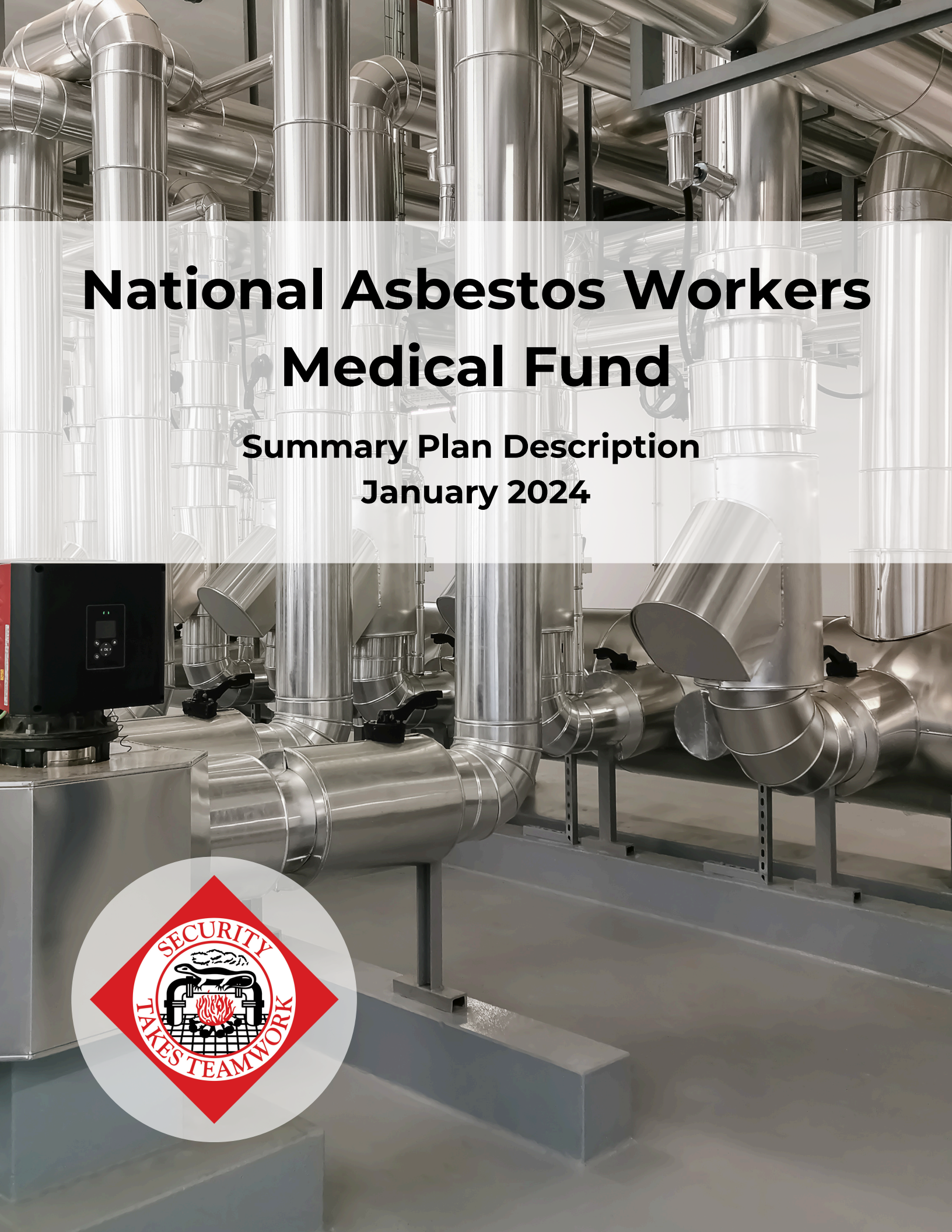

National Asbestos Workers Medical Fund

Summary Plan Description
January 2024

NATIONAL ASBESTOS WORKERS MEDICAL FUND

Summary Plan Description and Plan Document

Letter to Participants

To All Participants:

We are pleased to provide you with this updated Summary Plan Description and Plan Document (referred to as the SPD or Plan). Unless expressly stated otherwise, this SPD is effective as of January 1, 2024. You've received this SPD based on your work in employment covered by the National Asbestos Workers Medical Fund. However, you must satisfy the eligibility requirements shown on the following pages in order to qualify for benefits. Since the purpose of the National Asbestos Workers Medical Fund is to benefit you and your family, we urge you to read this SPD carefully so that you will understand the complete Plan of Benefits, as well as the eligibility rules and procedures for filing claims.

We strive to offer a Plan of Benefits that makes meaningful contributions to your security, health and well-being. Nevertheless, changing economic conditions require a constant assessment of the Plan to maintain the Fund's financial stability. Within this framework, we will continue to monitor the Fund's resources in an effort to ensure that it will provide high-quality health coverage to members and their families for years to come.

Very truly yours,

The Board of Trustees

IMPORTANT

The Board of Trustees, in its sole discretion, may interpret, amend, or terminate the Plan and any of its provisions, in whole or in part, at any time. This means that: (1) the Board of Trustees has the exclusive discretionary authority to interpret the Plan and to determine all questions regarding coverage, eligibility, entitlement to benefits and other related matters; (2) all Plan benefits made available to Participants are conditional and subject to the Board of Trustees' exclusive discretionary authority to improve, reduce, eliminate or otherwise modify them; and (3) the Board of Trustees has the exclusive discretionary authority to modify or terminate the Plan's provisions related to classes of coverage, eligibility, the availability, nature and extent of benefits, and the conditions, methods and rates of payment and self-payment. Decisions made by the Board of Trustees are final and binding on all parties. Judicial review of any decision made by the Board of Trustees will be limited to determine only whether the decision was arbitrary and capricious.

Interpretations concerning eligibility for benefits, claims, status of Participants and Employers, or any other matter relating to the Medical Fund should be obtained through the Trustees' Executive Committee. The Trustees are not bound by, responsible for, or obligated by opinions, information or representations from other sources. All the provisions of the Plan are very important, and we encourage you to read them carefully. For additional information and assistance, feel free to contact the Fund Office:

National Asbestos Workers Medical Fund
c/o National Employee Benefits Administrators, Inc. (NEBA) | Administrative Agent
2010 N. W. 150th Avenue, Suite 200
Pembroke Pines, FL 33028
Toll Free: (888) 352-0629

Fund History & How Your Welfare Fund Works

The origins of the National Asbestos Workers Medical Fund go back to July, 1953 when Local 80, Charleston, West Virginia established a health and welfare fund which was later expanded to become the Central States Welfare Fund. Atlanta, Georgia's Local 48 Health and Welfare Fund, which was originally established in December, 1954, also expanded to become the Southeast States Welfare Fund. Each regional fund grew until the Board of Trustees of the Asbestos Workers Central States Welfare Fund and the Board of Trustees of the Asbestos Workers Southeast States Welfare Fund resolved to merge the two Funds into one large Welfare Fund, effective August 1, 1968. The merged Funds became known as The National Asbestos Workers Welfare Fund. In 1980, the Trustees voted to change the name to "The National Asbestos Workers Medical Fund."

This National Fund was developed to provide improved benefits, lower benefit rates, lower administrative expenses, and continuous coverage for employees when they travel from one local area participating in the Fund to another local area participating in the Fund.

HOW THE FUND WORKS

- Participating Local Unions and their partnering, signatory contractors have joined together to make available a comprehensive health program to you and your family.
- This program is maintained by a health benefit trust fund (“Fund”, “Trust Fund” or “Medical Fund”) that is governed and managed by a Board of Trustees.
- The Board of Trustees has equal representation from both Union and Employer representatives.
- The Executive Committee, a group of Trustees selected periodically by the Board of Trustees, serves as the legal Plan Administrator, and meets as frequently as necessary to hear appeals, oversee the operation of the Trust Fund, and make strategic decisions for the Fund.
- The Executive Committee has designated National Employee Benefits Administrators, Inc. (NEBA) as their Administrative Agent.
- NEBA is responsible for the Fund's day-to-day operations. In other words, NEBA serves as the Fund Office. Accordingly, NEBA’s staff will be your point of contact for any coverage questions after you become eligible for benefits.
- It is important to understand that the Fund is financed through Employer contributions negotiated by participating Local Unions, which are paid for every hour you work in covered employment as specified in your collective bargaining agreement.
- This money is grown through investment earnings and then used to pay benefits and cover administrative costs.
- The way the Fund is financed means that it is *self-funded*. Consequently, with limited exception, the Fund does not pay premiums to an insurance company in exchange for health care coverage.
- So, while you may see UnitedHealthcare (UHC) on your ID card after you become eligible for benefits, it is the Medical Fund that pays your claims.
- In other words, UnitedHealthcare makes available a network of doctors who offer services at discounted prices, but it's the Medical Fund that is financially responsible for your benefits.
- This *self-funded* arrangement helps keep costs down and enables the Fund to provide more benefits for its 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.

YOUR RIGHT TO PRIVACY

The U.S. Department of Health and Human Services has issued regulations establishing strict standards on how health funds, like the National Asbestos Workers Medical Fund, may use and disclose your medical records. These regulations will affect some of your dealings with the Fund Office. We recognize that the requirements of the Privacy Rules may be an inconvenience to you. However, the Fund Office and the Fund's Trustees are doing everything possible to minimize the burden on you.

The Privacy Rules are detailed. The following questions and answers provide some important information on how the Privacy Rules will affect you directly.

- **What do the privacy regulations require?**

  In general, the regulations require the Fund to secure all medical information so that it is not readily accessible or available to those who do not need access to it. If your spouse, Business Manager, or other person calls the Fund Office with a question about you or your family's benefits from the Fund, then we will be prohibited by law from disclosing any information to them. It does not matter that your spouse or Business Manager may already know all the details directly from you. (There is an exception in the Rules allowing parents to obtain information from us concerning their minor children.)

- **How do I authorize my spouse or Business Manager to assist me in dealing with the Fund Office?**

  If you are not present, your spouse or the Business Manager cannot get specific information from the Fund Office about you unless you first submit a **written authorization** to the Fund Office. Once properly authorized by you, the Fund Office is permitted to disclose necessary information about you to whomever you have designated.

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Chapter 1 – Eligibility for Employees

1.01 IN GENERAL

All individuals for whom the Fund has received Employer contributions for hours worked may become eligible for benefits in accordance with the rules of this Chapter. The Plan uses different terms to refer to categories of Employees who are affected by such 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. (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 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.
- A **"Participant"** refers to a person who is eligible for benefits under this Plan.

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.

1.02 THE QUARTERLY ELIGIBILITY SYSTEM

(a) In General

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 relate to each other.

During the Work Quarter you establish your *eligibility* for benefits in a later time period. 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.

In short, you earn rights to benefits during the Work Quarters. These rights entitle you to benefits that are payable to you in Eligibility Quarters that follow.

(b) Earning Eligibility Quarters

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.

Here is a breakdown of the Worker Quarter and Eligibility Quarter system:

The Work Quarters…	Determine Eligibility For…	The Eligibility Quarters…
January | February | March	→→→→→→→→	June | July | August
April | May | June	→→→→→→→→	September | October | November
July | August | September	→→→→→→→→	December | January | February
October | November | December	→→→→→→→→	March | April | May

(c) Initial Eligibility

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

In addition, if your Employer has filed bankruptcy and has not contributed to the Fund on your behalf, you may self-pay for the number of hours you worked for that Employer for which contributions were due in order to gain initial eligibility. You must verify the hours through pay stubs or other documentation and the self-payment must be received in the Fund Office no later than 30 days after you learned that you were able to make the self-payment under this rule.

Example. Assume Mike started working as an Asbestos 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 shall include 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.

(d) 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.

(e) 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.

(f) Maintaining Eligibility While 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 your physician makes a determination that you are disabled.

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.

1.03 SELF-PAYMENTS TO CONTINUE ELIGIBILITY WHEN YOU DON'T HAVE ENOUGH HOURS

(a) In General

If you have less than 400 hours reported and paid to the Fund for you by your Employer for a Work Quarter (or less 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, THE LOCAL UNION BUSINESS MANAGER, THE LOCAL UNION, AND EMPLOYER TRUSTEES FOR THE AREA IN WHICH YOU ARE WORKING. YOU SHOULD INSIST ON PROMPT PAYMENT OF ALL DELINQUENT CONTRIBUTIONS OWED ON YOUR BEHALF.

You may make self-payments to continue your eligibility as long as you are immediately available for work as an Asbestos 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 Asbestos 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.

(b) Self-Payment Notice

During the months of February, May, August and November of each year, those Employees whose

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

(c) More About Self-Payments | The Rules

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.

(1) You may make self-payments to preserve your eligibility only if you are immediately available for full-time employment as an Asbestos Worker with a participating Employer in your Home Local Union.

(2) You must remain a resident in your Home Local Union'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.)

(3) 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.

(4) If you *don't get* a Self-Payment Notice by the 15th day of the first month of the Eligibility Quarter, *it is your responsibility* to contact the Fund Office. This must be done by the end of the month or *you will lose eligibility from the first day of the Eligibility Quarter.*

(5) 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.

(6) 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.

(7) The contribution rate on which your self-payment is calculated is the rate in effect in your Home Local Union under this Plan on the last day of the eligibility quarter.

(8) A new Retiree may self-pay for active or Retiree coverage for the first self-payment after retirement.

(d) COBRA Payments

You may also continue your coverage under the Plan if you make the appropriate COBRA Continuation Coverage premium payments, as set forth in Chapter 3, in the manner and in the amount established, as may be changed from time to time, by the Trustees.

1.04 ELIGIBILITY FOR DEPENDENTS

(a) In General

In general, your dependents will become eligible for benefits under the Plan upon the later of the effective date of your eligibility, the date your dependents qualify as Eligible Dependents, or the date that all required enrollment procedures, as may be established by the Plan, are completed for such dependent. The following individuals qualify as Eligible Dependents:

(1) Your legal spouse. The term "Dependent" shall not include a prior spouse from whom the Employee is divorced or a spouse from whom the Employee is legally separated.

(2) Your Dependent child or Dependent children. The term Dependent child refers to a biological, step, foster, adopted or grandchild (pursuant to custody order or legal guardianship) until the date the child reaches age 26. For purposes of this section a child includes a son or daughter by birth or legal adoption. A child who is placed with you for adoption will be covered from the time of placement and will not be subject to any coverage exclusions based on pre-existing conditions. A child or children also includes a stepchild or a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

(3) Your unmarried dependent child who is age 26 and is disabled due to a physical or mental incapacity which prevents self-support if the incapacity began before the usual loss of eligibility (the date the child turns age 26), and either (a) lives with the Employee for more than one-half of the year and does not provide more than one-half of his/her own support (including federal disability benefits) or (b) depends on you for more than one-half of his/her financial support. Proof of total disability must be submitted to the Administrative Agent. A physician's determination of physical or mental incapacity must be received by the Administrative Agent prior to the end of the calendar year in which the child attains age 26. A child who has already attained age 26 at the time you become eligible is not eligible under the Plan under any circumstances.

(4) The child of an Active Employee whose coverage under this Plan is established in accordance with a QMCSO. However, if your child who is the subject of the QMCSO is not your "dependent" as defined in the Internal Revenue Code Section 105(b) or 152, you may be subject to income tax on the fair market value of the coverage provided to that child by the Plan pursuant to the QMCSO.

Each Eligible Dependent must be listed on a "Benefit Enrollment Form" signed by you and filed with the Fund Office before benefits are paid. Each change in Dependent enrollment after the initial enrollment must be submitted with proof of dependent status satisfactory to the Trustees.

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.

(b) Continued Eligibility for Eligible Dependents of Deceased Employees

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.

To be eligible for widow(er) coverage, the individual must:

(1) Be a widow(er) of an Eligible Employee;

(2) Have been married to the Employee for at least one year prior to death;

(3) Have no other group health benefits coverage;

(4) 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.);

(5) Make payment prior to eligibility terminating; and

(6) Sign an initial certification of eligibility and advise the Fund Office immediately of any changes in status.

The eligibility of the widow(er) and Dependent children will terminate at the earlier of the remarriage of the widow(er) the widow(er)'s eligibility for Medicare or other group health benefits.

Widowers may also be eligible for Retiree coverage as summarized in Chapter 2A.

(c) Special Rule for Children Covered by a QMCSO

The Plan is required to recognize Qualified Medical Child Support Orders. A Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree, or order. To be a QMCSO, a judgment, decree, or order must require a child to be enrolled in the Plan as a form of child support or health benefit coverage pursuant to state domestic relations law or to enforce a state law relating to medical child support. To be a QMCSO, an order must include: (1) The name and last known address (if any) of the Participant and the name and mailing address of each child covered by the order; (2) a reasonable description of the type of coverage to which the order pertains as well as the period of coverage; and (3) the name of the Plan.

Such an order is not "qualified" if it requires the Plan to provide any type or form of benefit not otherwise provided under the Plan except to the extent necessary to comply with a state law relating to medical child support orders. Upon receipt of an order, the Plan will notify, in writing, the eligible Employee and each child covered by the order of the Plan's procedures for determining whether the order is qualified. The Plan will also notify the eligible Employee and each affected child in writing of its determination as to whether an order is a QMCSO.

1.05 TERMINATION OF ELIGIBILITY

(a) In General

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:

(1) Fewer than 400 hours of Employer contributions are received by the Fund for a Work Quarter on your behalf.

(2) Fewer than 800 hours of Employer contributions are received by the Fund for the preceding two

Work Quarters on your behalf.

(3) 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 Asbestos 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.)

(4) You fail to make self-payments on time.

(5) You are inducted into the Armed Forces. (See below on how to regain your status once discharged.)

(6) There is a Plan amendment that affects eligibility.

(7) Your Local Union withdraws from this Fund.

(b) Additional Termination Events for Dependents

Unless otherwise provided by the Plan, an Eligible Dependent will lose coverage under this Plan on the date your Employee coverage terminates. In addition, an Eligible Dependent will lose coverage under this Plan on the date the dependent ceases to qualify as an Eligible Dependent pursuant to either the terms of this Plan or the terms of a Plan amendment.

(c) Effect of Termination of Eligibility | Treatment of Claim if Hospitalized When Eligibility Terminates

In general, upon termination of eligibility, benefits will not be payable under the Plan except for covered expenses for covered services incurred prior to the date eligibility terminates.

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

1.06 REINSTATEMENT OF ELIGIBILITY

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.

The only exception is if you lose eligibility because of induction into the Armed Forces. In this case, notify the Fund Office, in writing, and your status will be frozen for the length of your service or four years, whichever is less.

1.07 ELIGIBILITY DURING & AFTER PERIODS OF MILITARY SERVICE

If you enter the "Uniformed Services," as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination, coverage for you and your Eligible Dependents will freeze. If you are discharged from the Uniformed Services, except for a dishonorable discharge, you and your Eligible Dependents will receive coverage at no cost on the day you begin work with an Employer participating in this Fund, until you meet the Plan's Continuing Eligibility requirements. To protect your rights to reinstatement with your Employer prior to Uniformed Service, you must present yourself to that Employer within a time frame established by law as follows:

(a) *Service Less Than 31 Days*. For service of less than 31 days, you must apply for re-employment with an Employer at the beginning of the next regularly scheduled work period on the first day after your release from service, taking into account safe transportation plus an eight-hour rest period.

