands, both feet or sight in both eyes	$20,000
Loss of one hand and one foot	$20,000
Loss of either hand or foot and irrecoverable loss of sight in one eye	$20,000
Loss of either hand or foot or irrecoverable loss of sight in one eye	$10,000

The total payment for all losses due to any one accident will not be more than the full amount of Dismemberment Benefits. A hand or foot will be lost for purposes of this benefit if a portion of the hand or foot has been severed and the Employee has lost the use of the hand or foot for purposes of employment covered by this Fund.

Beneficiary

The Fund will pay death benefits according to the most recent beneficiary designation form which is received in the Fund Office prior to your death. You may change your beneficiary at any time. To change beneficiaries, contact the Fund Office. The Fund Office will give you the form needed to make the change. You may also change your beneficiary designation by letter or other document signed by you which is witnessed by two (2) disinterested persons. You may name more than one beneficiary. If your marital status or the number of your Dependents 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 will terminate. If there is no designated beneficiary on file, your death benefit will be paid to the following, in order, if living:

1. Your Spouse
2. Your children (equal shares)
3. Your parents (equal shares)
4. Your brothers and sisters (equal shares)

[*] Active Employees only.

5. Your Estate.

If any beneficiary is, in the opinion of the Fund Office, legally incapable of giving a valid receipt for any payment due him or her, the Fund reserves the right to make payment in monthly installments not exceeding $100 to the person or persons, or institution, who in its opinion, has been caring for or supporting the beneficiary, until claim is made for the remainder by a duly appointed guardian or committee of the beneficiary.

If any beneficiary is a minor, the Fund may pay benefits due to the minor to the person having present custody or care of the minor and with whom the minor resides. The recipient on behalf of the minor must agree in writing to apply the payments solely for the minor's support. The Fund may also make any payments of benefits to a minor by depositing the payments in a federally insured savings account in the sole name of the minor. The Fund may also make payments due to a minor in monthly installments as described above.

Payment made as described in this section will discharge the Fund from any liability to the beneficiary or anyone representing his or her interests.

Exclusions

The accidental death and dismemberment benefit does not cover the following:

- A loss that occurs more than 90 days after the accident.
- A loss resulting from declared or undeclared war or any act of war or armed aggression.
- A loss resulting from intentionally self-inflicted injury or injury sustained in the act of committing a crime.
- A loss from bodily or mental infirmity or disease.
- A loss resulting from an infection other than a pyogenic infection of an accidental cut or wound.
- A loss resulting from travel in any moving aircraft aboard which you are giving or receiving any training or have any duties.
- A loss payable to a beneficiary who willfully causes the loss.

Total and Permanent Disability

If you become totally and permanently disabled while eligible and before age 60, your Death Benefit (but not Accidental Death and Dismemberment Benefits) will remain in force as long as you remain so disabled, provided proof of disability is furnished as

required. 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 Medical Plan:

- Injury, illness or disease for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.
- 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 without 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.

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).
- 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

f you are a Retiree, an inactive disabled ployee 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. ***he Fund will pay benefits as if you have both Medicare Part A and Part B benefits whether you are signed up for the or not o have adequate coverage, you and your pouse ust sign up for both Medicare Part A and Part B when eligible ou do not need to enroll in Medicare Part D Prescription Drug nsurance***

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 WHERE A THIRD PARTY MAY BE LIABLE

The Fund will pay covered benefits if you or your Dependent are injured by, become ill or die through the fault of another party either directly or indirectly. If you or someone else should recover damages from an insurance company or from the other party (for example, in a lawsuit), then you or the person recovering must reimburse the Plan for payments it has made in connection with your or your Dependent's illness, injury or death. If another party may be liable for your or your Dependent's illness, injury or death, you or the person claiming a recovery from the third party, are required, as a condition of receiving benefits from the Fund, to sign a form acknowledging the Fund's subrogation interest under the terms of this Plan (Acknowledgment Form) and are required to protect the Fund's right to

reimbursement in the event of a recovery from a third party. Furthermore, the Fund may require your attorney to sign the form as well. The Fund's subrogation right is established by this Plan and not by the form. If the Fund pays benefits in such a case, the Fund's subrogation interest in any recovery is governed by the terms of the Plan whether or not you or someone acting on your behalf has signed the Acknowledgment Form.

The acceptance of benefits by an Employee or Dependent whose illness, injury or death may have been caused by another party ("Injured Person") or someone acting on his or her behalf is an agreement by the person accepting the benefits to reimburse the Fund for benefits paid up to the full amount of any recovery due to the illness, injury or death. By accepting benefits from the Fund, the Injured Person, or the person acting on his or her behalf, agrees that any amounts recovered due to the illness, injury or death, by judgment, settlement or compromise will be used first to reimburse the Fund. Amounts recovered which are in excess of benefits paid by the Fund are the separate property of the Injured Person or the person recovering. In addition, amounts received from a source other than the Fund are the separate property of the Injured Person if the amounts are received from an individual health insurance policy for which the Injured Person or a member of the Injured Person's family has paid premiums.

By accepting benefits from the Fund, the Injured Person or other person seeking a recovery agrees to notify the Fund promptly if suit is filed to recover amounts in connection with the illness, injury or death and agrees to notify the Fund promptly in the event the Injured Person or someone else receives payments from any source for claims related to the illness, injury or death. By accepting benefits from the Fund, the Injured Person or other person agrees that neither the Injured Person nor anyone seeking a recovery will settle any claim relating to the illness, injury or death without the written consent of the Fund.

In the event an Injured Person or other person accepts benefits from the Fund as a result of an illness, injury or death and amounts are recovered from claims arising from the illness, injury or death, the amounts recovered are assets of the Fund by virtue of the Fund's subrogation interest. These Fund assets may not be distributed without a written release from the Fund of its subrogation interest.

In the event monies are recovered and the Fund is not reimbursed to the extent of its subrogation interest under this provision, the Fund may bring suit against the Injured Person, a person acting on the Injured Person's behalf, insurers and any recipients of the Fund assets that were improperly distributed without the written consent of the Fund. The Fund may recover benefits paid on behalf of the Injured Person by treating

those benefits as an advance payment and deducting those amounts from benefits due or which later become due to the Injured Person and his or her immediate family until the Fund's subrogation interest is recovered. These benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage which the Fund may have given to those providers.