(b) *Service More Than 31 Days But Less Than 181 Days*. For service of 31 days or more but less than 181 days, you must apply for re-employment within 14 calendar days (not work days) after your release from service.

(c) *Service More Than 181 Days*. For service over 180 days, you must apply for re-employment within 90 calendar days (not work days) after your release from service.

If you or your Eligible Dependents want to purchase COBRA Continuation Coverage through the Fund to cover you during your period of Uniformed Service, you can do so, so long as you make your election within 60 days of your first day of Uniformed Service. COBRA Continuation Coverage made available because of your service in the Uniformed Services is available for a maximum of 24 months, but is otherwise the same as COBRA Continuation Coverage.

1.08 ELIGIBILITY DURING FMLA LEAVE

In addition, hours will be credited if you are on a leave of absence under the provisions of the Family and Medical Leave Act of 1993 ("FMLA"). The FMLA entitles Employees eligible under the FMLA to take up to 12 weeks of unpaid job-protected leave each year for the Employee's own Sickness, or to care for a seriously ill child, spouse or parent; the birth or placement of a child with the Employee in the case of adoption or foster care, or a "Qualifying Exigency" as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in support of a federal contingency operation. In addition, the FMLA provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 work weeks of leave in a single 12-month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

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 of that employer within a 75-mile radius of the employee is 50 or more.

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 an Employer is required to continue making contributions to the Fund on behalf of an Employee on FMLA leave.

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. 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, or visit the Department of Labor's website.

1.09 ELIGIBILITY FOR EMPLOYEES OF EMPLOYERS OWNED BY RELATIVES

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

(a) 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.

(b) If the Employer contributes on less 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).

(c) If the Employer contributes on less than 40 hours per week for the relative-Employee, the Employer must agree to permit the Fund to conduct an audit of the Employer if the pattern or amount of hours reported gives the Fund reason to believe that the Employer is not correctly contributing for the relative-Employee or is abusing the Fund's eligibility rules. The Employer will be obligated to pay the audit fee if the contributions owed to the Fund are 5% or more of total contributions due for the period audited.

(d) If the Employer does not keep records which document the hours and work performed by the relative-Employee, or 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.

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

1.10 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.

(a) 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.

(b) 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 at least 40 hours per week and must remain current in his contributions for Employees covered by the Collective Bargaining Agreement.

1.11 NON-BARGAINING UNIT STAFF EMPLOYEES OF INCORPORATED EMPLOYERS

The Fund will allow participation of non-bargaining unit staff of incorporated participating employers in accordance with a written participation agreement. A summary of the rules are as follows:

(a) The contribution rate paid must be the same rate as that of the contributing employer (with the option of including Active and Retired Employees' Separate Account (ARESA), if the local participates in ARESA).

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

(c) 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.

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

(e) All full-time (at least 30 hours per week) 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.

(f) The Fund reserves the right to terminate any employer's staff participation.

(g) 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.

1.12 EFFECT ON ELIGIBILITY DUE TO THE WITHDRAWAL OF YOUR LOCAL UNION

If a Local Union withdraws from this Fund or is merged or amalgamated into another Local Union which does not participant in this Fund, the following rules apply:

(a) Withdrawing Local Unions

(1) *In General*. An Eligible Employee and their Eligible Dependents for whom the withdrawing Local Union is the Home Local Union will continue his eligibility under the rules of the Plan until the last day of the month in which the Local Union withdraws.

(2) *Self-Payments*. An Eligible Employee for whom the withdrawing Local Union is the Home Local Union may not make self-payments to continue eligibility after a Local Union withdraws.

(3) *Disability*. An Eligible Employee for whom a withdrawing Local Union is the Home Local Union who is receiving disability benefits will continue his eligibility under the rules of the Plan until the last day of the month in which the Local Union withdraws from the Fund.

(4) *Notice*. A Local Union that withdraws from the Plan must notify the Plan in writing no less than 90 days in advance of the withdrawal. Any withdrawal must be effective as of the last day of the month on which the Local Union properly notifies the Plan of its intention to withdraw. Contributions from employers must be paid for all work performed through the last day of the month in which the withdrawal is to occur. The Plan will withhold payment of benefits or distribution of a Local Union's ARESA account until such time that it has ascertained substantial good faith compliance with the contribution obligation set forth in this paragraph. In the event that the Plan will incur additional expenses following the withdrawal of the Local Union in pursuing contributions owed to the Plan by employers working in the jurisdiction of the Local Union prior to withdrawal, the Plan may withhold payment of monies reasonably calculated to cover the cost of such expenses. Once any such delinquency matters are resolved, any monies withheld over and above the actual expenses incurred will be forwarded to any new fund which has been designated by the withdrawing Local Union to receive the proceeds of the ARESA account.

(b) Merger Local Unions

(1) *In General*. If a Local Union is merged or amalgamated into another Local Union which does not participate in this Fund, then the Eligible Employee and his Dependents will continue his eligibility under the rules of the Plan until the earlier of the following: (1) as long as the Eligible Employee would have been eligible if he had stopped work on the date of the Local Union's merger or amalgamation into the other Local Union, or (2) the date the Eligible Employee becomes eligible

in the medical fund of the other Local Union.

(2) *Self-Payments*. The Eligible Employee may not make self-payments to continue eligibility in the Plan following the date of merger or amalgamation.

(3) *Disability*. An Eligible Employee for whom a Local Union is merged or amalgamated into another Local Union which does not participate in this Fund, who is receiving disability benefits may continue receiving those benefits under the rules and limitations of the Plan for twenty four (24) months from his initial date of disability.

(c) Retiree and ARESA Issues

(1) *Retirees*. If a Local Union withdraws or merges into another Local Union which does not participate in this Fund, then a Retiree (and his Dependents) for whom it is the Home Local Union will cease participation in the Fund as of the last day of the month in which the Local Union withdraws or merges.

(2) *ARESA*. If a Local Union withdraws or merges into a Local Union which does not participate in the Fund, any assets remaining in its ARESA after payment of Retiree coverage for that month will be transferred to the medical fund in which the withdrawing or merged Local Union participates.

1.13 YOUR OBLIGATION TO REPORT IMPORTANT EVENTS TO THE FUND OFFICE

You must report to the Fund Office important events such as a divorce, loss of Eligible Dependent status, and any other event that impacts the eligibility of you or your dependent(s). You must reimburse the Fund for any claim paid in error because you failed to report to the Fund Office any of the previously described events. If you fail to reimburse the Fund for any claim paid in error as required by this Section, the Fund may take action in accordance with the Plan to recover the amount paid in error.

Chapter 2A – Eligibility and Benefits for Retirees

2A.01 COVERAGE | APPLICATIONS | PAYMENTS | TERMINATIONS | ETC.

(a) Persons Covered

(1) *In General.*

(i) 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. Retiree benefits as described in this Chapter will be provided as described below to Eligible Retirees and Eligible Dependents of Retirees.

(ii) In order qualify for Retiree Benefits, Eligible Employees must meet the eligibility criteria set forth in this Section. Employee Employees must also meet the timely application requirement set forth in subsection (b).

(iii) Finally, 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 National Asbestos Workers Pension Fund or a pension plan of a Local Union participating in the Medical Fund is eligible for Retiree coverage. Widows must likewise meet the timely application requirement set forth in subsection (b).

(2) *Eligibility Requirements for Employees*. In general, if you are receiving a pension *other* than a deferred pension or a disability pension from a Local Union participating in this Fund, you may continue your eligibility if you meet certain conditions. If you are receiving a disability pension from a Local Union in this Fund, you must be permanently and totally disabled based on your receipt of a Social Security Disability Award. If you are not receiving a pension from a Local Union participating in this Fund, you may continue your eligibility if you are receiving a disability benefit from the Social Security Administration.

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 a participating Local Union 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 Asbestos 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.

(3) *Eligibility Requirements for Owners*. 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 in paragraph (2). However, you may satisfy the pension requirement if you are receiving a pension other than a deferred pension from the pension fund of a Local Union participating in this Fund, from the National Asbestos Workers Pension Fund, from the pension plan of an Employer signatory to a Collective Bargaining Agreement or a retirement benefit from the

Social Security Administration.

(4) *Eligibility Requirements for Qualifying Production Workers & Non-Bargaining Unit Office Staff.* Effective December 1, 2018, if you are a covered Production Worker or Non-Bargaining Unit Office Staff Person, you may continue coverage while retired, irrespective of whether you are receiving a pension from a Local Union in this Fund, if you, in addition to meeting all other applicable Plan requirements, you are (1) at least 58 years old and have five or more years of continuous eligibility immediately prior to retiring, or (2) at least 58 years old and have ten or more years of participation prior to retiring with less than a three-year break in eligibility prior to retiring.

(b) Timely Application Requirement for Retiree Benefits

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 Executive Committee of 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. However, a retiree from a newly merged Local Union has up to one (1) year to select Retiree coverage provided that payment is made from the date that Retiree coverage would have been effective had the Employee elected it at the time of retirement. 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.

If you are receiving Retiree Benefits, you may add Dependents 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 (meaning a group health plan that is not the National Asbestos Workers Medical Plan). New spouses, through unions entered after retirement, are ineligible for enrollment in the Fund's Retiree medical coverage.

(c) Payment for Retiree Benefits

Retirees must remit periodic self-payments to continue their coverage. The self-payment rates for Retirees are set by the Trustees. The self-payment rates are subject to change at any time. (A new Retiree may self-pay for active or Retiree coverage for the first self-payment after retirement, depending on which is cheaper based on hours worked in covered employment leading up to retirement.)

Payment to the Fund for Retiree Benefits must be made quarterly in advance by: (a) the Retiree; (b) an eligible widow(er); and/or (c) someone on behalf of eligible Dependent children.

If the Local Union of the Retiree has established an Active and Retired Employees Separate Account (ARESA), all or a portion of the payment for Retiree Benefits may be made from the ARESA.

If your pension is paid from the National Asbestos Workers Pension Fund, you may elect to have your payment for Retiree Benefits deducted from your pension check. In this case, payments will be deducted monthly.

(d) Termination of Retiree Benefits

(1) *Failure to Timely Pay Premiums*. Your coverage for Retiree Benefits will terminate if payment for benefits is not made on a timely basis.

(2) *Cessation of Participation of Your Local Union*. Your coverage for Retiree Benefits will also terminate if your Local Union stops participating in this Fund, in which case your coverage will end as of the last day of the month in which the Local Union ceases to participate.

(3) *Impact of Returning to Employment*. 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 Asbestos Workers by a non-participating employer, 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. 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. At that time, you may reinstate your coverage as a Retiree if you are receiving a pension from the National Asbestos Workers Pension Fund or the pension fund of a Local Union which participates in the National Asbestos Workers Medical Fund, but you must do so immediately. You may not make self-payments to continue your active eligibility.

(4) *In General*, *No Reinstatement*. If your Retiree Benefits terminate for any reason described herein, except during periods in which you establish active eligibility, you may not reinstate those Retiree Benefits at a later date.

(e) Continuing Retiree Eligibility for Your Dependent Spouse and Children 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.

(f) Suspension of Retiree Eligibility When Retiree Has Other Coverage

Qualified Retirees, spouses and/or Dependents who are covered by other coverage may elect 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. 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.

2A.02 MEDICAL BENEFITS FOR RETIREES *NOT COVERED* BY MEDICARE

COMPREHENSIVE MAJOR MEDICAL BENEFIT FOR COVERED EXPENSES FOR ALL ELIGIBLE RETIREES NOT COVERED BY MEDICARE	
• Deductible (Per Individual)	$450
• Maximum Family Deductible Expense	$900
• Percentage of Major Medical Benefit Paid by the Plan	80%
• Percentage of the Major Medical Benefit Paid by the Retiree	20%
• In-Network Medical Out-of-Pocket Maximum (in addition to deductible)	$2,800/Individual $11,200/Family
• Out-of-Network Medical Out-of-Pocket Maximum	None
• Prescription Drug Benefit Out-of-Pocket Maximum	$1,000/Individual $4,000/Family

Please refer to Chapter 4 for more details about your medical coverage and Chapter 6 for more details about your prescription drug coverage.

A Copay of $100 will be applied if you or your dependents use the services of an emergency room. This copay will be waived only if the visit to the emergency room was for Emergency Services for an Emergency Medical Condition. The $100 Copay will not be applied to your deductible.

The Plan for Retirees who are not eligible for Medicare excludes maternity, Weekly Accident and Sickness Benefits and Annual Physical Benefits. The Plan provides dental and vision benefits to those Retirees who meet the requirements described below under Pan Section 2A.04.

If you begin to receive Weekly Accident and Sickness Benefits and then retire (either by receiving a Local Union Pension 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.

2A.03 MEDICARE-ELIGIBLE PARTICIPANTS / COVERAGE AND COORDINATION OF BENEFITS

(a) Requirement to Enroll in Medicare Parts A & B When First Eligible / Medicare is Primary for Retirees

Medicare Part A covers inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Medicare Part B covers Physician services, outpatient Hospital services, and other medical supplies. You must pay a monthly premium for Medicare Part B.

You and/or your spouse or other Eligible Dependent MUST enroll in Medicare Parts A and B when first eligible. Benefits will be determined as if you and/or your Medicare-eligible spouse or other Eligible Dependent(s) have both Medicare Parts A and B, regardless of whether such individuals actually enroll in Medicare Parts A and B. Therefore, to have adequate coverage, you and/or your spouse or Eligible Dependent(s) MUST sign up for both Medicare Parts A and B at the earliest possible opportunity. This paragraph applies to you regardless of whether you or your Eligible Dependent(s) become eligible for Medicare due to age, disability, end-stage renal disease, or any other reason.

If you are a Retiree or an inactive disabled Employee and become eligible for Medicare, Medicare will be your primary coverage. If you are a Retiree, inactive or disabled Employee not yet eligible for Medicare,

but your spouse or other Eligible Dependent is eligible for Medicare, Medicare will be the primary coverage of your Medicare-eligible spouse or Eligible Dependent.

(b) Automatic Enrollment in a Separate, Medicare Advantage Prescription Drug Plan

The Fund will automatically enroll all Medicare-eligible inactive Participants in a Medicare Advantage Prescription Drug Plan (MAPD Plan). The premiums for the MAPD Plan will be paid by the Fund.

The MAPD Plan is essentially a Medicare replacement for inactive Medicare-eligible Retirees only. The MAPD Plan also provides a comprehensive program of supplemental medical benefits and prescription drug coverage. Under this arrangement: (1) the MAPD Plan—in lieu of the Fund—will be responsible for your medical charges as well as your medications; and (2) the Fund Office will continue to handle inquiries related to eligibility, Retiree premiums, excepted dental, vision benefits and death benefits, and all other matters outside the purview of the MAPD Plan. The following paragraphs summarize the benefits of the MAPD Plan and what to expect if you are a Medicare-eligible Participant.

(1) The MAPD Plan provides comprehensive benefits designed to help Medicare-eligible participants achieve better health outcomes, including wellness and chronic disease management programs.

(2) Medicare-eligible Participants will receive one or more new ID cards for medical and prescription drug coverage.

(3) Medicare-eligible Participants will not have to change their current doctor or hospital as long as they accept Medicare Assignment and the plan. "Assignment" means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

(4) Medicare-eligible Participants must be enrolled in Medicare Parts A and B and continue to pay their Medicare Part B monthly premium to the Social Security Administration, including any income-related surcharges, to be eligible for coverage under the MAPD Plan.

(5) While the MAPD Plan is intended to replicate (and, in some cases, enhance) the medical and prescription drug benefits currently offered by the Plan, there will be some differences in benefits, as determined by both the insurance carrier for the MAPD Plan and the Centers for Medicare and Medicaid Services (CMS) guidelines. Please refer to literature furnished by the insurance carrier regarding the benefits available under the MAPD Plan.

If you are Medicare-eligible, or will soon be Medicare-eligible, please do not hesitate to contact the Fund Office if you have any questions regarding the MAPD Plan.

(c) Medicare Coordination for Active Employees

If you are Medicare-eligible, but return to active employment, your eligibility under the MAPD Plan will terminate, and thereafter you may be covered under the Plan as an Active Eligible Employee. Under these circumstances, medical benefits provided by the Fund will be your primary coverage (and your spouse's, if they are also eligible for Medicare); Medicare Benefits will be secondary. As long as you remain eligible due to hours worked, you should continue to have your claims submitted 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. This provision does not apply to

eligible Employees, their spouses or Eligible Dependents entitled to Medicare benefits because of Total Disability or end-stage renal (kidney) disease after 18 months.

Medicare is primary if you make COBRA Continuation Coverage payments after age 65.

2A.04 ADDITIONAL BENEFITS FOR RETIREES

(a) Death Benefits

You are eligible for Retiree Death Benefits at no cost to you if you were eligible under the Medical Fund on the date of your retirement, and you are entitled to receive a pension from the pension fund of a Local Union participating in this Fund or are receiving a disability benefit from the Social Security Administration. Both Retirees eligible for Medicare and those not eligible for Medicare can qualify for this benefit.

The amount of Death Benefits is $10,000. 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 your Local Union and submit it to the Fund Office.

(b) Dental Benefits

The Fund provides dental coverage to Retirees if the Retirees' Home Local Union has negotiated the extra contribution needed to provide dental coverage to the Local's active participants and the Local has opted to provide dental coverage to all its retirees. The Retiree's premium will increase to cover the cost of the dental coverage. The benefits provided are described in a subsequent Chapter of this Plan.

(c) Vision Benefits

The Fund provides vision coverage to Retirees if the Retirees Home Local Union has negotiated the extra contribution needed to provide vision coverage to the Local's active participants and the Local has opted to provide vision coverage to all its Retirees. The Retiree's premium will increase to cover the cost of the vision coverage. The benefits provided are described in a subsequent Chapter of this Plan.

Chapter 2B – Supplemental ARESA Benefits

2B.01 ACTIVE AND RETIRED EMPLOYEES' SEPARATE ACCOUNT (ARESA)

Some Local Unions have negotiated a separate contribution to pay for Retiree Benefits and Supplemental Medical Benefits. These contributions are accounted for separately. If you think you are entitled to participate, you should contact the Union and Employer Trustees representing your local area or the Fund Office.

If your Local Union participates in the ARESA program, the following guidelines apply to you and your Local Union. There are separate eligibility guidelines for subsidy of Retiree Premiums and Supplemental Medical Benefits.

2B.02 SUBSIDY OF RETIREE PREMIUMS

The following rules apply to the subsidization of Retiree premiums:

(a) Eligibility in General

(1) The Employee must be eligible for Retiree benefits from this Fund.

(2) The Employee must have pension eligibility from the local area, either in the Local Union pension fund or the National Asbestos Workers Pension Fund. An Employee with Ownership Interests in an Employer satisfies the requirements of this paragraph if the Employee: (i) is covered by a Special Participation Agreement for Employees with Ownership Interests; (ii) has pension eligibility from the local area either in the Local Union pension fund, the National Asbestos Workers Pension Fund, the pension plan of an Employer signatory to the Collective Bargaining Agreement in the local area or for a retirement benefit from the Social Security Administration; and (iii) was actively working and participating in the Fund immediately prior to retirement.