Please note that the Fund has a right to first reimbursement out of any recovery. By accepting benefits from the Fund, the Injured Person agrees that any amounts recovered by the Injured Person by means of judgment, settlement or compromise with a third party will be applied first to reimburse the Fund for the benefits it has paid. This obligation to reimburse the Fund will apply even if the injured party has not been made whole by means of amounts received from the third party.

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 74 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 70).

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 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 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 *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,

and a statement of your 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 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 Pension and Welfare Benefit 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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 typically 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. *he Fund will first require you to complete and e ecute a "Request for Protected ealth Information Form" and will provide you with access to P I 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 of access 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.
- 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.
- 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.

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.

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:

Claims Manager
Asbestos Workers Local 24 Medical Fund
7130 Columbia Gateway Drive
Suite A
Columbia, MD 21046

You may also file a complaint with the U.S. Secretary of Health and Human Services in Washington, DC. 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

The Medical Fund is classified with the U.S. Department of Labor as 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:

President, 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.

BOARD OF TRUSTEES

Union Trustees

Lino Cressotti
Heat and Frost Insulators and Allied Workers Local 24
901 Montgomery Street
Laurel, MD 20707

Brian Cavey
Heat and Frost Insulators and Allied Workers Local 24
901 Montgomery Street
Laurel, MD 20707

Robert McCourt
Heat and Frost Insulators and Allied Workers Local 24
901 Montgomery Street
Laurel, MD 20707

Employer Trustees

R. Steve Shegogue
TBN Associates
5050 Forbes Boulevard
Lanham, MD 20706

Rick Schmid
Advanced Specialty Contractors, LLC
7020 Troy Hill Dr.
Elkridge, MD 21075

Alan "Skip" Stortzum
Fain Padgett Insulation, Inc.
4931 Telsa Drive, Suite A
Bowie, MD 20715

September 2012

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Summary of Material Modification # 1

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund announces the following benefit changes:

I. Prescription Drug Coverage

Effective January 1, 2013, the Fund's pharmacy benefit manager, CVS/Caremark, has announced a change to its preferred products program. This change in coverage affects 50 medications - *a list of which is included with this notice.* CVS/Caremark has determined that more cost effective alternatives are available for each of these 50 excluded medications.

If you use one of these listed excluded medications, or if your doctor prescribes one of them to you after this change becomes effective, you will need to get prior authorization from CVS/Caremark in order to have it covered by the Fund. If your physician can show that the covered alternative medications would not be effective for you or would have undesirable side-effects, then CVS/Caremark will grant authorization for its continued coverage of the excluded medication by the Fund. If you choose to fill a prescription for one of these excluded medications without having received prior authorization, you will be charged the full price for the excluded drug.

CVS/Caremark is contacting all current participants and their physicians affected by this change to suggest alternative medications that are covered under the Plan. If you are taking one of the medications on the enclosed list, and you or your physician have not been contacted by CVS/Caremark, please contact CVS/Caremark at (866) 282-8503 to obtain information about available alternative medications that are covered under this Plan. If your physician believes there is a clinical reason why one of these covered alternatives will not work for you, he or she should call CVS/Caremark at (855) 240-0536 to request prior approval of your current drug(s).

As a reminder, the current prescription drug coverage is as follows:

	Co-payment for 30 day Supply	Co-payment for 90 day Supple (Mail Order or CVs Pharmacy)
Generic	$0.00	$0.00
Brand-Name Formulary	$20.00	$45.00
Brand-Name Covered Non-Formulary	$35.00	$75.00
Brand Name Non-Covered Non-Formulary	Full Cost	Full Cost

II. Eligibility for Reduced Retiree Premiums

Effective July 1, 2012, eligibility for Reduced Retiree Premiums has been modified to permit an employee under the age of 55 to qualify for Reduced Retiree Premiums if all other eligibility requirements are met and the employee has been determined to be totally and permanently disabled by Social Security.

III. Life Insurance Information

Effective July 1, 2012, Life Insurance Benefits are insured through:

AIG Benefit Solutions
Tampa Solutions Center
3501 Frontage Road
Tampa, FL 33607-1704
Policy # 492F94

As a reminder, the amount of life insurance (death benefit) provided by the Fund is:

	Benefit
Basic Death Benefit	
Active Employees	$15,000
Retirees	$ 5,500
Accidental Death (Actives Only)	$65,000

As an enhancement to this coverage, AIG is also offering Travel Guard Program benefits to Participants and beneficiaries of the Fund. A pamphlet detailing these benefits, along with a benefit card to maintain in your wallet is included as part of this Summary of Material Modification.

REMINDERS!!!

IV. Change in Marital Status

If you become divorced, 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, and your former spouse uses services that are covered by the Fund, that 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 18 of the Summary Plan Description, 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.

V. Medicare Reminder

Please remember, ***if you are a Retiree or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible***. Medicare is generally available to all individuals who are either disabled or age 65, and has three parts – Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Benefits (Part D). Part A covers inpatient Hospital care and generally is available at no cost. Part B covers doctors' services, outpatient hospital services and other medical supplies and requires a monthly premium. Part D covers prescription drugs and also requires a monthly premium. *If you are a Medicare-eligible Retiree or Dependent, you are required to sign up for Medicare Parts A and B, even though you will have to pay a premium for Part B.* **You are *not* required to sign up for Part D (Prescription Drug Coverage).** For a full explanation, *see* the Summary Plan Description, p.62 and the Annual Medicare Prescription Drug notice, or contact the Fund Office.

VI. Grandfathered Plan

The Trustees of the Asbestos Workers Local 24 Medical Fund 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 the Fund 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 telephone numbers listed below. 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 heath plans.

VII. Board of Trustees

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

Union Trustees

Lino Cressotti, Secretary
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Brian S. Cavey
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Robert S. McCourt
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Employer Trustees

Ronald S. Shegogue, Chairman
TBN Associates, Inc.
5050 Forbes Boulevard
Lanham, MD 20706

Rick Schmid
Advanced Specialty Contractors
7020 Troy Hill Dr., Suite E-F
Elkridge, MD 21705

Alan "Skip" Stortzum
Fain Padgett
4931 Telsa Drive, Suite A
Bowie, MD 20715

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you should have any questions about the coverage provided under the Asbestos Workers Local Union No. 24 Medical Fund, the Summary Plan Description or these changes, please contact the Fund Office.

Very truly yours,

The Board of Trustees

SPD 03/2012 SMM #1

Asbestos Workers Local 24 Medical Fund
Asbestos Workers Local 24 Pension Fund
7130 Columbia Gateway Drive, Suite A **(410) 872-9500**
Columbia, MD 21046 **(410) 872-1275 Fax**

September 2013

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Summary of Material Modification # 2

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund is pleased to announce the following changes and improvements, which are designed to make the Plan fully compliant with Health Care Reform and other recent changes in the law:

I. Enhanced Dental and Vision Benefits for Dependents

Effective August 1, 2013, dental benefits provided to children age 18 and under will no longer be subject to an annual cap of $2,000. Routine examinations will continue to be limited to two per year, and dental benefits are still subject to standard medical protocols and reasonable and customary limitations. Orthodontia will continue to be subject to the $1,500 lifetime maximum.

Also effective August 1, 2013, optical benefits provided to children age 18 and under will no longer be subject to the annual cap of $250. Optical benefits are still subject to standard medical protocols and reasonable and customary limitations.

II. Clarification of Vision Benefits

The section entitled "Benefit Schedule of Allowances" on page 62 of your Summary Plan Description is modified to read as follows:

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.

III. Benefits where a Third party May be Liable

Effective August 1, 2013, the section entitled "Benefits Where a Third Party May be Liable" on page 70 of your Summary Plan Description is replaced with the following:

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.

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 must be included in the 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 or were paid 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 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.

IV. Grandfathered Plan

The Trustees of the Asbestos Workers Local 24 Medical Fund 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 the Fund 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 telephone numbers listed below. 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.

REMINDERS!!!

Change in Marital Status

If you become divorced, 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, and your former spouse uses services that are covered by the Fund, that 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 18 of the Summary Plan Description, 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.

Medicare Reminder

Please remember, ***if you are a Retiree or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible***. Medicare is generally available to all individuals who are either disabled or age 65, and has three parts – Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Benefits (Part D). Part A covers inpatient Hospital care and generally is available at no cost. Part B covers doctors' services, outpatient hospital services and other medical supplies and requires a monthly premium. Part D covers prescription drugs and also requires a monthly premium. *If you are a Medicare-eligible Retiree or Dependent, you are required to sign up for Medicare Parts A and B, even though you will have to pay a premium for Part B*. **You are *not* required to sign up for Part D (Prescription Drug Coverage).** For a full explanation, *see* the Summary Plan Description, p.62 and the Annual Medicare Prescription Drug notice, or contact the Fund Office.

V. Board of Trustees

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

Union Trustees

Lino Cressotti, Secretary
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Brian S. Cavey
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Robert S. McCourt
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Employer Trustees

Ronald S. Shegogue, Chairman
TBN Associates, Inc.
5050 Forbes Boulevard
Lanham, MD 20706

Rick Schmid
Advanced Specialty Contractors
7020 Troy Hill Dr., Suite E-F
Elkridge, MD 21705

Scott Grant
Insul-Tech, Inc.
5300 Westview Dr., Suite 101
Frederick, MD 21703

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you should have any questions about the coverage provided under the Asbestos Workers Local Union No. 24 Medical Fund, the Summary Plan Description or these changes, please contact the Fund Office.

Very truly yours,

The Board of Trustees

SPD 04/12 SMM #2

Asbestos Workers Local 24 Medical Fund
Asbestos Workers Local 24 Pension Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(410) 872-1275 Fax

November 2013

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Summary of Material Modification # 3

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund announces the following benefit changes:

I. Prescription Drug Coverage

The Fund's pharmacy benefit manager, CVS/Caremark, has announced a change to its preferred products program. Effective January 1, 2014, 76 medications ***will no longer be covered by the Fund*** without prior authorization. A list complete list of the 76 medications is enclosed with this notice. CVS/Caremark has determined that more cost effective alternatives are available for each of these 76 excluded medications.

If you wish to continue using any of these listed excluded medications, or if your doctor prescribes any of them to you after this change becomes effective, you will need to get prior authorization from CVS/Caremark in order to have it covered by the Fund. If your physician can show that the covered alternative medications would not be effective for you or would have undesirable side effects, then CVS/Caremark will grant authorization for continued coverage of the excluded medication by the Fund. Prior Authorization can be sought by calling CVS/Caremark at 1-866-251-9383. If you choose to fill a prescription for one of these excluded medications without prior authorization, you will be charged the ***full price*** for the excluded drug.

CVS/Caremark is contacting all participants and their physicians who are known to be using any of the excluded drugs to suggest alternative medications that are covered under the Plan. If you are taking one of the medications on the enclosed list and you or your physician have not been contacted by CVS/Caremark, please contact CVS/Caremark at (866) 282-8503 to get information about covered alternative medications. If your physician believes there is a clinical reason why one of these covered alternatives will not work for you, he or she should call CVS/Caremark at (855) 240-0536 to request prior approval of your current drug(s).

As a reminder, the current prescription drug coverage is as follows:

	Co-payment for 30 day Supply	Co-payment for 90 day Supple (Mail Order or CVs Pharmacy)
Generic	$0.00	$0.00
Brand-Name Formulary	$20.00	$45.00
Brand-Name Covered Non-Formulary	$35.00	$75.00
Brand Name Non-Covered Non-Formulary	Full Cost	Full Cost

REMINDERS!!!

II. Dependent Coverage

Remember that, effective October 1, 2010, children of Employees continue to be covered by the Fund until they reach age twenty-six (26), unless they are eligible for Employer-sponsored coverage or for coverage under their spouses' employer-sponsored plan. Although this change was made to conform to the Healthcare Reform Laws, the Trustees made it effective nine months prior to the legally required date of July 1, 2011. Natural, adopted, step and foster children no longer have to remain unmarried or show they are dependent upon the Employee for support. "Children" also include other children who depend upon the Employee for support and who live with the Employee in a regular parent-child relationship. Except as otherwise provided in the Summary Plan Description, coverage for your Eligible Dependent child will end on the last day of the month in which the child turns age 26.

Each Covered Child or other dependent must be listed on a "Dependent Eligibility Form" signed by the Employee and filed with the Fund Office, along with evidence or proof of status satisfactory to the Trustees. Each change in Dependent enrollment after the initial enrollment must be submitted with evidence or proof of Child or other Dependent status satisfactory to the Trustees.

III. Change in Marital Status

If you become divorced, 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, your former spouse's continued use of Fund coverage after the date of the divorce 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 21 of the Summary Plan Description, 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.