(3) The Employee must have ten (10) years of participation in the local area in this Fund.

(4) The Employee must have seven (7) years of eligibility in the local area in this Fund.

(5) For those Local Unions that have not participated in this Fund for ten (10) years, the requirements of paragraphs (3) and (4) above can be met by an Employee who has participated in this Fund for all years since a particular Local Union has participated in this Fund and has been eligible for Benefits in seventy percent (70%) of the years the particular Local Union has participated in this Fund.

(6) A Local Union with an ARESA 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 ARESA eligibility guidelines indicated herein.

(7) Contributions must have been made on the Employee's behalf into the ARESA for thirty-six (36) out of the sixty (60) months, immediately preceding the Employee's pension effective date, to the Local Union account that will be paying the cost of Retiree Benefits for such Employee. If a Local Union has not been participating in this account for at least sixty (60) months, then contributions must have been made for such Employee for 3/5 of the entire period such Local Union has been participating. A Local Union may waive this requirement in accordance with subsection (b)(4) below.

(8) If you meet the guidelines for the ARESA based on your employment with a Local Union that

participates in the program, but you are not working out of that Local Union at the time of your retirement, you may still be eligible to participate in the ARESA of that Local Union when you retire. In order to qualify under this rule you must have worked for the International Association of Heat and Frost Insulators and Asbestos Workers, the AFL-CIO, a Building Trades Council or, subject to approval by the 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.

(b) Rules Adopted by Local Unions

(1) A Local Union participating will be permitted to structure retiree premium payment options from its ARESA as it decides, provided that the decision is approved by this Fund. The current ARESA programs are as follows: (i) Retirees only; (ii) Retirees and spouses; (iii) Retirees and Dependents; (iv) Retirees, spouses and widow(er)s; (v) Retirees, Dependents and surviving Dependents; (vi) Programs i. through v., excluding any person entitled to Medicare (age 65); (vii) any program with or without spouses and/or Dependents acquired after retirement; and (viii) Programs i. through v., excluding retirees under the age of 55 (Any participant excluded under this provision would be eligible for ARESA once the retiree reaches age 55 as long as the participant continued retiree coverage by making timely payments.)

(2) A Local Union with an ARESA may include a widow(er) of an Active Eligible Employee as long as the widow(er) meets the conditions for widow(er) coverage as described in the Plan.

(3) A Local Union with an ARESA may exclude a Retiree from receiving a Retiree premium subsidy if the Retiree commences work in a non-bargaining unit capacity.

(4) The Local Union's choice concerning waiver of the requirements of subsection (a)(7) and concerning its ARESA programs must apply uniformly to all ARESA participants from the Local Union. The Local Union will be required to complete a form to indicate its choice concerning the requirements of subsection (a)(7) and its choice of ARESA programs in writing. Any choice concerning the requirements of subsection (a)(7) and any choice of ARESA programs will apply until a new choice is filed. Any choice concerning the requirements of subsection (a)(7) and any choice of ARESA programs must remain in effect for at least one year. A change of ARESA programs must apply on a uniform basis to existing ARESA participants.

(5) Each Local that opts to pay other than 100% of the premium may be required to pay a fee to offset the additional administrative cost incurred. This fee will be deducted from the ARESA of the Local Union. The fee is determined from time to time by the Executive Committee.

(c) Financing Rules Applicable to Local Unions, Impact of Cessation of Contributions or Withdrawal

(1) Before Retirees' payments will be made from a Local Union's ARESA, the Local Union participating in the ARESA program must have enough money in its account to pay four quarterly premiums on all its Retirees.

(2) If a Local Union's ARESA balance falls below an amount equal to two quarterly payments for all its Retirees, the ARESA will discontinue payments for Retirees of that Local Union. The Retirees will automatically be advised they must make their own payments for Retiree benefits until further notice. Self-payment by the Retirees will continue until the ARESA balance again equals at least four quarters of payments for all Retirees of that Local Union.

(3) If a Local Union ceases contributions to its ARESA, the ARESA will continue to make payments for existing Retirees of that Local under these rules until the ARESA funds are depleted.

Additional Employees of the Local may qualify under these rules, however, subsection (a)(7) will be modified as follows: Contributions must have been made on the Employee's behalf into the Active and Retired Employees' Separate Account for thirty-six (36) out of the sixty (60) months, immediately preceding the date that the Local Union's ARESA contributions ceased, to the Local Union account that will be paying the cost of Retiree Benefits for such Employee. If a Local Union has not been participating in this account for at least sixty (60) months, then contributions must have been made for such Employee for 3/5 of the entire period such a Local Union has been participating. A Local Union's choice concerning the requirements of subsection (a)(7) will also apply to this Paragraph.

(4) If a Local Union ceases contributions to its ARESA and payments for Retirees of that Local Union are discontinued under these rules, the Home Local Union of a Retiree may elect to cover the Retiree under its ARESA provided this rule is applied uniformly by the Home Local Union.

(5) If a Local Union withdraws or merges into a Local Union which does not participate in the Fund, any assets remaining in its ARESA after payment of Retiree coverage for that month will be transferred to the medical fund in which the withdrawing or merged Local Union participates.

2B.03 SUPPLEMENTAL MEDICAL BENEFITS

(a) In General

(1) Supplemental Medical Benefits are available to all Eligible Participants of the Local Union which provides a Supplemental Medical Benefit Account through its ARESA. A Supplemental Medical Benefit Account can be provided to all Eligible Employees (active, disabled, retired) and Eligible Dependents of a Local Union or all Active Eligible Employees (including disabled individuals, and excluding retirees and dependents) only.

(2) The Local Union providing a Supplemental Medical Benefit Account must have enough money in its account to pay twelve (12) months of benefits provided. The estimate of this amount will be determined by the cost of the benefit for the most recent twelve months ending July 31.

(3) If a Local Union's Supplemental Medical Benefit Account balance falls below an amount equal to six (6) months of estimated benefits, the Supplemental Medical Benefit Account will discontinue payments and benefits for the Supplemental Benefits will be discontinued. A notice will be sent to the affected participants. Benefits can resume once the balance again reaches twelve (12) months.

(4) The effective date of the Supplemental Medical Benefit Account for any Local Union will be the first day of the second month following notification to the Fund. The effective date of any change to the Supplemental Medical Benefit Account will be the first day of the second month following notification of the change to the Fund.

(b) Benefits

(1) *Deductible and Basic Benefit*. The Supplemental Medical Benefit Account may be used for all or some of the following benefits: (i) Provide annual deductible of $250 per individual/$600 per family; (ii) Provide a Basic Benefit of $4,000 at 100%, after deductible is met.

(2) *Hour Bank*. The Supplemental Medical Benefit Account may be used to provide for an Hour Bank (either 200 or 400 hours). The Local Union providing this benefit must decide whether to provide a 200 or 400 hour bank and can only change this option once per calendar year. The rules of the Hour Bank and the funding through the ARESA account will be as follows:

- Any hours reported on a participant's behalf in excess of the hours required for initial eligibility or to continue eligibility will be put into an "Hour Bank" for purposes of continuing eligibility when a participant fails to meet the eligibility requirements. The maximum number of hours a participant may have in the "Hour Bank" at any time is 400 (200) hours.
- The cost of the Hour Bank will be determined by adding up the hours used for the quarter for each participant and multiplying the hours times the current contribution rate.

(3) *Additional Death Benefit*. The Supplemental Medical Benefit Account may be used to provide additional Death Benefits to eligible active and retired participants. Spouses and dependents of the eligible participant are not eligible for this benefit. The amount of death benefits may be either $3,000 or $5,000. The effective date of this benefit is the first day of the second month following the date of written notification to this benefit to the Fund. Subsections (a)(2), (3), and (4) of the Supplemental Medical Benefit Account rules apply.

(4) *Self-Payment Benefit*. For an Employee whose eligibility for coverage under the Plan's basic eligibility provisions has terminated due to insufficient work hours, a Local Union's Supplemental Medical Benefit Account may cover the self-payment due to the National Asbestos Workers Medical Fund for such Employee, up to 100% of the first $1,000 due, and 50% of any remaining amount due, *once in a calendar year*. The Employee must timely pay the remaining balance of the self-payment for amounts due in excess of $1,000.

Eligibility for this benefit is contingent upon final approval by the Union Trustee of the Local Union. During the period that the Employee is off work, he or she must remain available for work on a daily basis and remain in the geographic area covered by his or her Local Union. The self-payment for such Employee will not be made available to anyone who has refused any work in covered employment during the period of unemployment, or to an Employee who has left the unionized insulation industry.

Application for this benefit must be made prior to the due date for the self-payment to the National Asbestos Workers Medical Fund to avoid denial for late payment. The application for this benefit may be obtained from the Fund Office.

(5) *Medical Reimbursement Allowance.* A Local Union's Supplemental Medical Benefit Account may provide Eligible Employees and Retirees with an allowance that may be used to reimburse them for eligible expenses incurred during the calendar year which are not covered by the National Asbestos Workers Medical Fund or any other source. This allowance is called a Medical Reimbursement Allowance (MRA). Although there are not separate allowances provided for your spouse and Dependent children covered by the Plan, their expenses will also be reimbursable through your MRA, given that they meet the requirements for eligibility. Each Local Union that offers an MRA through its Supplemental Medical Benefit Account has the discretion to determine the maximum allowance amount available per calendar year, so long as such amount does not exceed $500.00.

You may use your MRA to be reimbursed for eligible health care expenses which are now only partially reimbursed or are not covered under the Plan. Such expenses, as defined under Section 213 of the Internal Revenue Code, include Deductibles, Copayments, Coinsurance, charges over the Usual, Customary, and Reasonable amount, and other non-covered eligible expenses for medical, prescription drug, dental, vision, and psychiatric services.

To be eligible for reimbursement, the expenses must be:

- incurred between January 1 and December 31 of the MRA calendar year;
- incurred while you are eligible for benefits under the Plan;
- submitted while you are eligible for benefits under the Plan;
- submitted for reimbursement on or before March 31st of the calendar year following the year the expenses were incurred; and
- properly submitted to the Fund Office with a copy of the Explanation of Benefits, the bill from the provider, and other acceptable proof that you paid the expenses and that they were not reimbursed by this or any other plan. You must also provide a written statement that the expense has not been reimbursed or is not reimbursable under any other health plan coverage, and, if reimbursed from the MRA, such amount will not be claimed as a tax deduction.

You may submit a claim to the MRA at any time during the calendar year after you have accumulated the full amount of the MRA in expenses eligible for reimbursement from the MRA. Any amounts under the full MRA amount may be submitted only after the end of the year. **Remember, all claims for a given calendar year must be submitted by March 31st of the following year. Any remaining MRA balance will be forfeited.**

If an Eligible Employee or Retiree dies prior to submitting a claim to the Fund Office for eligible expenses that would be reimbursed from his or her MRA but for the death of the Employee or Retiree, payment will be made to his or her estate. In such cases, the reimbursement claim must be completed and submitted to the Fund Office by either the surviving spouse or dependent of the Eligible Employee or Retiree, or by a representative of his or her estate.

You are permitted to opt out of and waive future reimbursements from your MRA annually and upon termination of covered employment, in which case you will not be eligible to receive MRA reimbursements for otherwise eligible expenses incurred during the waiver period. If you elect to opt out of and waive future MRA reimbursements, you may recommence your eligibility for MRA reimbursements effective on January 1st of a subsequent calendar year by advising the Fund Office in advance of such calendar year, so long as you are eligible for benefits under the Plan at the time your eligibility for MRA reimbursements recommences.

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

Chapter 3 – Right to COBRA Continuation Coverage

3.01 COBRA CONTINUATION COVERAGE

(a) In General

If you lose eligibility because your contribution hours are insufficient you may continue coverage under the regular self-payment rules or under these alternative self-payment rules which the Plan provides under COBRA. Also, if you are a new Retiree who is eligible for Retiree Health Benefits you may elect either the Retiree Benefits described in the previous Chapter or continue your coverage under the COBRA provisions of the Plan.

Under the COBRA rules you and/or your Dependents may continue limited 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 and your decision is irrevocable. 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 a widow(er) 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.

(b) COBRA Options

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 as provided by your Home Local Union ("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.

(c) Alternative Options

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan) even if that plan generally doesn't accept late enrollees.

3.02 COBRA RULES FOR 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.

As a Retired Employee, you have the right to purchase 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.

3.03 COBRA RULES FOR DEPENDENTS

If you choose not to purchase COBRA coverage for yourself, 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. However, the coverage can be continued for up to 36 months for your spouse and Dependent children if coverage would otherwise end because of: (a) your death; (b) divorce from your spouse; (c) your child's loss of status as a "Dependent" under the Plan; or (d) 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.

3.04 NOTICE REQUIREMENTS FOR COBRA

You or your spouse or Dependent children must notify the Fund Office in writing within 60 days of a divorce 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/or your Dependent's 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.

3.05 ELECTING COBRA

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.

The Plan is not responsible if a parent or guardian, acting on behalf of a minor Qualified Beneficiary, does not inform the minor Qualified Beneficiary of his or her rights to COBRA coverage within the 60-day period.

3.06 TERMINATION OF COBRA

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

(a) All health benefits provided by the Plan terminate.

(b) You, your spouse or eligible Dependent who has elected COBRA coverage do not make the required payments to the Fund on time.

(c) An Employee who has elected COBRA becomes covered by Medicare.

(d) You become covered by another group health plan after the loss of coverage from this Plan, unless the replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to you after your coverage under this Plan is taken into account.

(e) Coverage has been extended for up to 29 months due to disability, and there has been a final determination that the individual is no longer disabled.

Once COBRA terminates, it cannot be reinstated. You need not be immediately available for work in covered employment to continue coverage under the COBRA self-payment rules.

3.07 NOTIFICATION OF UNAVAILABILITY OR EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

If a Participant applies for COBRA and the Fund Office determines that the Qualifying Event or, second Qualifying Event, as the case may be: (a) does not entitle the Participant to COBRA; or (b) that the Participant's application or notice of Qualifying Event was not timely, the Fund Office will provide the Participant an explanation of why the Participant is not entitled to COBRA.

Furthermore, if a Participant's COBRA is terminated before the end of the maximum COBRA period, then (as soon as practicable) the administrator will provide an explanation of such termination to the Participant. The explanation shall state: (a) the reason why the COBRA has terminated early; (b) the effective date of termination; and (c) an explanation of any rights the Participant may have under the Plan or under any applicable law to elect an alternative group or individual coverage, such as a conversion right.

3.08 OBLIGATION TO NOTIFY THE PLAN OF A DIVORCE

In addition to the notice requirements under COBRA, you have an obligation to promptly notify the Fund Office in writing following a divorce. Unless COBRA is elected, the divorced spouse and children of the divorced spouse (stepchildren of the Employee) become ineligible for benefits upon the divorce. If notice of the divorce is not provided to the Fund Office, and as a result, benefits are paid to an ineligible person, the Trustees may decide to recover those benefits by treating such benefits as an advance, and deducting such amounts from benefits which become due to you until the entire amount of benefits erroneously paid is recovered. Also, if notice of divorce is not provided to the Fund office within 60 days, an Employee's spouse and children of the divorced spouse will lose their right to elect COBRA.

Chapter 4 – Major Medical Benefits

PART A – GENERAL INFORMATION REGARDING YOUR BENEFITS

Part A of this Chapter is designed to educate you about how to access medical care covered by the Plan. It is also designed to inform you about how financial responsibility for such care is allocated between you and the Fund. It addresses topics such as:

- How to access medical care through the PPO network.
- The distinctions between In-Network and Out-of-Network care.
- The importance of staying In-Network to minimize your expenses and the Fund's expenses.
- The meaning of: (a) Deductible; (b) Out-of-Pocket Maximum; (c) Coinsurance; and (d) Copayment.

Part B of this Chapter contains the Schedule of Major Medical Benefits. Part C of this Chapter provides additional information regarding the types of services covered by the Plan. Part D of this Chapter includes information regarding case management and utilization review. Finally, you should also note that the next Chapter describes what is excluded from coverage under the Plan.

As always, if you have any questions regarding the Plan or the manner in which the Fund operates, feel free to contact the Fund Office.

4.01 UnitedHealthcare

(a) In General

The Fund is party to a preferred provider organization network administration agreement with UnitedHealthcare (UHC or PPO). Pursuant to that agreement, UnitedHealthcare provides Participants with access to health care through a select group of providers through the **UnitedHealthcare Choice Plus Network** (In-Network or PPO providers). Providers outside of the UnitedHealthcare Choice Plus Network are referred to as Out-of-Network providers. The Fund will only cover an Out-of-Network claim if coverage is required by federal law, in which case it will cover the claim as if it were In-Network. Otherwise, Out-of-Network claims are NOT covered.

(b) How to Use the UnitedHealthcare Network | Your Identification Card

Participants will each receive a UnitedHealthcare identification (ID) card. Your ID card verifies your participation in the UnitedHealthcare network. It is important to take your ID card with you wherever you go, and you should present your ID card whenever you seek medical care. If any information on your ID card is incorrect, you misplace it, or need a new ID card, please contact the Fund Office.

(c) Finding an In-Network Provider

You can find providers in the UnitedHealthcare network by going to www.uhc.com/find-a-doctor. Please make sure you search the UnitedHealthcare Choice Plus Network. Finally, you may always contact the Fund Office if you have any issues with finding or dealing with a provider.

4.02 IN-NETWORK | OUT-OF-NETWORK

(a) In General, You Must See In-Network Providers to Receive Coverage and Have Your Claims Paid

If you receive care from an In-Network provider, the Fund will provide benefits at the In-Network Coinsurance and/or Copayment level specified in the Schedule of Benefits.

The Fund will only cover an Out-of-Network claim if coverage is required by federal law, in which case it will cover the claim as if it were In-Network. Otherwise, Out-of-Network claims are NOT covered.

(b) Risk of Using Out-of-Network Providers | Risk of Balance Billing

If you use an Out-of-Network provider, you may incur significantly higher out-of-pocket expenses. In addition, in certain cases, the Out-of-Network provider also may charge the Participant for the remainder (or "balance") of the provider's bill after applying payment (if any) from the Fund. This practice is often referred to as *balance billing*. Balance billing can occur regardless of whether you use an Out-of-Network provider by choice, for level of expertise, for convenience, for location, because of the nature of the services, or based on the recommendation of a provider.

However, you should be aware that certain states prohibit balance billing, in which case you should not be responsible for amounts balance billed. In addition, when you receive Emergency Services for an Emergency Medical Condition, you are protected from balance billing by a federal law known as the No Surprises Act. This protection extends to services you may receive after you're in a stable condition, unless you give written consent and give up your protection from being balance billed for these post-stabilization services in a manner that complies with federal law.

You are also protected from balance billing by the No Surprises Act if you are treated by an Out-of-Network provider at an In-Network facility, unless you give written consent and give up your protection from being balance billed for such treatment. However, in certain cases, such a provider cannot balance bill you under any circumstances. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, intensivist services, and other items or services rendered by an Out-of-Network provider if there was no In-Network provider at the facility who could provide the item or service.

Finally, you are also protected from balance billing if you receive air ambulance services and while you are considered a Continuing Care Patient as defined in subsection (c) below.