IV. Medicare Reminder

Please remember, ***if you are a Retiree or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible***. Medicare is generally available to all individuals who are either disabled or age 65, and has three parts – Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Benefits (Part D). Part A covers inpatient Hospital care and generally is available at no cost. Part B covers doctors' services, outpatient hospital services and other medical supplies and requires a monthly premium. Part D covers prescription drugs and also requires a monthly premium. *If you are a Medicare-eligible Retiree or Dependent, you are required to sign up for Medicare Parts A and B, even though you will have to pay a premium for Part B.* **You are *not* required to sign up for Part D (Prescription Drug Coverage).** For a full explanation, *see* the Summary Plan Description, p. 70 and the Annual Medicare Prescription Drug notice, or contact the Fund Office.

V. Grandfathered Plan

The Trustees of the Asbestos Workers Local 24 Medical Fund 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 the Fund 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 telephone numbers listed below. 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.

VI. Prescription Drug Card Reimbursement – Reminder

Remember that your co-payments when you use your prescription drug card are reimbursable by the Plan up to $400 per person per year. Save your receipts and submit them to the Plan Office as you would any other claim.

VII. Board of Trustee

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

Union Trustees

Lino Cressotti, Secretary
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Brian S. Cavey
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Robert S. McCourt
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Employer Trustees

Ronald S. Shegogue, Chairman
TBN Associates, Inc.
5050 Forbes Boulevard
Lanham, MD 20706

Rick Schmid
Advanced Specialty Contractors
7020 Troy Hill Drive, Suite E-F
Elkridge, MD 21075

Scott Grant
Insul-Tech, Inc.
5300 Westview Drive, Suite 101
Frederick, MD 21703

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you should have any questions about the coverage provided under the Asbestos Workers Local Union No. 24 Medical Fund, the Summary Plan Description or these changes, please contact the Fund Office.

Very truly yours,

The Board of Trustees

CVS/Caremark Formulary Excluded Drugs

List of excluded drugs as of January 1, 2014		
1. ACTOS	27. HUMALIN 70/30	53. OXYTROL
2. ADVICOR	28. HUMALOG	54. PLAVIX
3. ALTOPREV	29. HUMALOG MIX 50/50	55. PREVACID
4. ALVESCO	30. HUMALOG MIX 75/25	56. PROTONIX
5. ANDROGEL	31. HUMULIN N	57.QNASL
6. ARTHROTEC	32. HUMULIN R	58. RAYOS
7. ASACOL HD	33. INTERMEZZO	59. RHONOCORT AQUA
8. ATACAND	34. JALYN	60. RIOMET
9. ATACAND HCT	35. KAZANO	61. ROZEREM
10. BECONASE AQ	36. KOMBIGLYZE XR	62. SAIZEN
11. BREEZE 2 STRIPS AND KITS	37. LASTACAFT	63. SANCTURA XR
12. BREO ELLIPTA	38. LESCOL XL	64. SUBOXONE FILM
13. CONTOUR NEXT STRIPS AND KITS	39. LEVITRA	65. TESTIM
14. CONTOUR STRIPS AND KITS	40. LIPITOR	66. TEVETEN
15. DELZICOL	41. LIPTRUZET	67. TEVETEN HCT
16. DETROL LA	42. LIVALO	68. TEV-TROPIN
17. DIOVAN HCT	43. LUMIGAN	69. TOVIAZ
18. DYMISTA	44. MAXAIR	70. TRICOR
19. EDARBI	45. NESINA	71. TUDORZA PRESSAIR
20. EDARBYCLOR	46. NUTROPIN / NUTROPIN AQ	72. VALTREX
21. FLECTOR	47. OLEPTRO	73. VENTOLIN HFA
22. FORTAMET	48. OLUX-E	74. VERAMYST
23. FREESTYLE STRIPS AND KITS	49. OMNARIS	75. XOPENEX HFA
24. GENOTROPIN	50. OMNITROPE	76. ZETONNA
25. GLUMETZA	51. ONGLYZA	
26. HECORIA	52. OSENI	

* Prior Authorization can be sought for the above listed medications by calling CVS/Caremark at 1-866-251-9383.

Asbestos Workers Local 24 Medical Fund
Asbestos Workers Local 24 Pension Fund
7130 Columbia Gateway Drive, Suite A **(410) 872-9500**
Columbia, MD 21046 **(410) 872-1275 Fax**

May 2014

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Summary of Material Modification # 4

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund announces the following benefit changes:

I. Eligibility for Weekly Accident & Sickness Benefits

Under the Fund's rules, you are entitled to Weekly Accident and Sickness Benefits for a maximum of twenty-six (26) weeks per period of disability as well as up to thirty-one (31) hours per week credited towards your continued eligibility for medical benefits for up to twenty-four (24) months per period of disability. *See* SPD pp. 22 and 42. For both purposes, 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.

II. Plan of Benefits Under Newly Organized Group and Newly Indentured Apprentice Rules

Effective July 1, 2014, the **"Preexisting Condition Exclusion"** under the rules for Newly Organized Groups and Newly Indentured Apprentices (see SPD page 28) is eliminated.

REMINDERS!!!

III. Dependent Coverage

Remember that, effective October 1, 2010, children of Employees continue to be covered by the Fund until they reach age twenty-six (26). For the period prior to July 1, 2014, coverage will not be provided to any children who are eligible for Employer-sponsored coverage or for coverage under their spouses' employer-sponsored plan. Although this change was made to conform to the Healthcare Reform Laws, the Trustees made it effective nine months prior to the legally required date of July 1, 2011. Natural, adopted, step and foster children no longer have to remain unmarried or show they are dependent upon the Employee for support. "Children" also include other children who depend upon the Employee for support and who live with the Employee in a regular parent-child relationship. Except as otherwise provided in the Summary Plan Description, coverage for your Eligible Dependent child will end on the last day of the month in which the child turns age 26.

Each Covered Child or other dependent must be listed on a "Dependent Eligibility Form" signed by the Employee and filed with the Fund Office, along with evidence or proof of status satisfactory to the Trustees. Each change in Dependent enrollment after the initial enrollment must be submitted with evidence or proof of Child or other Dependent status satisfactory to the Trustees.

IV. Change in Marital Status

If you become divorced, 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, your former spouse's continued use of Fund coverage after the date of the divorce 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 21 of the Summary Plan Description, 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.

V. Medicare Reminder

Please remember, ***if you are a Retiree or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible***. Medicare is generally available to all individuals who are either disabled or age 65, and has three parts – Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Benefits (Part D). Part A covers inpatient Hospital care and generally is available at no cost. Part B covers doctors' services, outpatient hospital services and other medical supplies and requires a monthly premium. Part D covers prescription drugs and also requires a monthly premium. *If you are a Medicare-eligible Retiree or Dependent, you are required to sign up for Medicare Parts A and B, even though you will have to pay a premium for Part B.* **You are *not* required to sign up for Part D (Prescription Drug Coverage).** For a full explanation, *see* the Summary Plan Description, p. 70 and the Annual Medicare Prescription Drug notice, or contact the Fund Office.

VI. Grandfathered Plan

The Trustees of the Asbestos Workers Local 24 Medical Fund 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 the Fund 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 telephone numbers listed below. 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.

VII. Prescription Drug Card Reimbursement – Reminder

Remember that your co-payments when you use your prescription drug card are reimbursable by the Plan up to $400 per person per year. Save your receipts and submit them to the Plan Office as you would any other claim.

VIII. Board of Trustee

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

Union Trustees

Lino Cressotti, Secretary
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Brian S. Cavey
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Robert S. McCourt
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Employer Trustees

Ronald S. Shegogue, Chairman
TBN Associates, Inc.
5050 Forbes Boulevard
Lanham, MD 20706

Rick Schmid
Advanced Specialty Contractors
7020 Troy Hill Drive, Suite E-F
Elkridge, MD 21705

Scott Grant
Insul-Tech, Inc.
5300 Westview Drive, Suite 101
Frederick, MD 21703

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you should have any questions about the coverage provided under the Asbestos Workers Local Union No. 24 Medical Fund, the Summary Plan Description or these changes, please contact the Fund Office.

Very truly yours,

The Board of Trustees

SPD 03/2012 SMM #4

May 2015

SUMMARY OF MATERIAL MODIFICATION # 5
IMPORTANT NOTICE

Dear Participant:

The Trustees of the Asbestos Workers Local 24 Medical Fund are pleased to announce that the Medical Fund is transitioning its Network services (currently with CareFirst BlueCross/BlueShield) **effective July 1, 2015**. This letter will introduce you to Cigna HealthCare and also answer some frequently asked participant questions.

The Trustees conducted a search to improve network access, enhance access to state-of-the-art programs and ensure that quality service would be provided to the participants and their families. At the same time, it was critical that the new vendor aggressively improve the network discounts and care management savings to ensure the Fundôs fiscal integrity during these very difficult times ï times that are challenging Health Funds throughout the country. This change to Cigna is a very positive one for everyone ï the participants, the Fund, the Union and the Employers.

This change from CareFirst BlueCross/BlueShield to Cigna HealthCare **does not affect the processing of your claims or your coverage in any way.**

Cigna HealthCare Network – A Vast Improvement in Network Access

The new Cigna OAP has in and out-of-network benefits just like our existing program. Under the new Cigna OAP program, you do not need a referral to see a specialist and you do not need to select a Primary Care Physician. The Cigna OAP has the same freedom of provider choice that our current PPO program has. In essence, the core features and the core benefits available today through our existing plan options will remain unchanged. However, the new Cigna program will provide you and your family with a number of enhancements to the current program, as outlined below.

The Cigna HealthCare OAP network provides seamless coverage throughout the United States. The switch will provide greater network access than our current PPO. To you, that means a greater chance of accessing in-network providers and therefore lowering your potential out-of-pocket amounts. To the Fund, Cigna's network will provide enhanced savings, which is also critical to maintaining the financial integrity of our program.

Between now and July 1, 2015, feel free to visit the Cigna HealthCare website at www.cignasharedadministration.com. Click on the óFind a Providerò tab, then click on the ñShared Administration OAP Directoryò link to determine if your provider is in the Cigna network. Also, you may contact Cigna beginning on July 1, 2015 at 1-(800) 768-4695 to find out if a specific provider is in the network.

If your doctor/provider is not in the Cigna network and you would like Cigna to reach out to your doctor(s), please fill out the attached nomination form and mail the completed form to the Fund Office at:

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

Phone Number: (410) 872-9500
Fax: (410) 872-1275

Additionally, the nomination form can be faxed to Cigna at (800) 657-3073. Once the form is received at CIGNA, you can expect a reply within 7 to 10 business days on the status of your request.

Medical Care Management Enhancements through The New CIGNA Program

The following additional member enhancements are available through the new Cigna program, via a Cigna subsidiary called CareAllies, the nationôs leading provider of member-friendly, effective care management programs. These programs are intended to improve your health, make the benefits program more convenient and easier to use, help you access the right level of care, and help the Fund control future claims expenses. These Cigna programs are available to you effective July 1, 2015.

24-Hour NurseLine: This program provides toll-free telephone access to medical care professionals 24-hours a day and 365-days a year. This voluntary, toll free line is perfect for new mothers with lots of questions, for parents looking for home care suggestions so that they can avoid a trip to the emergency room, for participants with questions on illnesses or health related news topics like how to treat the flu, treating a fever, etc. The telephone number for NurseLine is (800) 768-4695, and is available to you on and after July 1, 2015.

Maternity Management: Our participants now have access to a voluntary maternity management program that works to achieve a healthy outcome for both mother and baby. As part of this program, participants receive valuable prenatal guidance and are given access to a toll free 24-hour a day, 365-day a year answer line. A high-risk maternity screening is also conducted through this program and when necessary, maternity and prenatal care is subsequently coordinated and supported through a Cigna Case Management nurse to increase the likelihood of a healthy delivery for mother and baby. Participants should call (800) 768-4695 to access these services on or after July 1, 2015.

LifeSource Organ Transplant Program: Should a covered participant need an organ transplant, our program through Cigna now provides access to a voluntary Centers of Excellence program.

Through this program, care coordination will be provided into transplant centers of excellence across the country and case management will be provided to the participant and their family. Should you wish to access this program, please contact the Fund Office at 410-872-9500.

MyCareAllies.com: There are several other unique services available to Fund participants through the https://new.mycareallies.com website, a component of our care management program, which we strongly encourage you to utilize. These services will enable you to:

- Visit an electronic Health Library and learn about a disease state(s), your current medical condition(s), how to treat your condition(s), questions to ask your doctor(s) about your condition(s), etc.
- Take a Health Risk Assessment to help you determine what medical conditions you have a risk of getting over time due to your personal habits and family history, and what to do to reduce the chances of getting these conditions
- Access to Cigna's Healthy Rewards Program. The program will provide participants of the Asbestos Workers Local 24 Medical Fund with access to discounts on treatments and items that are not covered under your benefit program. For example, effective July 1, 2015 participants will have access to discounts as high as 25%-70% for Lasik surgery, cosmetic items, massage therapy, fitness memberships, etcé .
- Review medications and their potential interactions and alternatives
- Review preventative care tips
- Gain access to tools to quit smoking, lose weight and live a healthier life.