(c) Out-of-Network Services Treated as In-Network.

(1) *Services Covered by the No Surprises Act*. Out-of-Network services covered by the No Surprises Act will be treated as if rendered In-Network. These services include **Emergency Services** for an **Emergency Medical Condition**, services rendered by an Out-of-Network provider at an In-Network facility (unless, if permitted, you waive your protection from being balance billed), and air ambulance services.

In general, the term "Emergency Medical Condition" means an illness, injury, symptom, or condition severe enough that you reasonably believe it will risk serious danger to your health if you don't get medical attention right away. Officially, the term "**Emergency Medical Condition**" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

In general, the term "Emergency Services" means services received in an emergency room or appropriately licensed urgent care facility to check for an Emergency Medical Condition and treat you to keep such a condition from getting worse. Officially, the term "**Emergency Services**" means, with respect to an Emergency Medical Condition: an appropriate medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department appropriately licensed under state law

(including ancillary services routinely available to the emergency department or independent freestanding emergency department) to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the emergency department or independent freestanding emergency department, as are required under the Social Security Act (or would be required if the Social Security Act applied to the freestanding emergency department) to stabilize the patient. Emergency Services also include services you may receive after you're in a stable condition, unless you give written consent and give up your protection from being balance billed for these post-stabilization services in a manner that complies with federal law.

(2) *Continuity of Care*. Federal law requires extended In-Network treatment for qualifying "Continuing Care Patients" when such a patient's In-Network provider suddenly becomes an Out-of-Network provider. If you are a Continuing Care Patient, you may not be balance billed for services provided by the specified Out-of-Network provider or facility during a transitional care period. The transitional care period begins on the date of the notice that an individual qualifies as a Continuing Care Patient and ends after ninety days or until the individual no longer qualifies as a Continuing Care Patient, whichever is sooner.

A "Continuing Care Patient" is an individual who is: (i) undergoing a course of treatment for a serious and complex condition; (ii) undergoing a course of institutional or inpatient care; (iii) is scheduled to undergo nonelective surgery, including receipt of postoperative care; (iv) is pregnant and undergoing a course of treatment for the pregnancy; or (v) is or was determined to be terminally ill and is receiving treatment for such illness. A "serious and complex condition" means a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or a chronic illness or condition that is life threating, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time. If you may qualify as a Continuing Care Patient, as determined by the Fund, you will be notified of this possible status and how to apply.

(3) *Provider Directory Issues*. The Fund maintains a provider directory and other protocols for verifying a provider's In-Network or Out-of-Network status. If the directory or other protocol incorrectly advises you that a provider is In-Network, the services you receive from that provider will be treated as if rendered In-Network. (Incorrect advice furnished by the provider directory or other protocol must be verified through supporting documentation for this provision to apply.)

4.03 COINSURANCE | COPAYMENTS | DEDUCTIBLES | OUT-OF-POCKET MAXIMUM

(a) How much is paid under the Major Medical Benefit?

Unless otherwise stated in the Plan, covered expenses will be paid at 80% for In-Network UCR charges after the satisfaction of the Major Medical Deductible. After you have met the applicable calendar year Out-of-Pocket Maximum, all applicable UCR charges will be paid at 100%.

The Fund will only cover an Out-of-Network claim if coverage is required by federal law, in which case it will cover the claim as if it were In-Network. Otherwise, Out-of-Network claims are NOT covered.

(b) Coinsurance

The term Coinsurance refers to a type of cost-sharing whereby the Participant assumes responsibility for a percentage of the covered expenses for a covered service. It is the amount a Participant must pay for covered medical services after the Participant has satisfied any applicable Copayment or Deductible. The Coinsurance rates for specific covered services are listed in the Plan.

(c) Copayments or Copays

The term Copayment (or Copay) refers to a type of cost-sharing whereby the Participant pays a flat dollar amount each time a covered service is provided. The Copayment rates for specific covered items are listed in this Plan. Copayments do not apply towards the Annual Out-of-Pocket Maximums.

(d) Deductible

The term Deductible refers to the amount of covered expenses that a Participant must pay each calendar year before the Plan pays benefits.

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.

The Deductible does not apply towards the Annual Out-of-Pocket Maximums.

(e) Out-of-Pocket Maximum

The Plan limits your responsibility to pay for covered expenses to the Annual Out-of-Pocket Maximums listed in the following Section. After you meet the applicable Out-of-Pocket Maximum, the Plan will cover 100% of all applicable covered UCR charges for the remainder of the calendar year.

PART B – SCHEDULE OF MAJOR MEDICAL BENEFITS

4.04 SCHEDULE OF MAJOR MEDICAL BENEFITS

COMPREHENSIVE MAJOR MEDICAL BENEFIT FOR COVERED EXPENSES FOR ELIGIBLE EMPLOYEES, DEPENDENTS, AND ELIGIBLE EMPLOYEES NOT COVERED BY MEDICARE	
• Deductible (Per Individual)	$450
• Maximum Family Deductible Expense	$900
• Percentage of Major Medical Benefit Paid by the Plan (**In-Network**)	80%
• Percentage of the Major Medical Benefit Paid by the Participant (**In-Network**)	20%
• **In-Network** Individual Medical Out-of-Pocket Maximum (in addition to deductible)	$2,800
• **In-Network** Family Medical Out-of-Pocket Maximum (in addition to deductible)	$11,200
• **Out-of-Network** Medical Out-of-Pocket Maximum	None

[1] **IMPORTANT – The Fund will only cover an Out-of-Network claim if coverage is required by federal law, in which case it will cover the claim as if it were In-Network. Otherwise, Out-of-Network claims are NOT covered.**

[2] All percentages are percentages of Usual, Customary and Reasonable (UCR) Charges.

[3] A Copay of $100 will be applied if you or your dependents use the services of an emergency room. This Copay will be waived only if the visit to the emergency room was for Emergency Services for an Emergency Medical Condition. The $100 Copay will not be applied to your Deductible.

PART C – INFORMATION REGARDING SPECIFIC COVERED BENEFITS

All Employees (including Retirees not covered under the MAPD Plan) and their eligible Dependents who have satisfied the eligibility requirements of the Fund are covered for Comprehensive Medical Benefits as shown on the applicable Schedule of Benefits.

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. In addition, maternity benefits are available only for Eligible Employees and their spouses.

Remember: The Fund will only cover an Out-of-Network claim if coverage is required by federal law, in which case it will cover the claim as if it were In-Network. Otherwise, Out-of-Network claims are NOT covered.

As always, if you have any questions regarding the Plan or the manner in which the Fund operates, feel free to contact the Fund Office.

4.05 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 as follows:

- For a service or supply rendered by a PPO provider, the UCR charge is the fee the PPO provider has agreed to accept as payment in full under its contract with the PPO.
- For a service or supply rendered by an Out-of-Network provider that is subject to the No Surprises Act, the UCR charge is the Qualifying Payment Amount (QPA), determined in accordance with applicable federal regulations, based on the median contracted rate for the service, as adjusted periodically by the consumer price index. Participant cost-sharing will be based on the QPA. Initial payment to the provider will be based on the QPA, after which, if necessary, the Fund will resolve the remainder of the provider's bill in accordance with the negotiation and dispute resolution provisions of the No Surprises Act and its underlying regulations.
- For a service or supply rendered by an Out-of-Network provider that is not subject to the No Surprises Act, if applicable, the UCR charge is 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 95th percentile to make this determination.

4.06 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.

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 physical rehabilitation that are approved by (1) the Joint Commission on Accreditation of Hospitals, and (2) by the Accreditation Association for Ambulatory Health Care of Free Standing Ambulatory Surgical Association, and licensed by appropriate regulatory authorities.

Ambulatory Surgical Centers that do not meet the above requirement will be considered 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.

4.07 PHYSICIAN CHARGES

The term "Physician" means a person who is licensed to practice medicine or to perform surgery in the state in which he or she practices, who is practicing within the scope of his or her license, and who is providing a service covered by the Plan. The term "Physician" also includes any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

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.

4.08 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.

4.09 MATERNITY AND OBSTETRICAL BENEFITS

Maternity and obstetrical benefits are available only to you or your spouse (while you are eligible), with the caveat that such benefits will be covered for all Participants to the extent they qualify as preventive services under applicable federal law. Complications arising during pregnancy that result in surgery, treatment, or Hospital service are also covered by the Plan.

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).

4.10 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 incurred for Emergency Services to treat an Emergency Medical Condition. A Copay of $100 will be applied if you or your dependents use the services of an emergency room. This Copay will be waived only if the visit to the emergency room was for Emergency Services for an Emergency Medical Condition. The $100 Copay 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;
- 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 that are dispensed and administered by your provider;
- 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.

4.11 SURGICAL

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.

4.12 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 and, the repair is initiated within 6 months after the accident causing the injury. 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.

4.13 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.

4.14 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 (including Retirees) 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.

4.16 PREVENTIVE SERVICES

(a) In General

The Plan covers preventive services and supplies in the form of periodic physical exams, routine screening tests, immunizations, and other benefits to the extent required by applicable law. **Preventive services are not subject to the Plan's Deductible and are paid in full by the Fund when rendered In-Network.**

The Plan adheres to certain federal guidelines in determining the preventive services or treatments it will cover. To the extent not already set forth in the guidelines, the Plan may impose reasonable, recognized rules or other limits with respect to the number of visits or treatments it will cover in any given period of time for any one particular preventive service. To the extent any such limits or other rules are inconsistent with applicable law or the guidelines, applicable law or the guidelines will control.

The types of preventive services the Plan covers are described as follows:

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

(2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.

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

(4) With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force), which will be commonly known as HRSA's Women's Preventive Services: Required Health Care Plan Coverage Guidelines.

A comprehensive list of available preventive services may be found at the following website:

www.healthcare.gov/preventive-care-benefits/

The types of preventive services required by law may be updated from time to time and will be deemed to have been incorporated in the Plan by reference. Any change or update to the types of preventive services required by law will take effect with respect to the benefits provided under the Plan on the first day of the Plan Year beginning on or after one year following the date the change or update occurs.

Important Note: To the extent the comprehensive list referenced above is inconsistent with applicable law or the preventive service guidelines, such applicable law or guidelines will control. In addition, this Section will supersede any inconsistent or conflicting Plan provision regarding the coverage of services that are considered preventive under applicable law or the guidelines.

(b) Preventive Service Billing Practices

The following rules apply with respect to charging for Physician office visits that include covered preventive services:

(1) If a preventive service is billed separately (or is tracked separately) from an office visit, then this Plan will impose the applicable cost-sharing provisions with respect to the office visit but not for the preventive service;

(2) If a preventive service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive service, then the Plan will not impose the applicable cost-sharing provisions with respect to the office visit; and

(3) If a preventive service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive service, then the Plan will impose the applicable cost-sharing provisions with respect to the office visit.

The following example demonstrates the application of the Plan's preventive service billing practice rules:

Example. A Participant visits an In-Network provider to discuss recurring abdominal pain. During the visit, the Participant receives a blood pressure screening. Blood pressure screening has in effect a rating of A or B in the current recommendations of the United States Prevent Service Task Force with respect to the Participant and is covered under the Plan as a preventive service. The provider bills the Fund for an office visit and does not bill the blood pressure screening separately.

Conclusion. In this example, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver a preventive service. Therefore, because the provider did not bill the blood pressure screening separately from the charge for the office visit, the Participant must pay the charges pursuant to the Plan's cost-sharing provisions he or she would normally incur for the office visit.

(c) Additional Information Regarding Preventive Services

You should also take note of the following restrictions and other conditions related to preventive services:

(1) Preventive services must be billed correctly under the appropriate services codes.

(2) Preventive services may be subject to reasonable medical cost management techniques and standards (e.g., treatment, setting, frequency, and medical management standards) as imposed and altered by the Trustees from time to time.

(3) Preventive services may not be covered depending on the service at issue and the presence of various risk factors.

(4) Preventive services incurred for non-medical reasons (e.g., to maintain a license or employment, as part of judicial or administrative proceedings, a prerequisite for traveling or education purposes) are not covered under the Plan.

(5) A service that is provided to monitor or treat an existing condition and not as a preventive service will be covered to the extent otherwise covered by the Plan and will be subject to the Plan's applicable cost-sharing provisions.

(d) Coronavirus Preventive Services

Preventive services identified as qualifying coronavirus preventive services under applicable federal law are not subject to the Plan's Deductibles and are paid in full by the Fund when rendered In-Network.

The types of qualifying coronavirus preventive services the Plan will cover are items, services, or immunizations that are intended to prevent or mitigate COVID-19 and that are either:

(1) evidence-based items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) or

(2) immunizations with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

The Plan will cover qualifying coronavirus preventive services within 15 days of the Task Force's or CDC's recommendation.

PART D – CASE MANAGEMENT & UTILIZATION REVIEW

4.17 CASE MANAGEMENT

Case management is a collaborative process that facilitates and coordinates treatment to assure that it is appropriate, efficient, and in the most effective setting. It may be helpful for the Fund to use case management with individuals whose treatment needs are covered by the Plan, but may be difficult to manage appropriately because they are complex, costly, extensive, rehabilitative, or repetitive.

Case management may take many forms, but typically, a case management professional works closely with the patient, family, and health care providers to assist in determining appropriate treatment options to best meet the patient's needs, while also keeping costs manageable to protect the Fund's ability to provide benefits to all.

4.18 UTILIZATION REVIEW

Precertification is sometimes referred to as utilization management. It involves a team of UnitedHealthcare nurses and Physicians who work with your doctor to determine the medical necessity and right course of treatment or care based on nationally accepted guidelines. You must get precertification for: (a) all inpatient admissions including acute hospital, rehabilitation facilities, and skilled nursing facilities; (b) acute care; (c) high-risk maternity and routine (routine only if the stay exceeds federal requirements); (d) long-term acute care; and (e) applied behavioral analysis therapy. In addition, you must obtain precertification for certain categories of services performed on an outpatient basis, including but not limited to:

- High-tech Radiology (MRI, PET, CT, nuclear cardiology)
- Ear Devices
- Erectile Dysfunction
- Gastric Bypass
- Home Health Care

- Home Infusion Therapy
- Medical Injectables
- Musculoskeletal services (major joint surgery and pain management services)
- Orthotics and Prosthetics
- Durable Medical Equipment (insulin pumps, specialty wheelchairs, etc.)
- Cosmetic/Reconstructive Procedures
- Potential Experimental, Investigational, or Unproven Procedures
- Sleep Management
- Spinal Procedures
- Therapeutic Radiology
- Transplants
- Certain Outpatient Surgical or Unlisted Procedures

When you use an In-Network provider, that provider is responsible for precertification on your behalf. In case of an emergency admission, either you or your Physician must call to certify your admission within two business days of your admission.

Chapter 5 – Exclusions

5.01 IN GENERAL

The Plan provides benefits only for those medically necessary covered services and UCR charges expressly described in the Plan. **Any omission of a service or charge from the Plan of benefits shall be presumed to be an exclusion even though not expressly stated as such.** In addition, the Plan (including, but not limited to, Chapters 4, 6, and 10) does not cover (or limits) the services and supplies listed in this Chapter. These exclusions are in addition to any other exclusions set forth elsewhere in the Plan.

5.02 EXCLUSIONS

Comprehensive Medical Benefits provide coverage for most medical 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:

(a) Injury, illness or disease for which benefits are payable in accordance with the provisions of any worker's compensation or similar law.

(b) Eye glasses, hearing aids, eye re-fractions, and the fitting of eye glasses and hearing aids.

(c) Injuries caused by declared or undeclared war.

(d) 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.

(e) 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.

(f) An expense which would not be incurred except for the existence of insurance.

(g) Services rendered without charge.

(h) 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.

(i) Dental services, including dental x-rays, except for accidental injuries, osseous surgery and TMJ treatment subject to the limits of the Plan.

(j) 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:

  (1) It is required and appropriate for care of the illness or injury;

  (2) 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;

  (3) 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;

  (4) It is approved for reimbursement by the Health Care Financing Administration; and

  (5) It is not furnished in connection with medical or other research.

(k) 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.

Notwithstanding the foregoing, this general exclusion for investigational or experimental services or products does not include the routine patient costs for items or services furnished in connection with participation in a clinical trial if those costs would otherwise be covered under the Plan. "Routine patient costs" has the same meaning as that term is defined in the Public Health Services Act Section 2709 and includes items or services that are otherwise covered under the Plan and are used for the direct clinical management of the patient, but does not include items or services used solely to satisfy the data collection and analysis needs of the clinical trial.

(l) Charges in excess of the Usual, Customary and Reasonable Charge as defined in this Plan.

(m) 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, except as provided in Section 11.02(c).

(n) 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.

(o) Charges for custodial care.

(p) Charges in excess of the most prevalent semi-private Hospital rate except as specifically provided by this Plan.

(q) Charges for reversals of tubal ligations and vasectomies.

(r) Radial keratotomy, lasik or other laser eye surgery.

(s) Acupuncture, unless performed by a Physician.

(t) Occupational therapy or rehabilitation, except following illness or injury.

(u) Services provided or paid for by any other group health plan sponsored by an employer.

(v) Charges for treatment of intentionally self-inflicted injury, or injury sustained in the act of committing a crime, unless if due to domestic violence or mental illness.

(w) Charges for dietary control.

(x) Services or supplies not specifically listed as a covered service.

(y) Non-legend drugs.

(z) Vitamins (except prescription prenatal vitamins), minerals, dietary supplements, dietary drugs, etc., unless coverage is required by federal law.

(aa) Medications which can be legally purchased over the counter without a prescription, even if prescribed by a doctor, unless coverage is required by federal law.

(bb) Therapeutic devices or appliances.

(cc) Hypodermic needles or syringes (except those associates with insulin injections).

(dd) Any medication to promote hair growth.

(ee) Anabolic steroids.

(ff) Diet Aids.

(gg) Fluoride, unless coverage is required by federal law.

(hh) Charges in excess of the limits provided by the Plan.

(ii) Charges attributable to an Out-of-Network provider other than charges for which federal law requires coverage.

(jj) Charges attributable to the treatment of alcoholism, drug addiction, or substance abuse.

(kk) Charges for which prior authorization or precertification has been denied, or for which it was required but not obtained.

5.03 LIMITATIONS

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

(a) Charges for gastric bypass surgery for morbid obesity, if medically necessary, will be paid as any other covered surgery.

(b) 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:

(1) Consultation and office visits to dentists and medical doctors;

(2) X-rays and lab;

(3) Appliances and adjustments to appliances;

(4) Behavior modification (usually bio-feedback training) -- only when clinical evaluation indicates;

(5) Surgery;

(6) Orthodontia -- only covered if the Employee's coverage is under a Local which has dental coverage and 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.

(c) Claim payments involving transplants are paid as follows:

(1) If only the donor is eligible under this Plan no benefits will be paid, unless no other Plan or program will cover these expenses.

(2) If only the recipient is eligible under this Plan, the Plan provides benefits for both donor and recipient under recipient's benefits and limits.

(3) If both donor and recipient are eligible under this Plan, the Plan provides benefits for each under their respective benefits and limits.