On July 1, 2015, you may visit https://new.mycareallies.com website. Just click on the ñ I need to registerò link to create your user ID and Password.

Continuation of Programs Currently In Place

The new Cigna program will not change any of the current programs in place, including no requirement for a Hospital Pre-Admission Certification. The new program will work in the same manner as before, when you go to a hospital that is in the Cigna Shared Administration OAP Network, you must have you medical ID card with you to give to the hospital at the time of the admission. This should not cause you, the patient, to be inconvenienced.

Case Management: The new Cigna program includes Case Management, which is a patient-focused program that is intended to provide assistance and care coordination to our chronically or critically ill patients (i.e.: cancer, serious spinal cord injury, diabetes, heart disease, etc). If you wish to have a case manager assigned to you regarding an illness or hospital confinement, please contact the Fund Office to speak with a representative to engage in this helpful program.

New ID Cards and Claims Submission Procedures

Your new ID cards will be mailed in June. The new card will include important benefits and claims submission information for the Cigna Hospital and Medical Providers.

Medicare eligible participants will also receive a new ID card in June.

More Information

The Trustees are very pleased to provide these many network and care management enhancements to you. You may contact Cigna beginning on July 1, 2015 at 1-(800) 768-4695 for general information on the new program effective July 1, 2015. Other participant questions on Claims or Benefits should be directed to the Fund Office at (410) 872-9500.

We are confident that you will enjoy this new Cigna program, and all its enhancements, now available to the eligible participants of the Asbestos Workers Local 24 Medical Fund.

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you should have any questions about the coverage provided under the Fund, the Summary Plan Description or these changes, please contact the Administrative Manager.

Very truly yours,

The Board of Trustees

June 24, 2015

Dear Participant:

The Asbestos Workers Local No. 24 Medical Fund has changed its Participating Provider network to the CIGNA Shared Administration Open Access Plus Network effective July 1, 2015. As a result, you will have access to more physician and facility discounts both locally and nationally. This is strictly a PPO network enhancement and there have been no changes in benefits and there are no additional steps required to access benefits. **As a result of this enhancement, the Fund is issuing new identification cards, which are enclosed.** Please make sure to destroy your current card and dispose of it.

As a reminder, you can search for CIGNA Healthcare Network providers online at www.cignasharedadministration.com

Grandfathered Plan Disclosure

This group health plan believes this plan is a ñgrandfathered health planò 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, Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046, (888) 490-8800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or ww.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Additional Information

This Summary of Material Modifications is intended to provide you with an easy-to-understand description of certain changes to the health and welfare plan. While every effort has been made to make this description as complete and as accurate as possible, if any conflict should arise between this Summary and the Plan, the terms of the Plan will govern in all cases.

Board of Trustees

The Board of Trustees of the Asbestos Workers Local No. 24 Medical Fund is:

Union Trustees	Employer Trustees
Lino Cressotti Asbestos Workers Local 24 901 Montgomery Street Laurel, MD 20707	Scott Grant Insul-Tech, Inc. 5724 Industry Lane Frederick, MD 21704
Brian Cavey Asbestos Workers Local 24 901 Montgomery Street Laurel, MD 20707	R. Steve Shegogue TBN Associates, Inc. 5050 Forbes Boulevard Lanham, MD 20706
Robert McCourt Asbestos Workers Local 24 901 Montgomery Street Laurel, MD 20707	Rick Schmid Advanced Specialty Contractors 7020 Troy Hill Drive, Suite E-F Elkridge, MD 21705

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you should have any questions about the coverage provided under the Fund, the Summary Plan Description or these changes, please contact the Administrative Manager.

Very truly yours,

The Board of Trustees

SMM #6 / SPD 3/2012

January 2016

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Summary of Material Modification # 7

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund announces the following benefit changes:

I. Eligibility for Retiree Death Benefits

Eligibility for Retiree Death Benefits, described on page 30 of your SPD, is modified as follows.

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 or 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.

II. Eligibility for Death Benefits Upon Total and Permanent Disability

Eligibility for Death Benefits, described on page 66 of the SPD, is modified as follows:

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.

III. Eligibility for Active Death Benefits

Eligibility for Active Death Benefits, described on pages 64-66 of the SPD is modified to provide that non-bargaining unit staff of incorporated participating employers who opt-out of benefits due to other coverage are not eligible for the Active Death Benefit during the period of opt-out.

IV. Clarification of Major Medical Coverage Limits

After the Individual Deductible (presently $200 per person) is met, Major Medical is paid:

100% of the First $4,000
80% of the Next $8,000 (payment of $6,400 by Fund - $1,600 by Eligible Participant)
Balance paid at 100%

The Schedule of Benefits on page 9 should reflect:

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 ï 1st 4 Weeks 5th Through 26th Weeks Apprentices ï 1st 4 Weeks 5th Through 26th Weeks	Max - 26 wks $350 $380 $220 $250
Supplemental Workers Compensation Benefit Maryland Virginia West Virginia	Max - 52 wks $75 $115 $50
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 $4000 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 July 1, 2011 ï June 30, 2012 July 1, 2012 ï June 30, 2013 July 1, 2013 ï June 30, 2014 July 1, 2014 and thereafter	 $750,000 $1,250,000 $2,000,000 Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See*, pages 38 and 39 for more information about the Plan rules regarding use of providers in its PPO network (presently provided through Cigna Health). Otherwise, all percentages are of Usual, Customary and Reasonable (UCR) charges. *See,* page 43.

Additionally, the Schedule of Retiree Benefits on page 32 should reflect:

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	
July 1, 2011 ï June 30, 2012	$750,000
July 1, 2012 ï June 30, 2013	$1,250,000
July 1, 2013 ï June 30, 2014	$2,000,000
July 1, 2014 and thereafter	Unlimited

Plan only pays 50% of stated amount if non-PPO provider is used. *See,* page 38 for more information about the Plan rules regarding use of providers in its PPO network (presently provided through Cigna Health). Otherwise, all percentages are percentages of Usual, Customary and Reasonable (UCR) charges. *See,* page 43.

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.