(4) Should you need an organ transplant, the Fund’s PPO provides access to a voluntary Centers of Excellence program. Through the program, care coordination will be provided into transplant centers of excellence across the country and case management will be provided to the patient. Contact the Fund Office to access the program.

(d) 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.

(e) 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.

(f) Smoking cessation products will be covered as required under federal law.

(g) 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.

(h) Viagra (or similar drug) is limited to eight (8) pills per month.

(i) 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.

(j) Benefits for nutritional counseling for participants and dependents with a diagnosis of diabetes, will be reimbursed, within the normal provisions of the Plan, with a lifetime maximum of $240.00.

Chapter 6 – Prescription Drug Benefits

6.01 INTRODUCTION

The National Asbestos Workers Medical Fund offers a comprehensive program of prescription drug benefits to active Participants, non-Medicare Retirees, and their non-Medicare Dependents. The Trustees have appointed CVS/Caremark as the Fund's Pharmaceutical Benefit Manager (PBM) to oversee this program. You may access the program with your combined medical and prescription drug card, which enables you to purchase medications at discounted prices from participating pharmacies across the country.

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 unless coverage is required by federal law.

To obtain a list of participating pharmacies that have partnered with CVS/Caremark, you may visit the CVS/Caremark website at www.caremark.com, call CVS/Caremark directly at 1-844-379-1677, or contact the Fund Office. The CVS/Caremark website also allows you to set up a personal account, refill mail order prescriptions, view claims, research medications, and much more.

The following sections include additional information regarding the Plan's prescription drug program. We encourage you to read this information carefully and to contact the Fund Office if you have any questions.

6.02 THE PLAN'S PRESCRIPTION DRUG PROGRAM

(a) Schedule of Benefits

Type of Drug	Your Cost If You Use Any In-Network Retail Pharmacy for a 30-Day Supply	Your Cost If You Use the CVS/ Caremark Mail Order Service or a CVS Pharmacy for a 90-Day Supply
Generic	20% Coinsurance	20% Coinsurance
Brand / Non-Preferred	20% Coinsurance	20% Coinsurance
Brand / Preferred	20% Coinsurance	20% Coinsurance
Specialty drugs must be filled through CVS/Caremark's specialty pharmacy.		
Specialty / On PrudentRx List	If enrolled in PrudentRx: No Charge If not enrolled in PrudentRx: 30% Coinsurance	
Specialty / Other	20% Coinsurance	

(b) Out-of-Pocket Maximum / No Deductible

The annual out-of-pocket maximum for prescription drugs is $1,000 per person and $4,000 per family. Participants who reach the out-of-pocket maximum will have their covered CVS/Caremark-filled prescriptions paid for by the Fund in full for the remainder of the year.

If you do not enroll in PrudentRx your out-of-pocket expenses for any drugs that are on the PrudentRx drug list will not accumulate towards your out-of-pocket maximum and those drugs will not be covered at 100% if you meet your out-of-pocket maximum.

The prescription drug program is not subject to a Deductible.

(c) You Must Use Participating Pharmacies

(1) *In General*. Participants must fill their prescriptions through participating pharmacies with their combined medical and prescription drug card. Except as provided for specialty and maintenance medications, participants are not limited to CVS stores, as the vast majority of independent pharmacies and chains also participate in the CVS/Caremark network.

(2) *Paper Claims*. If participants do not use their combined medical and prescription drug card and pay the full cost of the drug out-of-pocket, they may submit a paper claim for reimbursement based on the CVS/Caremark contracted rate less the Copayment.

(3) *No Coverage for Out-of-Network Claims*. No reimbursement is available if participants use an out-of-network pharmacy. In other words, the Fund does not pay for drugs that participants purchase from pharmacies outside of the CVS/Caremark network.

(d) Types of Medications and Special Rules

(1) *Brand-Name Medications*. A brand-name medication 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.

(2) *Generic Medications*. A generic medication is an FDA-approved drug with chemically identical active ingredients to its corresponding brand-name drug. A generic medication typically becomes available when the patent for the corresponding brand-name drug has expired. Generic medications are normally much less expensive than their brand-name equivalent. In order to save you and the Fund money, the Trustees encourage you to use generic medications whenever possible.

(3) *Mandatory Use of Generic Medications When Available*. If a participant purchases a brand-name medication when a generic equivalent is available, the participant must pay the applicable coinsurance amount plus the cost difference between the generic medication and the brand-name medication, unless the participant's physician demonstrates that the brand-name medication is medically necessary.

(4) *Specialty Medications*. Specialty medications include drugs that have been developed through advances in pharmaceutical research and are used to treat specific chronic conditions. These medications may include genetically bioengineered proteins, blood derived products, or complex molecules that require refrigeration or special handling. Specialty medications can be significantly more expensive than other types of drugs offered under the Plan.

All specialty medications must be filled through CVS/Caremark's specialty pharmacy.

(5) *Maintenance Medications*. Maintenance drugs include medications that participants take on a regular basis, such as medications for diabetes, high blood pressure, or heart conditions. When filling prescriptions for maintenance drugs, you are permitted to receive up to a 90-day supply, provided you utilize the CVS/Caremark mail order service or a local CVS/Caremark pharmacy. Other participating pharmacies may not fill more than a 30-day supply.

(6) *Compound Medications*. Compound medications are a class of expensive drugs consisting of a multi-ingredient mixture of medications. These medications may not be medically necessary, and suitable alternatives could be available. To help eliminate unnecessary waste, compound medications that cost in excess of $300 must be authorized in advance by CVS/Caremark.

(e) The Formulary / Official List of Covered Medications

The Plan covers drugs in CVS/Caremark's official list of covered medications, referred to as the PDL or *formulary*, as tailored for the Plan. Conversely, CVS/Caremark must review and pre-approve all specialty medications.

Provisions of the Plan Design Document or PDD (as that term is defined in the Fund's PBM agreement with CVS/Caremark) relating to the prescription drug benefits offered by the Plan, as amended, are incorporated into the Plan by reference.

(f) Formulary Changes, Prior Authorization and Step-Therapy

To help control prescription drug costs and maintain the long-term viability of the Plan's prescription drug program, the Trustees may agree to accept changes to CVS/Caremark's formulary. Such changes may result in the removal of medications from the formulary, require you to obtain prior authorization for medical necessity, or require you to try certain medications first before using other more expensive medications for the same condition ("step-therapy"). This may result in the Plan not covering certain drugs or denying claims in cases where you do not obtain prior authorization or have not satisfied the step-therapy protocols.

An updated list of drugs covered by the Plan due to changes in CVS/Caremark's formulary and an updated list of medications requiring prior authorization will be made available online at www.caremark.com, or you may request a copy of these lists by calling CVS/Caremark at 1-844-379-1677.

If you have been previously prescribed a prescription drug that the Plan ceases to cover because CVS/Caremark removes the prescription drug from its formulary, you should receive notice in writing of such change. However, the change will become effective even if you do not receive notice before the effective date of such change.

(g) Special Programs

(1) *Review Programs*. To help control prescription drug costs for you and the Fund, the Trustees may authorize the Fund to participate in certain clinical and utilization review programs, including programs similar to the foregoing. Among other things, these programs may require you to obtain certain medications from designated pharmacies or the mail order service. In addition, these programs may impose prior approval requirements or quantity limits on certain medications.

(2) *Fraud, Waste and Abuse*. The Trustees may authorize CVS/Caremark to monitor physician and patient prescription drug utilization patterns to help the Fund reduce health risks and unnecessary spending associated with fraud, waste and abuse. Such monitoring enables the Fund to identify potential problem prescribers and unusual or excessive utilization patterns. When CVS/Caremark identifies an unusual or excessive pattern of prescription drug use, the Trustees may authorize CVS/Caremark to restrict the filling of that prescription drug to one designated pharmacy or restrict a patient to a single physician for the prescribing of prescription drugs.

(3) *Dose Optimization*. Many prescription drugs are available at various strengths and their total cost may vary depending on the dosage strength. At times, for example, it may be more cost-effective to receive a daily dose of a 100mg tablet versus a daily dose of two 50mg tablets. Evaluating the cost-effectiveness of a particular drug dosage is referred to as dose optimization.

The Trustees may authorize CVS/Caremark to engage in dose optimization in an effort control prescription drug costs for you and the Fund.

(4) *CVS Caremark PrudentRx Specialty Drug Copay Program.* In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the Fund has contracted to offer the PrudentRx Solution for certain specialty medications effective April 1, 2023. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution. *In other words, the medication for that member will be provided at <u>no cost</u> to the member.*

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient's cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403.

Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your deductible or ACA out-of-pocket maximum (if any), unless otherwise required by law.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

6.03 UNAUTHORIZED OR FRAUDLENT USE OF YOUR CARD

Your combined medical and prescription drug card may only be used on behalf of eligible persons. Unauthorized or fraudulent use of your card to obtain prescription drugs will result in the immediate cancellation of your prescription drug benefit.

6.04 LIMITATIONS AND EXCLUSIONS

The following items are limited or excluded under the Plan's prescription drug program:

(1) Medications that can be legally purchased over the counter without a prescription, even if prescribed by a doctor.

(2) 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.

(3) Charges for dietary control, diet aids, or medications used for the purpose of weight loss.

(4) Non-legend drugs.

(5) Vitamins (except prescription prenatal vitamins), minerals, dietary supplements, dietary drugs, etc, unless coverage is required by federal law.

(6) Hypodermic needles or syringes (except those associated with insulin injections).

(7) Any medication to promote hair growth.

(8) Anabolic steroids.

(9) Charges for which prior authorization or precertification has been denied, or for which it was required but not obtained.

(10) Nicoderm/Habitrol Patches and smoking cessation products are covered only to the extent required under federal law.

(11) Medically necessary services for the treatment of infertility for active participants and their spouses are subject to a lifetime family cap of $10,000 (including prescriptions). This benefit will not cover any procedures for the reversal of voluntary sterilization or any procedure if the participant and/or spouse has previously undergone voluntary sterilization.

(12) Viagra (or similar erectile dysfunction drugs) is limited to eight (8) pills per month.

(13) Any medication for the treatment of alcoholism, drug addiction, or substance abuse.

(14) The cost difference between a brand name drug and its available generic equivalent when the Participant or provider requests the brand name drug, unless the brand name drug is approved due to medical necessity.

The above-referenced limitations and exclusions apply in addition to those listed elsewhere in the Plan.

6.05 CLAIMS AND APPEALS

In its capacity as the Fund's Pharmaceutical Benefit Manager, CVS/Caremark is responsible for making initial prescription drug claim determinations and handling several levels of appeals. If CVS/Caremark denies your appeal, you may submit a voluntary appeal to the Executive Committee for consideration.

The Plan's claims and appeals procedures for prescription drug claims contain detailed information regarding the timeframes for making decisions, the deadlines for submitting appeals, information regarding your rights as a participant, and other special rules. We encourage you to refer to these rules and read them carefully.

CHAPTER 6 | APPENDIX
NATIONAL ASBESTOS WORKERS MEDICAL FUND
CLAIMS AND APPEALS PROCEDURES FOR PRESCRIPTION DRUG CLAIMS

As the Fund's Pharmaceutical Benefit Manager, CVS/Caremark is responsible for making initial prescription drug claim determinations and handling several levels of appeals. The following paragraphs summarize the procedures CVS/Caremark will follow in performing its duties on behalf of the Fund.

DEFINITIONS

A **claim** is a request for a Plan benefit that is made in accordance with the established procedures for filing benefit claims. Interactions between you and your pharmacy do not qualify as a claim.

A **pre-service claim** is any claim for which the terms of the Plan condition receipt of a benefit, in whole or part, on receiving approval in advance of obtaining the benefit.

An **urgent care claim** is a pre-service 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 is not addressed within the 72-hour "urgent care" timeframe. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Fund, 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 Fund will treat your claim as an urgent claim. Only pre-service claims may be considered urgent care claims.

A **post-service claim** is a claim that is not a pre-service claim.

Products or services are considered **medically necessary** (medical necessity) if: (1) use of the product or service meets clinically appropriate criteria in accordance with U.S. Food and Drug Administration (FDA)-approved labeling or nationally recognized compendia (such as American Hospital Formulary Service [AHFS] or Micromedex) or evidence-based practice guidelines; (2) use of the product or service represents the most appropriate level of care, based on the seriousness of the condition being treated, the frequency and duration of the use of the product or service, and the place where the product or service is administered; and (3) use of the product or service is not solely for the convenience of you, your family or your provider.

The term **adverse benefit determination** refers to a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit, including such action resulting from the application of any utilization review, clinical review, or other similar program authorized by the Trustees and implemented by CVS/Caremark. The term adverse benefit determination also refers to a failure to cover a product or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically appropriate.

The term **adverse coverage determination** refers to a determination that a particular product or service is not covered under the Plan by virtue of the Plan's terms. The Plan covers drugs in CVS/Caremark's official list of covered medications, referred to as the PDL or formulary, as tailored for the Plan. Provisions of the Plan Design Document or PDD (as defined in the Fund's PBM agreement with CVS/Caremark) relating to the prescription drug benefits offered by the Plan, as amended, are incorporated into the Plan by reference.

INITIAL CLAIMS DETERMINATIONS

CVS/Caremark will make a decision on a pre-service claim within **15 days** after it receives the claim. If the claim is urgent, CVS/Caremark will make a decision on the claim as soon as possible, but not later than **72 hours**. CVS/Caremark will make a decision on a post-service claim within **30 days** after it receives the claim.

APPEALS

- **In General**

  You may file an appeal in response to any adverse benefit determination or adverse coverage determination. You, your physician, or your authorized representative must submit your appeal to CVS/Caremark with **180 days** of receipt of such determination. In general, your appeal must be made in writing. However, if your appeal relates to an urgent care claim, you may also submit your appeal by calling CVS/Caremark.

  Your appeal should include: (1) a clear statement that your communication is intended to appeal an adverse determination; (2) your identification number as listed on your combined medical and prescription drug card; (3) your date of birth; (4) the name of the drug or benefit being requested; and (5) comments, documents, records, relevant clinical information, and any other materials relating to the claim.

- **Pre-Service Adverse Benefit Determinations**

  Pre-service appeals relating to adverse benefit determinations are subject to two levels of review. CVS/Caremark will conduct the first-level of review, which involves an evaluation of your appeal in the context of pre-determined medical criteria relevant to the drug or benefit being requested. However, if your appeal does not meet these criteria, a review will be conducted by an appropriately-qualified reviewer. CVS/Caremark will make a decision regarding your first-level appeal within **15 days** after it receives your appeal.

  If the first-level review of your appeal is denied, you will receive a denial notice with instructions on how to request a second-level review. If you request a second-level review, an appropriately-qualified reviewer or sub-delegated review organization will determine whether the drug or benefit requested is medically necessary. CVS/Caremark will make a decision regarding your second-level appeal within **15 days** after it receives your appeal.

  If your appeal is related to an urgent care claim, CVS/Caremark will perform both the first-level and second-level medical necessity review, combined, within **72 hours**. If the first-level request is approved, no further review is required and you will receive a notice of approval. However, if the first-level review results in a denial, a second-level review will be initiated automatically. You will receive notice of CVS/Caremark's determination at the conclusion of the medical necessity review.

- **Pre-Service Adverse Coverage Determinations**

  Pre-service appeals relating to adverse coverage determinations are subject to one level of review. CVS/Caremark will conduct this review, which involves an evaluation of your request for a particular drug or benefit against the terms of the Plan. CVS/Caremark will make a decision regarding your appeal within **30 days** (**72-hours** for an urgent appeal) after it receives your appeal.

- **Post-Service Adverse Determinations**

  Post-service appeals relating to adverse determinations are subject to one level of review. CVS/Caremark will conduct this review, which involves an evaluation of your request for a particular drug or benefit against the terms of the Plan. CVS/Caremark will make a decision regarding your appeal within **60 days** after it receives your appeal.

- **Appeal Review Procedure**

  During its review of an appeal of an adverse determination, CVS/Caremark will:

1. Provide for a full and fair review, allowing you to review the claim and to present evidence and testimony. This includes providing you (free of charge) with new or additional evidence or rationale relied upon-in advance of a final adverse benefit determination, and giving you a reasonable opportunity to respond.
2. Take into account all comments, documents, records and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
3. Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents.
4. Follow reasonable procedures to ensure that the applicable Plan provisions are applied in a manner consistent with how such provisions have been applied to similarly situated participants.
5. Provide a review that is designed to ensure the independence and impartiality of the person making the decision.
6. Provide a review that does not give deference to the initial benefit determination and is conducted by someone other than the individual who made the initial benefit determination (or a subordinate of such individual).

For a claim requiring a medical necessity review, CVS/Caremark, in addition to the above, will also: consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; ensure that the health care professional was not consulted in connection with the initial benefit determination (nor a subordinate of such individual); and, upon request, identify the health care professional, if any, whose advice was obtained in connection with the initial benefit determination.

- **Decision Letters**

Following a review of your claim or appeal, CVS/Caremark will notify you of its decision in writing. Decisions on urgent care claims and appeals will also be communicated by telephone.

The decision letter will include: (1) the specific reason or reasons for the decision in easily-understood language; (2) reference to pertinent Plan provisions on which the determination was based; (3) in the case of a notice of adverse benefit determination, a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; (4) a statement that you are entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; (5) if an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, either a copy of the specific rule, guideline, protocol or similar criterion; or a statement that such information will be provided free of charge upon written request; (6) if the decision was based on medical necessity, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances, or a statement that such explanation will be provided free of charge upon written request; (7) a statement of your right to bring action under ERISA Section 502(a); (8) a description of the available appeals process, including information on how to file an appeal; and (9) information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review.

- **Authority as Claims Fiduciary**

The Trustees have delegated CVS/Caremark the authority to serve as the Fund's claims fiduciary with

respect to prescription drug benefit claims arising under the Plan and review of appeals of adverse benefit determinations and adverse coverage determinations. Accordingly, CVS/Caremark has, on behalf of the Fund, full and complete discretionary authority to: (1) interpret the Plan's provisions relating to prescription drug benefits; (2) make factual findings; and (3) make conclusive determinations with respect to prescription drug claims for all parties. Such determinations shall be final, subject to judicial review only for abuse of discretion. These provisions extend to any sub-delegated medical necessity review organization designated by CVS/Caremark.

- **Required Exhaustion of Claims Procedures**

  You may not commence a judicial proceeding against any person, including the Fund, any of its Trustees, any fiduciary of the Plan, or the Administrative Agent, with respect to a claim for prescription drug benefits without first exhausting the procedures set forth in this Appendix.

EXECUTIVE COMMITTEE REVIEW

If CVS/Caremark denies your appeal, you may submit a voluntary appeal to the Executive Committee for consideration. Your appeal will be considered during the Executive Committee's next regularly scheduled meeting. The Executive Committee encourages all participants to take advantage of this voluntary level of review to ensure that all issues relating to your prescription drug coverage are resolved appropriately.

As required by regulation, the Fund: (1) waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit your claim to the Executive Committee; (2) agrees that any statute of limitations or other defense based on timeliness is tolled during the time that such voluntary appeal is pending; and (3) will not require you to pay any fees or costs associated with the voluntary review. In addition, you may submit your claim for voluntary review only after exhausting all prior available levels of review, and the decision of whether to submit your claim for voluntary review will have no effect on your rights to any other benefits under the Plan.

The Fund will provide you, upon request, sufficient information regarding the voluntary appeals process to enable you to make an informed judgment about whether to submit a voluntary appeal. As previously indicated, the Executive Committee believes the voluntary appeals process is an important feature of your prescription drug program and encourages you to use the voluntary appeals process whenever possible.

The Executive Committee has full discretion and authority to determine all matters relating to the benefits provided under the Plan, including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Executive Committee denies your appeal of a claim, and you decide to seek judicial review, the Executive Committee's decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

EXTERNAL REVIEW

Regardless of whether you initiate a voluntary review by the Executive Committee as described in the previous paragraphs, you may ask for an external review to be conducted by an impartial third party. Information regarding the external review process may be found in Chapter 13.

Chapter 7 – Dental Benefits

7.01 IN GENERAL

(a) Required Contributions

The Fund provides coverage for dental care for Eligible Employees, their Dependents and Eligible Retirees and their Dependents only if their Home Local Union has negotiated the extra contribution needed to support this benefit and their Home Local has opted to provide Dental Coverage to Retirees.

If a Local Union adds Dental Coverage, coverage is effective the first of the month following the month contributions are required. If a Local Union terminates Dental coverage, coverage terminates the last day of the month contributions are required.

Note: If you travel outside of your Home Local Union, dental benefits and vision benefits will be determined by the contribution rate under the Collective Bargaining Agreements of your Home Local Union for your classification. The formula to calculate your self-payment amount is also based on the contribution rate of your Home Local Union and your classification. Your "Home Local Union" is the participating Local Union of which you are a member or, if you are not a union member, the participating Local Union in which you worked when contributions were first made to this Fund on your behalf.

Upon written request to the Fund Office a Participant may opt out of (and, if applicable, opt back into) dental care from this Plan. Because contribution rates to the Fund are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after your written request is received by the Fund Office.

(b) Usual, Customary and Reasonable

Usual, Customary and Reasonable charges are determined by taking into consideration: (a) the fee charged by a majority of dentists for the services or supplies in the geographic area where the care was provided; and (b) complications or special circumstances that arose, if any.

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

7.02 COVERED ITEMS

80% of the Usual, Customary and Reasonable charge, as certified to by the doctor, with an annual calendar year maximum of $800.00 per Employee and covered Dependent, for the following procedures:

(a) 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.

(b) 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.)

(c) Oral prophylaxis (cleaning of teeth) twice a year.

(d) Emergency treatment for the relief of pain.

(e) Fillings or restorations consisting of amalgam, silicate, acrylic or composite material once per calendar year per tooth surface.

(f) One recementation during a calendar year for any given crown, bridge, facing or inlay.

(g) One consultation by any one dentist consultant (other than the attending dentist) during the calendar year.

(h) Simple extractions -- not involving cutting of tissue or bone.

(i) One topical fluoride application (used to reduce susceptibility to decay) during a calendar year for individuals under age 17.

(j) One of the following repairs of the same removable denture during a calendar year:

(1) Repair broken full or partial denture, no teeth damaged.

(2) Repair broken full or partial denture and replace broken teeth.

(3) Replace broken tooth on denture, no other repairs.

(4) Adding teeth to partial denture to replace extracted teeth.

(5) Re-attach or replace damaged clasps on denture.

(k) Endodontia (root canal treatments and fillings; removal of pulp; and amputation of root tip).

(l) Pulp capping; placement of mediated material to protect the nerve.

(m) Space maintainers to preserve space created by prematurely lost primary (baby) teeth.

(n) Gold inlays and onlays -- not part of a bridge.

(o) 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.)

(p) Gold foil restoration.

(q) Oral surgery -- limited to:

(1) Biopsy and examination of oral tissue.

(2) Treatment of dislocated or fractured jaw.

(3) Removal of tumors and cysts; treatment of abscesses.

(4) Surgical extraction of erupted teeth.

(5) Extraction of impacted teeth.

(6) Removal of abnormal bony growths (tori).

(r) Radiograph (special x-ray) temporo-mandibular joint, single film.

(s) Models for diagnostic purposes.

(t) Some of the more frequently performed surgical procedures are:

(1) Extraction of retained root tips

(2) Tooth replantation

(3) Surgical preparation of bony tissues for dentures (alveoli-plasty)

(4) Removal of foreign bodies

(5) Repair of traumatic wounds

(6) Removal of abnormal oral tissue growth (hyperplastic tissue)

(7) Excision of inflammatory lesions

(8) Other oral surgical procedures approved by the Fund.

(u) Dentures, removable, full and partial.

(v) Bridges, except that benefits are not provided for:

(1) 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.

(2) Any denture or bridge replacement made necessary by reason of the loss or theft of a denture or bridge.

(3) Replacement of an existing denture or bridge which could have been repaired.

(4) Precious metals used in preparing any denture including any increased charge occasioned by the use thereof.

(5) 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.

(w) 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).

(x) Relining or rebasing of denture (no Treatment Plan required).

(1) For existing dentures -- If performed in laboratory, limited to one relining per denture during three consecutive calendar year period; 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.

(2) Immediate denture -- (that placement following extraction of natural teeth) limited to two relinings during the first two years following placement.

(y) 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.)

(z) Gingival curettage -- removal of diseased tissue (no Treatment Plan required).

(aa) Gingivectomy (removal of gum tissue) or gingivoplasty (recontouring and re-attachment of gum tissue).

(bb) Osseous surgery (related to the bone) as a result of a periodontal condition, including flap entry and closure.

(cc) Treatment of acute infection and oral lesions (no Treatment Plan required).

(dd) Orthodontics -- limited to a lifetime payment of $1,500.00. (This benefit is not in addition to the annual calendar maximum of $800.00 per Employee or Dependent per year unless an additional contribution rate is contributed for all participants in your Local to provide for additional orthodontic coverage.)

(ee) Sealants - limited to one application per tooth, once every five years.

(ff) If your Home Local Union has negotiated the extra contribution needed to support the additional orthodontia benefit, the plan will cover 80% of the Usual, Customary and Reasonable charge for orthodontia benefits, as certified by the doctor, for a maximum of $2,000 per lifetime per Employee and Dependent.

Dental benefits provided to children age 18 and under are not subject to an annual cap. Routine examinations will be limited to two per calendar year, and the benefit is subject to standard medical protocols and Reasonable and Customary limitations.

Orthodontia is subject to the above-referenced maximums. Once the maximums are reached, medically necessary pediatric orthodontic treatment will still be covered, provided that the participant receives precertification from the Fund that the pediatric orthodontic treatment is, in fact, medically necessary. Precertification requests must be submitted to the Fund Office and must include diagnosis, treatment plan, x-rays, photographs and photographs of teeth models.

7.03 DENTAL CARE EXCLUSIONS

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

(a) 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.

(b) Dental services for which the Employee or Dependent incurs no charge.

(c) Dental services for which coverage is available to the Employee or Dependent, in whole or in part, under any Worker's Compensation Law or similar legislation whether or not the Employee or Dependent claims compensation or receives benefits thereunder.

(d) Dental services for cosmetic or aesthetic purposes.

(e) 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.

(f) Precious metals, including any increased charge occasioned by the use thereof.

(g) Dental services which are not necessary for the diagnosis or treatment of any dental disease, defect or injury.

(h) Dental services rendered prior to the date Dental Benefits become effective, or dental services in process on the date the Dental Benefits become effective.

(i) Services not specifically listed.

(j) Broken appointments.

(k) General Anesthesia, if not administered for a covered procedure *and* performed by a dentist.

(l) Injectable drugs not administered by a dentist for therapeutic purposes under this program.

(m) Dental implants.

Chapter 8 – Vision Benefits

8.01 IN GENERAL

The Fund provides coverage for vision care for Eligible Employees, their Dependents and Eligible Retirees and their Dependents only if their Home Local Union has negotiated the extra contribution needed to support this benefit and their Home Local has opted to provide Vision Coverage to Retirees.

If a Local Union adds Vision Coverage, coverage is effective the first of the month following the month contributions are required. If a Local Union terminates Vision Coverage, coverage terminates the last day of the month contributions are required.

Note: If you travel outside of your Home Local Union, dental benefits and vision benefits will be determined by the contribution rate under the Collective Bargaining Agreements of your Home Local Union for your classification. The formula to calculate your self-payment amount is also based on the contribution rate of your Home Local Union and your classification. Your "Home Local Union" is the participating Local Union of which you are a member or, if you are not a union member, the participating Local Union in which you worked when contributions were first made to this Fund on your behalf.

Upon written request to the Fund Office a Participant and/or Eligible Dependent may opt out of (and, if applicable, opt back into) vision care from this Plan. Because contribution rates to the Fund are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after your written request is received by the Fund Office.

8.02 SCHEDULE OF ALLOWANCES & COVERED BENEFITS

Vision benefits covered include professional fees for vision surveys / analyses, materials, lenses and frames. The maximum allowance for all benefits is $200 per Employee and covered Dependent per calendar year. Professional fees, materials and lenses are available once each calendar year, if necessary. Frames and contact lenses are available every other calendar year.

Optical benefits provided to children age 18 and under are not subject to the annual cap of $200. Routine examinations and replacement of frames and lenses will be limited to once every two calendar years, and the benefit is subject to standard medical protocols and Reasonable and Customary limitations.

8.03 EXCLUSIONS

This Chapter does not cover the following:

(a) Sunglasses, plain or prescription, unless the Employee or Dependent is eligible for benefits again and then in lieu of new glasses.

(b) Special procedures such as orthoptics, vision training, subnormal vision aids, aniseikonia, etc.

(c) Replacement of broken lenses and/or frames, unless the Employee or Dependent is eligible for benefits again and then in lieu of new glasses.

(d) Medical or surgical treatment of the eyes -- this may already be covered under existing medical and surgical benefits, and any Eligible Employee or his Dependents found to be in need of such treatment should check other benefits available under another portion of the Plan.

(e) 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.

(f) Vision services for which the Employee or Dependent incurs no charge.

(g) Vision services for which coverage is available to the Employee or Dependent, in whole or in part, under any Worker's Compensation Law or similar legislation whether or not the Employee or Dependent claims compensation or receives benefits thereunder.

(h) Vision 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 vision services from any health or vision benefits plan.

(i) 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.

(j) Services not specifically listed.

(k) Broken appointments.

Chapter 9 – Death | AD&D Benefits

9.01 IN GENERAL

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.

Dismemberment benefits are paid if you suffer an accidental loss *while on or off the job* 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 eligible participant.

9.02 SCHEDULE OF DEATH | AD&D BENEFITS

(a) Schedule of Benefits

(1) Death Benefit | $25,000

(2) Accidental Death | $25,000

(3) Dismemberment

- ✓ 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

(b) Special Rules

(1) *Eligibility for Benefits.* All Eligible Employees and Retirees who have satisfied the eligibility requirements are covered by the basic death benefit. See Chapter 2 for a description of the eligibility requirements for Retiree Death Benefits. All Eligible Employees are covered by the accidental death and dismemberment benefit program.

(2) *Covered Losses*. 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.

(3) *Multiple Losses Attributable to One Accident*. The total payment for all losses due to any one accident will not be more than the full amount of Dismemberment Benefits.

9.03 DESIGNATED BENEFICIARY

(a) In General

The Fund will pay death benefits according to the most recent beneficiary designation 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.*

Notwithstanding the foregoing, your designation of an individual as beneficiary who is or will later become your spouse shall be automatically revoked upon divorce, dissolution of marriage, annulment, or the completion of any other proceeding pursuant to which that person is no longer your spouse. You may re-designate a former spouse as your beneficiary with a written designation provided to the Fund Office.

(b) No Designated Beneficiary

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);

(5) Your Estate.

(c) Incapacitated Beneficiary

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

(d) Minor 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.

9.04 EXCLUSIONS

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

(a) A loss that occurs more than 90 days after the accident.

(b) A loss resulting from declared or undeclared war or any act of war or armed aggression, unless the loss occurs within one year of the accident if you were continuously hospitalized during that period as a result of the accident.

(c) A loss resulting from intentionally self-inflicted injury or injury sustained in the act of committing a crime.

(d) A loss from bodily or mental infirmity or disease.

(e) A loss resulting from an infection other than a pyogenic infection of an accidental cut or wound.

(f) A loss resulting from travel in any moving aircraft aboard which you are giving or receiving any training or have any duties.

(g) A loss payable to a beneficiary who willfully causes the loss.

9.05 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 the 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. Proof of continuing disability must be furnished each year thereafter.

Chapter 10 – Weekly Accident & Sickness Benefits

10.01 WEEKLY ACCIDENT AND SICKNESS BENEFIT

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 Worker's 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 disability in order to maintain eligibility for other illnesses or injuries. If Worker's 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 reimbursement and subrogation provisions of the Plan.

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.

10.02 PERIOD AND AMOUNT 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 (**$300 PER WEEK**) 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.

Chapter 11 – Coordination of Benefits

11.01 COORDINATION OF BENEFITS IN GENERAL

Members of a family are often covered under more than one group health plan, which could result in duplication of health coverage. To avoid this, the health care benefits provided by this Plan are coordinated with similar benefits payable under other plans.

Your 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.

11.02 HOW BENEFITS ARE COORDINATED

(a) Coordination with Other Group Health Plans

Here's how benefits will be coordinated:

(1) The plan covering a person as an employee will pay benefits first (Primary Plan).

(2) 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.

(3) 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).

(4) When a determination cannot be made, the plan that covered the person for the longer time will pay benefits first (Primary Plan).

(5) When the parents are divorced or separated the order is: (i) the plan of the parent with custody pays benefits first. (Primary Plan); and (ii) the plan of the parent without custody pays benefits second. If the parent with custody has remarried, the order is: (i) the plan of the parent with custody; (ii) the plan of the step-parent; and (ii) the plan of the parent without custody. However, 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 above.

(6) 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).

(7) 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.

(b) Effect on Benefits

The Fund will pay benefits as stated above when this Fund 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.

(c) Coordination of Benefits for Dual Coverage

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.

(d) Coordination with HMOs

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.

(e) 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.

(e) Other Benefits

The coordination rules set forth in this Chapter apply to other benefits made available under the Plan, such as dental and vision benefits.

11.03 RIGHT TO INFORMATION

For purposes of determining the applicability and implementation of this Chapter or a provision of similar purpose of another group health plan, the Board of Trustees, without the consent of or notice to any person, may release to, or may obtain from, any insurance company, organization, or person any information that the Board of Trustees deems necessary for such purposes (to the extent permitted under the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to HIPAA). An individual claiming benefits under the Plan shall furnish, upon request by the Fund, information, in writing, as may be requested to implement this provision.

The Fund, however, is not required to determine the existence of any other plan or the amount of benefits payable under any such plan, and the payment of benefits under this Plan will be affected by the benefits that would be payable under any and all other plans only to the extent the Fund is furnished with information relative to such other plans.

11.04 RIGHT TO CORRECT ERRONEOUS PAYMENTS

Whenever a payment that should have been made under the Plan in accordance with this Chapter has been made under another group health plan, the Board of Trustees shall have the right, exercisable alone and at its sole discretion, to pay to the organization making such payment an amount it shall determine to be warranted in order to satisfy the intent of this Chapter. The amount so paid shall be deemed to be a benefit provided under the Plan, and, to the extent of such payment, the Fund shall be fully discharged from liability. Pursuant to the provisions of the following Chapter, the Plan also reserves the right to seek recovery for any excess paid by it over the maximum it should have paid under this Chapter, from any insurance company, other plan(s), or any person to or from whom payments were made.

Chapter 12 – Reimbursement & Subrogation

12.01 RIGHT TO RECOVERY

(a) Fraudulent Claims

If a fraudulent claim is submitted, benefits will be denied. A Participant must reimburse the Fund for any fraudulent claim paid in error.

(b) Erroneous Payments

A Participant must reimburse the Fund for any claim that is paid in error because of a mistake of law or fact. Also, a Participant must reimburse the Fund for any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, irrespective of to whom paid.

(c) Payments Made Due to Failure to Update Enrollment Status, Etc.

A Participant must report to the Fund Office important events such as a divorce, legal separation, loss of custody, loss of Eligible Dependent status, and any other event that impacts the eligibility of the Participant or the Participant's dependent(s).

A Participant must reimburse the Fund for any claim paid in error because the Participant failed to (1) report to the Fund Office any of the previously described events; (2) update the Participant's enrollment status; or (3) update the status of the Participant's previously enrolled dependents.

(d) Improper Payments Described in this Chapter Are Fund Assets

Any payment made by the Fund in error as described in this Chapter, including any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, is due and owing to the Fund and is an asset of the Fund. (In other words, such payment is a "plan asset" as that term is used in ERISA.) The recipient of any such Fund asset will be considered a fiduciary under Section 3(21) of ERISA with respect to such Fund asset to the extent he or she exercises control over such Fund asset. Exercising control over such Fund assets includes, but is not limited to, disposing of such Fund assets. Among other things, the Fund's fiduciaries must act prudently, for the exclusive benefit of the Fund's participants and beneficiaries, and in accordance with the Fund's governing documents (e.g., the Plan, including this Chapter). The recipient of any payment made by the Fund in error as described in this Chapter must promptly return such payment (plan asset) to the Fund.

(e) Recovery of Improper Payments Described in this Section

If the Fund pays a claim in error as described in this Chapter, or makes any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, the improperly paid amount (overpayment) may be deducted from any benefits due to the Participant and his or her Eligible Dependents until the Fund is reimbursed for the amount improperly paid.

The Fund may take any other action it deems appropriate to recover any improperly paid amount against one or more of the following parties: (1) the recipient of the payment; (2) the Participant with respect to whom the payment was made; (3) an insurance company; and (4) any other person, organization or entity. The Participant will be liable to the Fund for all of its expenses, including attorneys' fees, related to the cost of collecting any improperly paid amount.

12.02 REIMBURSEMENT OF CONDITIONAL BENEFIT PAYMENTS

(a) In General

(1) *Conditional Benefit Payments*. The Plan does not provide benefits to diagnose and treat illnesses or injuries for which a third party may be responsible or liable. However, if a Participant incurs an illness or injury for which a third party may be responsible or liable, the Fund may make one or more conditional benefit payments to or on behalf of the Participant to cover claims arising from such illness or injury. Such payments are conditioned upon the Participant's compliance with this Chapter, including all of the Participant's obligations set forth in this Section.

(2) *Agreement to Reimburse the Fund*. By accepting conditional benefit payments from the Fund, the Participant agrees to actively pursue his or her claim against the third party and agrees to reimburse the Fund for claims paid up to the full amount of any recovery arising from the illness or injury. The Participant agrees that any amounts recovered by judgment, settlement, or otherwise will be applied first to reimburse the Fund, without reduction for attorneys' fees and other costs, even if the Participant is not made whole, regardless of whether the amounts recovered are designated to cover medical expenses, and regardless of how the amounts recovered are characterized. Finally, the Participant agrees that the Fund's right to reimbursement as described in this Chapter applies irrespective of the Participant's cause of action, demand, claim, right of recovery, judgment, order, award, settlement, or compromise against or with the third party, regardless of whether the Participant actually obtains the full amount of such judgment, order, award, settlement or compromise, and regardless of whether the third party is found responsible or liable (or admits responsibility or liability) for the illness or injury.