Page 45 of the Summary Plan Description should reflect:

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 for other than alcohol and chemical dependency disorders as follows:

100% of UCR up to the First	$ 4,000
80% of UCR up to the Next	$ 8,000

V. Prescription Drug Coverage

Effective January 1, 2016, certain prescription drugs will cease being covered by the Plan unless prior authorization is obtained from CVS/Caremark for use of these medications. These specific medications are listed below. Each of these medications has a therapeutic equivalent prescription drug that is covered under the Plan.

You may have received written notification or a telephone call advising you that these prescription drugs will no longer be covered, if you have an existing prescription for these medications. You and your physician should discuss whether to use the alternate medication instead of the prescription drug on this list. If your physician believes that you should use one of the excluded drugs rather than the therapeutic equivalent, your physician will be asked to provide CVS/Caremark with certain information, so that CVS/Caremark may determine whether to provide you with prior authorization for use of this drug.

If CVS/Caremark provides prior authorization, then the drug will be covered under the normal rules of the Plan. If CVS/Caremark does not provide prior authorization, your prescription for the excluded 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.

The reason this prior authorization procedure is being implemented, and the reason the list of excluded drugs has been adopted is that these medications are extremely expensive and alternate medications have proven to be as effective in most cases. The following drugs are excluded from coverage under the Plan, effective January 1, 2016, without prior authorization:

List of excluded drugs as of January 1, 2016

1. ABILIFY	43. EXTAVIA	84. OLEPTRO
2. ACCU-CHEK STRIPS AND KITS	44. FLUOROURACIL CREAM 0.5%	85. OLUX-E
3. ACTOS	45. FORTAMET	86. OMNARIS
4. ADDERALL XR	46. FORTESTA	87. OMNITROPE
5. ADRENACLICK	47. FOSRENOL	88. ONGLYZA
6. ADVICOR	48. EXFORGE	89. ORTHOVISC
7. AEROSPAN	49. EXFORGE HCT	90. OSENI
8. ALTOPREV	50. FREESTYLE STRIPS AND KITS	91. OXYTROL
9. ALVESCO	51. GENOTROPIN	92. PENNSAID
10. AMITIZA	52. GLUMETZA	93. PLAVIX
11. AMRIX	53. HECORIA	94. PLEGRIDY
12. ANDROGEL	54. HUMULIN 70/30	95. PREVACID
13. APEXICON E	55. HUMALOG	96. PROTONIX
14. APIDRA	56. HUMALOG MIX 50/50	97. PROVENTIL HFA
15. ARTHROTEC	57. HUMALOG MIX 75/25	98. QNASL
16. ASACOL HD	58. HUMULIN N	99. QSYMIA
17. ATACAND	59. HUMULIN R	100. RAYOS
18. ATACAND HCT	60. INCRUSE ELLIPTA	101. RELISTOR
19. AVONEX	61. INTERMEZZO	102. RHINOCORT AQUA
20. BECONASE AQ	62. INTUNIV	103. RIOMET
21. BREEZE 2 STRIPS AND KITS	63. INVOKAMET	104. ROZEREM
22. BYDUREON	64. INVOKANA	105. SAIZEN
23. BYETTA	65. JALYN	106. SYMBICORT
24. CARAC	66. KAZANO	107. TESTIM
25. CARDIZEM	67. KOMBIGLYZE XR	108. TESTERONE GEL
26. CARDIZEM CD	68. LASTACAFT	109. TEVETEN
27. CARDIZEM LA	69. LESCOL XL	110. TEVETEN HCT
28. CLOBETASOL SPRAY	70. LEVITRA	111. TEV-TROPIN
29. CLOBEX SPRAY	71. LIPITOR	112. TOVIAZ
30. CONTOUR NEXT STRIPS AND KIT	72. LIPTRUZET	113. TRICOR
31. CONTOUR STRIPS AND KIT	73. LIVALO	114. TUDORZA
32. CYMBALTA	74. LUMIGAN	115. VALCYTE
34. DELZICOL	75. LUNESTA	116. VALTREX
35. DETROL LA	76. MATZIM LA	117. VENTOLIN HFA
36. DIOVAN	77. MONOVISC	118. VERAMYST
37. DIOVAN HCT	78. NAPRELAN	119. VIAGRA
38. DUEXIS	79. NATESTO	120. VIEKIRA PAK
39. DYMISTA	80. NESINA	121. VIMOVO
40. EDARBI	81. NORITATE	122. VOGELXO
41. EDARBYCLOR	82. NORVASC	123. XOPENEX HFA
42. EUFLEXXA	83. NUTROPIN AQ	124. ZETONNA
		125. ZUBSOLV

REMINDERS!!!

VI. Dependent Coverage

Remember that, effective October 1, 2010, children of Employees continue to be covered by the Fund until they reach age twenty-six (26). For the period prior to July 1, 2014, coverage will not be provided to any children who are eligible for Employer-sponsored coverage or for coverage under their spousesô employer-sponsored plan. Although this change was made to conform to the Healthcare Reform Laws, the Trustees made it effective nine months prior to the legally required date of July 1, 2011. Natural, adopted, step and foster children no longer have to remain unmarried or show they are dependent upon the Employee for support. ñChildrenò also include other children who depend upon the Employee for support and who live with the Employee in a regular parent-child relationship. Except as otherwise provided in the Summary Plan Description, coverage for your Eligible Dependent child will end on the last day of the month in which the child turns age 26.

Each Covered Child or other dependent must be listed on a ñDependent Eligibility Formò signed by the Employee and filed with the Fund Office, along with evidence or proof of status satisfactory to the Trustees. Each change in Dependent enrollment after the initial enrollment must be submitted with evidence or proof of Child or other Dependent status satisfactory to the Trustees.

VII. Change in Marital Status

If you become divorced, 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, your former spouseôs continued use of Fund coverage after the date of the divorce 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 21 of the Summary Plan Description, 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 Fundôs COBRA self-payment rules.

VIII. Medicare Reminder

Please remember, ***if you are a Retiree or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible***. Medicare is generally available to all individuals who are either disabled or age 65, and has three parts ï Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Benefits (Part D). Part A covers inpatient Hospital care and generally is available at no cost. Part B covers doctors' services, outpatient hospital services and other medical supplies and requires a monthly premium. Part D covers prescription drugs and also requires a monthly premium. *If you are a Medicare-eligible Retiree or Dependent, you are required to sign up for Medicare Parts A and B, even though you will have to pay a premium for Part B.* **You are *not* required to sign up for Part D (Prescription Drug Coverage).** For a full explanation, *see* the Summary Plan Description, p. 70 and the Annual Medicare Prescription Drug notice, or contact the Fund Office.

IX. Grandfathered Plan

The Trustees of the Asbestos Workers Local 24 Medical Fund believe this plan is a ñgrandfathered health planò 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 the Fund 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 telephone numbers listed below. 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.

X. Prescription Drug Card Reimbursement – Reminder

Remember that your co-payments when you use your prescription drug card are reimbursable by the Plan up to $400 per person per year. Save your receipts and submit them to the Plan Office as you would any other claim.

XI. Credit Cards Now Accepted by Medical Fund

The **Asbestos Workers Local 24 Medical Fund** now accepts credit card payments for self-pays, those electing COBRA and direct pay of retiree premiums. All major credit cards **except** American Express are accepted.

Retirees who elect to make a direct quarterly payment of retiree premiums may request the form from the Fund Office if they wish to charge their premiums to a credit card. A separate form will be required for each payment being authorized to the credit card and will not be automatically recharged each quarter.

Please note that if you elect to make your self-pay by credit card and any adjustments are made later (due to credit for late hours received, reciprocity, sick hours, etc.,) the same credit card will be refunded for the calculated adjustment.

XII. Board of Trustee

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

Union Trustees

Lino Cressotti, Secretary
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Brian S. Cavey
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Scott Grant
Insul-Tech, Inc.
5300 Westview Drive, Suite 101
Frederick, MD 21703

Very truly yours,

The Board of Trustees

We suggest that you keep this Summary of Material Modifications with your Summary Plan Description. If you should have any questions about the coverage provided under the Asbestos Workers Local Union No. 24 Medical Fund, the Summary Plan Description or these changes, please contact the Fund Office.

SPD 03/2012 SMM #7

June 2016

ASBESTOS WORKERS LOCAL 24 MEDICAL FUND

Summary of Material Modification # 8

The Board of Trustees of the Asbestos Workers Local 24 Medical Fund announces the following benefit changes:

I. Clarification of Rules for Self-Pay for Non-Bargaining Unit Employees of Incorporated Employers

The rules for participation of non-bargaining unit staff of incorporated participating employers has been revised to clarify availability of self-payment to continue coverage. Page 7 of the Summary Plan Description is modified to include additional language (below) to the rules for **Non-Bargaining Unit Employees of Incorporated Employers**:

- Employees who terminate employment with the Participating Employer are not considered ñavailable for workò 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 19.

Page 18 of the Summary Plan Description is modified to include additional language in the first bullet item (shown below in italics) to the section **What Happens if You Don't Have Enough Hours ...Self-Payments** (beginning on page 16):

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 24ôs 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. Alternative Self-Payment Rules (COBRA) described on page 19 does apply.*

REMINDERS!!!

II. Dependent Coverage

Remember that, effective October 1, 2010, children of Employees continue to be covered by the Fund until they reach age twenty-six (26). For the period prior to July 1, 2014, coverage will not be provided to any children who are eligible for Employer-sponsored coverage or for coverage under their spousesô employer-sponsored plan. Although this change was made to conform to the Healthcare Reform Laws, the Trustees made it effective nine months prior to the legally required date of July 1, 2011. Natural, adopted, step and foster children no longer have to remain unmarried or show they are dependent upon the Employee for support. ñChildrenò also include other children who depend upon the Employee for support and who live with the Employee in a regular parent-child relationship. Except as otherwise provided in the Summary Plan Description, coverage for your Eligible Dependent child will end on the last day of the month in which the child turns age 26.

Each Covered Child or other dependent must be listed on a ñDependent Eligibility Formò signed by the Employee and filed with the Fund Office, along with evidence or proof of status satisfactory to the Trustees. Each change in Dependent enrollment after the initial enrollment must be submitted with evidence or proof of Child or other Dependent status satisfactory to the Trustees.

III. Change in Marital Status

If you become divorced, 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, your former spouseôs continued use of Fund coverage after the date of the divorce 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 21 of the Summary Plan Description, 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 Fundôs COBRA self-payment rules.

IV. Medicare Reminder

Please remember, ***if you are a Retiree or a Dependent, you are required to enroll in Medicare Parts A and B as soon as you are eligible***. Medicare is generally available to all individuals who are either disabled or age 65, and has three parts ï Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Benefits (Part D). Part A covers inpatient Hospital care and generally is available at no cost. Part B covers doctors' services, outpatient hospital services and other medical supplies and requires a monthly premium. Part D covers prescription drugs and also requires a monthly premium. *If you are a Medicare-eligible Retiree or Dependent, you are required to sign up for Medicare Parts A and B, even though you will have to pay a premium for Part B.* **You are *not* required to sign up for Part D (Prescription Drug Coverage).** For a full explanation, *see* the Summary Plan Description, p. 70 and the Annual Medicare Prescription Drug notice, or contact the Fund Office.

V. Grandfathered Plan

The Trustees of the Asbestos Workers Local 24 Medical Fund believe this plan is a ñgrandfathered health planò 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 the Fund 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 telephone numbers listed below. 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.

VI. Prescription Drug Card Reimbursement – Reminder

Remember that your co-payments when you use your prescription drug card are reimbursable by the Plan up to $400 per person per year. Save your receipts and submit them to the Plan Office as you would any other claim.

VII. Credit Cards Now Accepted by Medical Fund

The **Asbestos Workers Local 24 Medical Fund** now accepts credit card payments for self-pays, those electing COBRA and direct pay of retiree premiums. All major credit cards **except** American Express are accepted.

Retirees who elect to make a direct quarterly payment of retiree premiums may request the form from the Fund Office if they wish to charge their premiums to a credit card. A separate form will be required for each payment being authorized to the credit card and will not be automatically recharged each quarter.

Please note that if you elect to make your self-pay by credit card and any adjustments are made later (due to credit for late hours received, reciprocity, sick hours, etc.,) the same credit card will be refunded for the calculated adjustment.

VIII. Board of Trustee

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

Union Trustees

Lino Cressotti, Secretary
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Brian S. Cavey
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Robert S. McCourt
Insulators Local 24
901 Montgomery Street
Laurel, MD 20707

Employer Trustees

Ronald S. Shegogue, Chairman
TBN Associates, Inc.
5050 Forbes Boulevard
Lanham, MD 20706

Kevin Orchard
Advanced Specialty Contractors
7020 Troy Hill Drive, Suite E-F
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