(3) *Equitable Lien*. By accepting conditional benefit payments from the Fund, the Participant agrees that the Fund will have a first priority equitable lien on the amount of any recovery arising from the illness or injury. The Participant further agrees that, except as otherwise provided in paragraph (5) of this subsection: (A) the amount of any recovery arising from the illness or injury is due and owing to the Fund and is an asset of the Fund (in other words, the recovery is a "plan asset" as that term is used in ERISA); (B) the equitable lien on the amount of any recovery arising from the illness or injury is an asset of the Fund (in other words, the equitable lien is a "plan asset" as that term is used in ERISA); and (C) the Participant, or anyone acting on the Participant's behalf, will be considered a fiduciary under Section 3(21) of ERISA with respect to such Fund assets to the extent he or she exercises control over such Fund assets. Exercising control over such Fund assets includes, but is not limited to, disposing of such Fund assets.

Among other things, the Fund's fiduciaries must act prudently, for the exclusive benefit of the Fund's participants and beneficiaries, and in accordance with the Fund's governing documents (e.g., the Plan, including this Chapter). As previously stated, this Chapter requires Participants who accept conditional benefit payments from the Fund to reimburse the Fund for claims paid up to the full amount of any recovery (plan asset) arising from the illness or injury.

(4) *Right to Reimbursement Not Impacted by Equitable or Legal Doctrines*. The Fund's right to reimbursement as described in this Section will not be reduced, eliminated or otherwise affected by the make whole doctrine, comparative fault or regulatory diligence, the common fund doctrine, or any other equitable or legal doctrine, rule, or principle.

(5) *Property of the Participant*. Amounts recovered by the Participant in excess of conditional benefit payments made by the Fund are the separate property of the Participant. In addition, amounts received from a source other than the Fund are the separate property of the Participant if the amounts are received from a policy of insurance for which the Participant or a member of the Participant's family has paid premiums.

(b) Acknowledgement Form Required

If a Participant incurs an illness or injury for which a third party may be responsible or liable, then, in order to receive one or more conditional benefit payments from the Fund to cover claims arising from such illness or injury, the Participant and the Participant's attorney (if any) must sign a Subrogation and Reimbursement Agreement | Acknowledgement of Plan Provisions Form (Acknowledgement Form) before any conditional benefit payments are made.

If the Participant or the Participant's attorney (if any) refuse to sign the Acknowledgement Form, the Fund may withhold conditional benefit payments and may recoup by offset, lawsuit, or other appropriate means any amount already paid.

The Fund's right to reimbursement as described in this Section is governed by the terms of the Plan whether or not the Participant or the Participant's attorney (if any) has signed the Acknowledgement Form.

(c) Notification | No Settlements or Disbursements Without the Fund's Consent | Cooperation

(1) *Obligation to Notify the Fund Office*. A Participant is obligated to notify the Fund of any illness or injury for which a third party may be responsible or liable. By accepting conditional benefit payments from the Fund, the Participant agrees to notify the Fund Office promptly of efforts made to recover from a third party, including (but not limited to) filing a lawsuit to recover amounts in connection with the illness or injury. Furthermore, in the event the Participant, or someone acting on the Participant's behalf, receives payment from any source for claims related to the illness or injury, the Participant must notify the Fund Office immediately.

(2) *No Settlements or Disbursements*. By accepting conditional benefit payments from the Fund, the Participant agrees that neither the Participant nor anyone acting on the Participant's behalf will settle any claim related to the illness or injury without the written consent of the Fund. The Participant further agrees that the amount of any recovery arising from the illness or injury will remain in the possession of the Participant, or someone acting on behalf of the Participant, and be placed and held in a specifically identifiable segregated account. Finally, the Participant agrees that neither the Participant nor anyone acting on the Participant's behalf will distribute the amount of any recovery arising from the illness or injury without a release from the Fund of the Fund's right to reimbursement as described in this Section.

(3) *Cooperation*. By accepting conditional benefit payments from the Fund, the Participant agrees to cooperate fully with the Fund in connection with any claim brought by the Fund to assert its right to reimbursement. The Participant further agrees to refrain from doing anything to impair, prejudice, or discharge the Fund's right to reimbursement. The Participant further agrees to execute and deliver any and all documents required by the Fund and do whatever else is necessary to fully protect the Fund's right to reimbursement. Finally, the Participant must provide the Fund with any information the Fund requires so that the Fund may successfully assert its right to reimbursement.

(d) Remedies

If a Participant fails to comply with this Chapter (e.g., fails to reimburse the Fund in accordance with this Chapter or otherwise fails to meet the Participant's obligations under this Chapter), the Fund may take one or more of the following actions:

(1) *Legal Action*. The Fund may bring suit to collect the full amount of the conditional benefit payments made to or on behalf of the Participant. The Fund may bring such a suit against the Participant, anyone acting on the Participant's behalf, insurers, any recipient(s) of Fund assets improperly distributed without the consent of the Fund, and any other person, organization, or entity. If it becomes necessary for the Fund to bring suit against the Participant for failure to comply with this Section: (A) the Participant will be liable to the Fund for all of its expenses, including attorneys' fees, related to the cost of collecting unreimbursed amounts; (B) the Trustees, in their sole discretion, may require the Participant to pay interest at the rate determined by the Trustees from the date the conditional benefit payments were made through the date the Fund is reimbursed in full; and (C) the Participant waives any applicable statute of limitations defense available regarding the enforcement of the Participant's obligation to reimburse the Fund.

(2) *Offset.* The Fund may recover the full amount of the conditional benefit payments made to or on behalf of the Participant by treating such benefits as an advance and deducting such amounts from benefits which become due to the Participant and/or to the Participant's immediate family members until the conditional benefit payments are recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage the Fund or anyone else may have given to such providers.

(3) *Any Other Action*. In addition to the remedies set forth herein, the Fund may take any other action it deems appropriate to ensure that the Fund is fully reimbursed, recover plan assets, and protect the Fund.

(e) Example

Let's assume that a Participant was injured in an automobile accident, and the other driver may have been at fault. If the Fund made a conditional benefit payment on the Participant's behalf in the amount of $5,000 due to the injuries resulting from the accident, and the Participant recovered any money from the other driver or the other driver's insurance company (by lawsuit, settlement, or otherwise), the Fund would be entitled to receive up to $5,000 of that money as reimbursement for the claims paid on the Participant's behalf.

12.03 SUBROGATION

If a Participant incurs an illness or injury for which a third party may be responsible or liable, and the Fund makes one or more conditional benefit payments to or on behalf of the Participant, the Fund is not required to participate in any claims the Participant may have against the third party. However, the Fund may require the Participant to assign his or her claims and any other right of recovery to the Fund so that the Fund may enforce its right to reimbursement. Moreover, by accepting conditional benefit payments from the Fund, the Participant authorizes the Fund to elect to pursue any claims arising from the illness or injury in the name of the Participant and/or the Fund's name, and to sue, compromise, or settle such claims without the approval of the Participant to the extent of benefits paid and/or to be paid.

If the Fund invokes its subrogation rights as described in this Section, the Participant must cooperate fully with the Fund in connection with any claim brought by the Fund to recover its assigned or subrogated

interest. If the Participant does not cooperate, or if the Participant or anyone acting in his or her interest takes any action which harms the Fund's subrogated interest, the Plan is entitled to cease payment of conditional benefit payments connected to the third-party caused illness or injury and to collect any conditional benefit payments already-made pursuant to this Chapter.

Chapter 13 – Claims & Appeal Procedures

13.01 IN GENERAL

The provisions of this Chapter shall apply to: (a) any claim for (or right to) a benefit under the Plan; and (b) any claim against the Plan or Fund, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

A "claim" is a request from a claimant or a claimant's authorized representative for payment of benefits from the Fund made in accordance with the Fund's procedures (**SEE ADDENDUM #2**). A claim is considered filed as soon as a claim form is received at the correct address. Filing an incomplete claim or filing a claim at the wrong address may delay payment. Properly completed claims must be accompanied by a bill from the provider and such other proof as may be required by the Fund.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. A request for a determination of whether an individual is eligible for benefits under the Plan is not considered a claim; however, if a claimant files a claim for specific benefits and the claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a claim. Also, a request for an optional pre-service evaluation of whether a particular benefit will be paid is not a claim.

You have the right to appoint an authorized representative to act on your behalf for the purpose of filing a claim and seeking a review of a denied claim. If the Fund Office is uncertain whether or not you have appointed a representative, it may request that you put such designation in writing and may decline to communicate with a third party claiming to be your representative until such written designation is received.

In determining eligibility for any benefit, the Plan has the right to have the person for whom the benefits are claimed examined by a professionally qualified practitioner designated and paid for by the Fund. Such examination may be repeated as often as may be reasonably required while the claim is pending. The Fund also has the right to conduct an autopsy, if not forbidden by law or court order, to be performed in case of death.

Decisions regarding whether to grant or deny all or part of a claim will be made by the Fund. For purposes of this Chapter, the term Fund includes a designated agent or applicable service provider of the Fund. Both in determining initial claims and in deciding appeals, the Fund will make all determinations in accordance with the applicable Plan documents, policies, and rules, and will apply such provisions consistently, to the extent reasonable, with respect to similarly situated claimants.

The Fund intends to follow all applicable legal requirements when adjudicating benefit claims. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to Fund staff or an individual providing services to the Plan, such as a claims adjudicator or medical expert, will not be based upon the likelihood that the individual will support the denial of benefits.

Throughout the procedures set forth below, there are time limits within which a claimant must file a claim or appeal and within which the Fund must issue a decision on the claim or appeal. The Fund 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 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.

Finally, the provisions of this Chapter do not apply to disputes initiated by providers regarding claims subject to the No Surprises Act. Such disputes shall be resolved in accordance with the open negotiation and dispute resolution provision of that Act, its underlying regulations, and other applicable governmental guidance.

13.02 APPLICABLE DEFINITIONS

In order to understand how your claim or appeal will be processed, it is important you understand how the Fund categorizes claims. A definition or explanation of each category the Fund will use is set forth below.

(a) Pre-Service Claim

A Pre-Service Claim is any claim for a benefit for which pre-approval of the benefit is **required** by the Fund before medical care is obtained. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Pre-Service Claims.

(b) Urgent Care Claim

An Urgent Care Claim is a **Pre-Service Claim** that: (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) a Physician with knowledge of your medical condition thinks would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame described in this Chapter. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Fund, 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 Fund will treat your claim as an Urgent Care Claim.

(c) Post-Service Claim

This is any claim for a benefit that is not a Pre-Service Claim. In the case of a Post-Service Claim, you request reimbursement after medical care has already been rendered. Most claims you submit will be Post-Service Claims.

(d) Concurrent Care Claim

This is any claim to extend an ongoing course of treatment beyond the period of time or number of treatments that the Fund has already approved. A Concurrent Care Claim can be either an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim.

(e) Incomplete Claim

A claim will be deemed incomplete if you do not provide enough information for the Fund to determine whether and to what extent your claim is covered by the Plan. This includes, but is not limited to, 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 approval.

(f) Disability Claims / Weekly Accident and Sickness Claims

Disability Claims / Weekly Accident and Sickness claims, which include claims relating to ongoing eligibility while disabled, will generally be handled like Post-Service Claims for medical benefits; however, there are special time periods that apply to processing such claims.

(g) Rescission

A rescission of coverage is a retroactive cancellation or termination of your coverage. The Fund may rescind coverage if the person whose coverage is rescinded (or the person through whom coverage of a dependent is obtained) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact. A prospective termination of coverage is not a rescission. Termination of coverage for failure to pay a required premium is not a rescission. Additionally, termination of coverage retroactive to the date of divorce (or other event

making a dependent ineligible for coverage) is not a rescission if COBRA is not elected and/or the full COBRA premium is not paid by you or your dependent(s). A rescission is a benefit claims decision that you have the right to appeal. If your coverage is rescinded for a reason other than fraud, intentional misrepresentation of material fact, your coverage under the Plan will continue during the appeal period. Coverage will not continue during any applicable appeal period if your coverage is terminated due to failure to pay a premium.

13.03 TIMEFRAMES FOR MAKING INITIAL CLAIM DECISIONS

(a) Pre-Service Claims

For properly submitted Pre-Service Claims, the claimant will be notified in writing of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from the claimant on an Incomplete Claim, the extension notice will specify the information needed. In that case, the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal period for making a decision on the claim will be suspended from the date of the extension notice until either the passage of 45 days or the date the claimant responds to the request, whichever is earlier.

(b) Urgent Care Claims

For properly filed Urgent Care Claims, the claimant will be notified of a decision in writing or by telephone as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. If the claimant is notified by telephone, the determination will also be confirmed in writing not later than 3 days after the telephone notification.

If an Urgent Care Claim is an Incomplete Claim, the claimant will be notified as soon as possible, but not later than 24 hours after receipt of the Incomplete Claim, of the specific information necessary to complete the claim. The claimant must provide the specified information within 48 hours from receipt of the notification to supply the requested information. If the information is not provided within that time, the claim will be denied.

During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either the passage of 48 hours from receipt of the request to supply additional information or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the 48-hour period given for the claimant to provide this information, whichever is earlier.

(c) Concurrent Care Claims

A reconsideration of a benefit with respect to a Concurrent Claim that involves a termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

Any request to extend approved urgent care treatment must be submitted in the same manner as Urgent Care Claims. The claimant will be notified of a decision within 24 hours of receipt of the claim,

provided the claim is received at least 24 hours prior to the expiration of the approved treatment. If the claim is not made at least 24 hours prior to the expiration of the approved treatment, the request must be treated as an Urgent Care Claim and decided according to the Urgent Care Claim time frames. A request to extend approved treatment that does not involve urgent care will be decided according to the Pre-Service or Post Service Claim time frames, whichever applies.

(d) Post-Service Claims

For properly filed Post-Service Claims, the claimant will be notified of decisions on Post-Service Claims within 30 days from the receipt of the claim by the Fund. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the claimant submits an Incomplete Claim, the notice will also describe the information it needs to make a decision. The claimant will have 45 days after receiving this notice to provide the specified information. In such case, the period for making the benefit determination will be tolled or frozen from the date on which the Fund sends the notification of the extension until the date the claimant responds to the request for additional information or the claimant's time to respond expires. If the claimant provides additional information in response to such a request, the Fund will make a decision within 15 days of when the additional information is received by the Fund.

(e) Disability Claims / Weekly Accident and Sickness Claims

The Fund will decide Disability / Weekly Accident and Sickness claims 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 notifies you of the extensions prior to the expiration 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.

If an extension is required because the claimant submits an Incomplete Claim, the notice will also describe the information it needs to make a decision. The claimant will have 45 days after receiving this notice to provide the specified information. If the information is not provided within that time, the period for making the benefit determination will be tolled or frozen from the date on which the Fund sends the notification of the extension until the date the claimant responds to the request for additional information or the claimant's time to respond expires. If the claimant provides additional information in response to such a request, the Fund will make a decision within 15 days of when the additional information was received by the Fund.

(f) Death / AD&D Benefit Claims

If a death benefit claim or an AD&D benefit claim is denied, in whole or in part, the Fund will provide a written notice of the denial within 90 days after it receives the claim. Should special circumstances require additional time to decide the claim, the Fund will provide a written notice of the extension

within 90 days after receipt of the claim explaining the special circumstances and the date by which the Fund expects to render the benefit determination. This extended due date cannot exceed 180 days from the date on which the claim originally was filed.

13.04 INITIAL BENEFIT DENIALS

(a) Medical Care Claims

If a medical care claim is denied, in whole or in part, the claimant will be provided written notice of the denial. However, for Urgent Care Claims and Concurrent Claims to extend approved urgent care treatment, the claimant may be notified of denial by telephone, provided that written notice is provided no later than 3 days after telephone notification.

The notice of denial will provide, where applicable:

(1) Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, the treatment code, and the meanings of these codes;

(2) The reason(s) for the denial of the claim (including the denial code and its corresponding meaning) or rescission;

(3) A description of any standard used to deny the claim;

(4) References to the specific Plan provisions on which the benefit determination or rescission was based;

(5) If an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;

(6) If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;

(7) A description of any additional material or information which might help your claim (including an explanation of why that information may be helpful);

(8) A description of any internal or external appeals available, how to initiate them, and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;

(9) A statement that you or your representative may submit information in support of your claim in writing upon filing a request for review of denial of benefits or a rescission;

(10) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

(11) Disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving a request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be an appeal request.

(b) Disability / Weekly Accident and Sickness Claims

If a Disability / Weekly Accident and Sickness claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

(1) The specific reason(s) for the adverse determination and references to any pertinent Plan provisions on which the determination was based;

(2) The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

(3) An explanation of the basis for disagreeing with or not following: (i) the views you presented to the Fund of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination; and (iii) if applicable, a disability determination that you presented to the Fund made by the Social Security Administration;

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

(5) A description of any additional materials or information which might help the claim (including an explanation of why that information may be helpful);

(6) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits; and

(7) A description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review.

(c) Death / AD&D Benefit Claims

If a death benefit claim or an AD&D benefit claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will include:

(1) The specific reason(s) for the adverse determination;

(2) References to the specific Plan provisions on which the determination was based;

(3) A description of any additional materials or information which might help the claim (including an explanation of why that information may be helpful);

(4) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits; and

(5) A description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review.

13.05 APPEALS

(a) Time Period in Which to Appeal

If a claim is denied, in whole or in part, or if a claimant disagrees with the decision made on a claim, or if your coverage is rescinded, the claimant or his authorized representative may ask for the benefit denial to be reviewed. To be reviewed, a claimant's written appeal must be filed in a timely manner:

(1) Generally, claimants have 180 days from the day they received notice of the initial decision to appeal. However, in the case of a Concurrent Care Claim that involves the termination or reduction of previously approved care, the appeal must be completed before the care is terminated or reduced.

(2) In the case of a death benefit claim or an AD&D benefit claim, the claimant has 60 days from the day he received notice of the initial decision to appeal.

(3) In the case of an Urgent Care Claim, a claimant may request, orally or in writing, immediate review of an adverse determination. Communications between the claimant (or claimant's authorized representative) and the Fund Office may be made by telephone, facsimile, or other similar means.

(b) Content of Your Appeal

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 the appeal. You should also submit any documents that support your claim. This does not mean that you are required to cite all 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 Plan policy, determination or action. 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 when making its initial determination. The Executive Committee can best consider your position if they clearly understand your claims, reasons and/or objections.

(c) Where to File Your Appeal

Your appeal should be filed at the following address:

Executive Committee
National Asbestos Workers Medical Fund
c/o National Employee Benefits Administrators, Inc. (NEBA) | Administrative Agent
2010 N. W. 150th Avenue, Suite 200
Pembroke Pines, FL 33028

(d) Review Process

The review on appeal shall be made by the Executive Committee or a designated Committee of the Executive Committee, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The review will take into account all comments, documents, records and other information submitted relating to your claim (regardless of whether this information was submitted or considered in the initial benefit determination). The Executive Committee or the designated Committee of the Executive Committee deciding the appeal shall give no deference to the initial denial or adverse determination.

If the initial denial was based, in whole or in part, on a medical judgment, the Executive Committee shall consult with a medical professional who has appropriate training and experience in the relevant field of medicine relating to the appeal. The medical professional will be an individual who was not

consulted, and is not the subordinate of any professional consulted, in connection with the initial denial. You have the right to learn the identity of any health care professional contacted in connection with your claim. In addition, 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.

If the Fund generates new evidence or a new rationale for denial to be reviewed by the Executive Committee when considering your appeal, the Fund will provide such new evidence or rationale for denial to you as soon as possible in advance of the date a determination on your appeal is to be made. Upon receipt of such new evidence or rationale for denial, you have the right to respond and submit additional evidence or arguments for the Executive Committee's consideration. However, if the Fund receives such new or additional information so late that it would be impossible to give it to you in time for you to have a reasonable opportunity to respond, the period for deciding your appeal will be tolled until you have a reasonable opportunity to respond.

(e) Failure to File a Timely Appeal

Failure to file a timely appeal will result in a complete waiver of your right to appeal, and the Fund's determination regarding the claim will be final.

13.06 TIMING OF NOTIFICATION OF DECISION ON APPEAL

(a) Pre-Service Claims

A notice of a decision on review will be sent within 30 days of receipt of the appeal.

(b) Urgent Care Claims

A notice of a decision on review will be sent within 72 hours of receipt of the appeal by the Fund.

(c) Concurrent Care Claims

A notice of a decision on review for a Concurrent Care Claim that involves termination or reduction of previously approved care will be sent before the care is terminated or reduced. Notice of a decision on review on a Concurrent Care Claim that involves an extension of care will be sent based on the time frames for Urgent Care, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

(d) Post-Service Claims and All Other Claims

The Executive Committee or a designated Committee of the Executive Committee 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 Executive Committee, a benefit determination will be rendered not later than the third Executive Committee 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 Executive Committee expect to reach a decision. You will receive written or electronic notice of the decision of the Executive Committee after review by the Executive Committee, within 5 days of their decision.

(e) New Evidence or Rationale for Denial

In cases where the Fund must provide you with any new evidence or rationale for denial considered, relied upon, or generated by the Fund in connection with your claim, and the Fund receives such new

or additional information so late that it would be impossible to give it to you in time for you to have a reasonable opportunity to respond, the period for deciding your appeal will be tolled until you have a reasonable opportunity to respond.

13.07 DECISION ON APPEAL

(a) Medical Benefit Appeals

If an appeal concerning a health care claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

(1) Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;

(2) The reason(s) for the denial of the claim (including the denial code and its corresponding meaning) and a discussion of the decision or rescission;

(3) A description of any standard used to deny the claim;

(4) References to the specific Plan provisions on which the benefit determination or rescission was based;

(5) If an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;

(6) If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;

(7) The identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;

(8) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(9) A description of the external review process, including information on how to initiate an external review and applicable time limits and the right to bring a civil legal action under ERISA; and

(10) Disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

The Fund will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving a request. The Fund will not consider a request for such diagnosis and treatment information, in itself, to be an external review request.

(b) Disability / Weekly Accident and Sickness Benefit Appeals

If an appeal concerning a Disability / Weekly Accident and Sickness claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

(1) The specific reason(s) for the adverse determination and references to any pertinent Plan provisions on which the determination was based;

(2) The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

(3) An explanation of the basis for disagreeing with or not following: (i) the views you presented to the Fund of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination; and (iii) if applicable, a disability determination that you presented to the Fund made by the Social Security Administration;

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

(5) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits; and

(6) A description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA.

(c) Death / AD&D Benefit Appeals

If an appeal concerning a death benefit claim or an AD&D benefit claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

(1) The specific reason(s) for the adverse determination;

(2) References to the specific Plan provisions on which the determination was based;

(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits; and

(4) A statement describing your right to bring a civil legal action under ERISA.

13.08 EXTERNAL REVIEW OF MEDICAL BENEFIT APPEALS

If your appeal is denied, you (or your authorized representative) have the right to request an external review. The external review process is limited to adverse benefit determinations that involve medical judgement, whether the Fund is complying with applicable surprise billing and associated cost-sharing protections under federal law, and recissions of coverage.

A determination involves medical judgment if, for example, it is based on the Plan's requirements for medical necessity, appropriate health care setting, level of care, or a determination that a treatment is experimental. Other examples of determinations that involve medical judgement include: (1) whether a treatment is for Emergency Services; (2) whether a claim for items or services provided by an Out-of-Network provider at an In-Network facility are subject to the protections under the No Surprises Act; (3) whether you were in a condition to receive a notice about the availability of the protections against balance billing and gave informed consent to waive those protections; (4) whether a claim for items and services was coded correctly, consistent with the treatment you received, thus entitling you to the protections against balance billing; and

(5) whether cost-sharing was correctly calculated for ancillary services provided by an Out-of-Network provider at an In-Network facility.

The request should be sent to the address identified in this Chapter for submitting an appeal to the Executive Committee. Your request for an external review must be made no later than four months after the date you receive the adverse decision on your appeal. If there is no corresponding date four months after the date of receipt of such notice, the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. Failure to file a timely appeal will result in a complete waiver of your right to appeal, and the Fund's determination regarding the claim will be final.

Within five business days following receipt, the Fund Office will make a preliminary review to determine whether: (1) you are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided; (2) the adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review); (3) you have exhausted the Plan's internal appeal process unless you are not required to exhaust the final internal appeals process; and (4) you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund Office will issue a written notification to you. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow you to perfect the request for external review within the later of: (1) the four-month filing period, or (2) the 48-hour period after the receipt of notification.

If your case is eligible for external review, it will be forwarded to an Independent Review Organization (IRO) accredited by a nationally-recognized accrediting organization, and the IRO will contact you. The Fund Office will contract with at least three IROs for assignments under the Fund and rotate claim assignments among them or incorporate other independent, unbiased methods for selection of IROs, such as random selection.

Once you are contacted in writing by the IRO, you will have ten business days to submit additional information directly to the IRO if you choose to do so. The IRO is not required to, but may accept and consider additional information submitted after ten business days. The IRO will use legal experts where appropriate to make coverage determinations under the Plan. Within five business days after the assignment of the IRO, the Fund Office will provide to the IRO the documents and information considered in making the adverse benefit determination or final internal appeal, including information that you previously submitted to the Fund Office. Failure by the Fund Office to timely provide the documents and information will not delay the conduct of the external review. If the Fund Office does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify you and the Fund.

Upon receipt of any information that you submit, the IRO must forward the information to the Fund within one business day. The Fund may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Fund will not delay the external review. If the Fund decides to reverse its adverse benefit determination or final internal adverse benefit determination

and provide coverage or payment, the Fund will provide written notice of its decision to you and the IRO within one business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Fund.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision: (1) your medical records; (2) the attending health care professional's recommendation; (3) reports from appropriate health care professionals and other documents submitted by you, your treating provider, or the Fund; (4) the terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law; (5) appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations; (6) any applicable clinical review criteria developed and used by the Fund, unless the criteria are inconsistent with the Plan's terms or with applicable law; and (7) the opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

Within 45 days after the IRO receives your request for external review from the Fund Office, the IRO will issue to you a written notice of its final external review decision. The written decision of the IRO will contain:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, and the reason for the previous denial);

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under the state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Upon receipt of a notice of final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Fund, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Fund from making payment on the claim or otherwise providing benefits at any time. The Fund must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether

the Plan intends to seek judicial review of the external review decision, and unless or until there is a judicial decision otherwise.

IROs must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the Fund, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

13.09 EXPEDITED EXTERNAL REVIEW OF MEDICAL BENEFIT APPEALS

When external review is otherwise available pursuant to this Chapter, the Fund will allow you to make a request for an expedited external review at the time you receive:

(a) An adverse benefit determination on appeal involving a medical condition for which the timeframe to complete an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, or

(b) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency care services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund Office will review the request to determine whether the request meets the reviewability requirements using the same criteria above that apply to a standard external review. The Fund will immediately send a notice of its eligibility determination that meets the requirements for a standard external review eligibility determination notice.

Upon determination that a request is eligible for expedited external review following the preliminary review, the Fund will assign an IRO in accordance with the requirements for assigning an IRO for a standard external review. The Fund will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method. The IRO's decision is binding on you and the Fund, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Fund from making payment on the claim or otherwise providing benefits at any time. The Fund must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Fund intends to seek judicial review of the external review decision, and unless or until there is a judicial decision otherwise.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Fund's internal claims and appeals process.

The IRO will provide written notice to you and the Fund of the final external review decision, in accordance with the requirements above for standard external review, except that the notice will be provided as expeditiously as possible, but not more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to you and the Fund.

If the IRO reverses the Fund's adverse benefit determination or final internal adverse benefit determination, the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

IROs must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the Fund, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

13.10 POLICIES, DETERMINATIONS OR ACTIONS

If you disagree with a policy, determination, or action of the Fund, you may ask the Executive Committee to review the policy, determination, or action with which you disagree by submitting a written appeal to the Executive Committee. You must state the reason for your appeal and submit any supporting documentation. Your written appeal must be submitted within 60 days after you learn of the policy, determination or action with which you disagree, which is not a benefits denial. The Executive Committee will have sole authority and discretion to interpret and apply Plan policy, determinations, and actions.

The Executive Committee or a designated Committee of the Executive Committee will review your appeal at its 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 an extension of the time for review for the Executive Committee, you will be notified in writing.

The Executive Committee's decision will be sent to you in writing and will include: (a) specific reasons for the decision, with specific references to the pertinent Plan provisions on which the decision is based; (b) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (c) a statement describing your right to bring a civil legal action under ERISA.

13.11 DECISIONS OF THE EXECUTIVE COMMITTEE ARE FINAL AND BINDING

(a) Executive Committee Discretion and Authority

The Executive Committee has full discretion and authority to interpret the Plan and determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, methods of providing or arranging for benefits, and the application of Plan policies or rules. The Executive Committee has full discretion and authority to determine if a benefit is covered or subject to reimbursement under the Plan.

(b) Decisions are Final and Binding | Option to Reconsider if New Information is Presented

The Executive Committee's decision on review or appeal is final and binding on all parties, including anyone claiming a benefit on your behalf. Except in cases where the Executive Committee determines that reconsideration of your claim or appeal is appropriate, there is no further level of appeal under this Plan absent external review where applicable. The Executive Committee may determine that reconsideration of your claim or appeal is appropriate based on new information that was not available at the time of the initial appeal. The Executive Committee has the exclusive discretionary authority to determine if reconsideration is warranted.

(c) Limited Judicial Review | 2-Year Limitations Period | Required Exhaustion of Claim Procedures

You may not commence a judicial proceeding against any person, including the Fund, the Plan, a fiduciary thereof, the Administrative Agent, the Executive Committee, the Board of Trustees, or any other person, with respect to a claim for benefits, Plan policy changes, or other determinations or actions, without first exhausting the claims procedures set forth in this Chapter.

If you have exhausted these procedures and are dissatisfied with the decision on appeal of a denied claim, you may bring an action under Section 502 of ERISA in an appropriate court to review the Fund Office's decision on appeal, but only if the action is commenced within a period of two years from the date of the Fund's decision on appeal.

If you decide to seek judicial review, the Executive Committee's decision shall be subject to limited judicial review to determine only whether their decision was arbitrary and capricious. Additionally, evidence may not be used in court unless it was first submitted to the Executive Committee prior to the decision on appeal.

If the Fund fails to adhere to all the claims procedure set forth within this Chapter, then to the extent mandated by law, the claimant may initiate an external review or bring an action in an appropriate court without exhausting the claims procedure set forth in this Chapter, but only if the action is commenced within the two-year limitations period. However, you cannot initiate an external review or bring an action in an appropriate court without first exhausting the claims procedures of this Chapter if the violation by the Fund is: (1) de minimis; (2) not likely to cause you prejudice or harm; (3) attributable to good cause or matters beyond the Fund's control; (4) in the context of an ongoing good-faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance by the Plan.

Within ten days of the Fund's receipt of your written request, you are entitled to an explanation of the Fund's basis for asserting that it meets the above exception. The explanation will include the specific description of its bases, if any, for asserting that the violation should not cause the claims procedure to be deemed exhausted. If an external review or a court rejects your request for immediate review on the basis that the Fund meets the requirement for the exception, then the Fund will provide you with notice of the opportunity to resubmit and pursue internal appeal of the claim within a reasonable time after the external review or court rejects the claim for immediate review (but not to exceed ten days). Time periods for refiling the claim will begin to run upon your receipt of such notice.

Chapter 14 – Important Miscellaneous Provisions

14.01 EXCLUSIVE DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES

(a) Plan Interpretation & Modification

The Board of Trustees, in its sole discretion, may interpret, amend, or terminate the Plan and any of its provisions, in whole or in part, at any time. This means that: (1) the Board of Trustees has the exclusive discretionary authority to interpret the Plan and to determine all questions regarding coverage, eligibility, entitlement to benefits and other related matters; (2) all Plan benefits made available to Participants are conditional and subject to the Board of Trustees' exclusive discretionary authority to improve, reduce, eliminate or otherwise modify them; and (3) the Board of Trustees has the exclusive discretionary authority to modify or terminate the Plan's provisions related to classes of coverage, eligibility, the availability, nature and extent of benefits, and the conditions, methods and rates of payment and self-payment. Decisions made by the Board of Trustees are final and binding on all parties. Judicial review of any decision made by the Board of Trustees will be limited to determine only whether the decision was arbitrary and capricious.

Interpretations regarding eligibility for benefits, claims, status of Participants or Employers, or any other matter relating to the Plan should only be obtained through the Trustees' Executive Committee. The Trustees are not bound by, responsible for, or obligated by opinions, information or representations from any other source.

(b) Plan Termination

The Trustees shall have the right to terminate, suspend, amend or modify the Plan in whole or in part at any time in accordance with the Agreement and Declaration of Trust of the National Asbestos Workers Medical Fund. This Plan may also be terminated upon termination of the National Asbestos Workers Medical Fund. The Fund may be terminated by an instrument in writing upon one of the following events: (a) the Trustees determine that the Fund is inadequate to carry out the purpose of the Trust Agreement, or is inadequate to meet the payments due or to become due under the Trust Agreement and under the Plan; (b) there are no individuals who qualify as Employees or Beneficiaries; (c) the Union and the Association agree to terminate the Fund; or (d) there is no longer in force and effect Collective Bargaining Agreements or signed stipulations requiring contributions to the Fund.

In the event of termination of the Fund, the Trustees shall make provisions for the payment of expenses up to the date of termination and the expenses incidental to termination; arrange for a final audit and other final reports; give notices and file reports required by law; and apply the Fund in accordance with the Plan until the entire Fund is disbursed. The Trustees shall not use any part of the corpus or income of the Fund for any purpose other than for the exclusive benefit of the employees and their beneficiaries or the administrative expenses of the Fund. Upon termination, the Trustees shall notify all interested parties and continue as Trustees for purposes of winding up the affairs of the Fund. Under no circumstances will any portion of the Fund revert to the benefit of any contributing employer or participating local union either directly or indirectly.

14.02 NO VESTING

Benefits made available through the Plan are not guaranteed to Participants. In other words, benefits made available under this Plan are not vested with respect to any individual. Benefits are provided only from the assets of the Fund collected and available to support them, and to the extent the benefits of the Plan are supported by an insurance policy.

As described in the previous paragraphs, the Trustees have the authority to increase, decrease or modify benefits of the Plan as they may find it necessary for the sound and efficient administration of the Fund. All benefits of the Plan are conditional and subject to the Trustees' authority under the Plan and Trust Agreement to change them.

14.03 EXCLUSIVE RIGHT TO BENEFITS

No individual shall have a right to benefits provided under the Plan except as specified in the Plan. No party may rely on any representations about the meaning of any provision of the Plan or the benefits provided under the Plan that are inconsistent with the terms of the Plan.

14.04 NO ASSIGNMENT OR ATTACHMENT OF BENEFITS

No Participant is permitted to assign any benefits, rights or claims for benefits to any third party including, but not limited to, a provider or facility, without the express written consent of the Administrative Agent. "Benefits, rights or claims for benefits" includes, but is not limited to, a claim for payment of a benefit under the terms of the Plan or other Plan document or communication, a claim for benefits under Section 502(a) of ERISA, a claim under ERISA for breach of fiduciary duty, or a claim for penalties assessable under law or regulation.

A Participant may direct that benefits payable from this Plan to him or her instead be paid to the provider or facility that provided the related medical care. However, the Plan is not obligated to accept such direction, and no payment made pursuant to such direction, nor any communication about benefits or payment between representatives of the Plan and a provider or facility, shall be considered an assignment of the benefit, a contract to pay benefits or a recognition by the Plan of a duty or obligation to pay a provider or facility, except to the extent the Plan actually chooses to do so.

All benefits under the Plan are exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal processes or proceedings.

14.05 NO LIABILITY FOR PRACTICE OF MEDICINE

The Fund, the Board of Trustees, and their designees are not engaged in the practice of medicine. They do not have control over the health care services provided or delivered to a Participant by any provider. They similarly do not have control over the diagnosis, treatment, care, or lack thereof with respect to any illness or injury. Using the services of a provider is a voluntary act, regardless of whether the Fund designates such provider, or participates in the PPO network. Nothing in the Plan is intended to be a recommendation or instruction to use a particular provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage under the Plan. Providers are not employees of the Fund.

The Fund is not responsible for any act or omission of any provider in connection with any service or treatment. The Fund makes no representation regarding the quality of the service or treatment rendered by any provider. Neither the Fund, the Board of Trustees, nor any of their designees will have any liability whatsoever for any loss caused to any participant by any provider by reason of negligence, failure to provide care or treatment, or otherwise. A provider is solely responsible for the services and treatments he or she renders.

14.06 WORKERS' COMPENSATION

The benefits provided by the Plan are not in lieu of any coverage mandated under a Workers' Compensation law or similar statute. This Plan does not provide benefits under circumstances where benefits are payable under a Workers' Compensation law or similar statute.

14.07 OVERPAYMENTS

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: (a) Interest will be added to the amount due at the rate of 6% per annum; (b) 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; and (c) 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. For more information, please refer to the Plan provisions regarding subrogation and reimbursement.

14.08 ALLOCATING / DELEGATING TRUSTEE AUTHORITY; ACTIONS IN ACCORDANCE WITH TRUST

To the extent permitted under ERISA, the Trustees may take action in accordance with the terms of the Trust Agreement to allocate and delegate their responsibilities, including fiduciary responsibilities, to others where it is deemed appropriate for the effective operation and administration of the Plan. The Trustees may also take action in accordance with the terms of the Trust Agreement to retain one or more persons to render advice regarding their responsibilities or to designate one or more persons to take such action on their behalf. Finally, in accordance with the terms of the Trust Agreement, the Trustees may appoint one or more investment managers to invest, reinvest and otherwise manage assets of the Fund, including the power to acquire or dispose of such assets. The Trustees may take any other action in accordance with the Trust Agreement as they deem necessary.

14.09 PRESERVATION OF PLAN PROVISIONS

This document supersedes and replaces any previous literature furnished regarding the Plan's benefits and is intended to serve as both the Summary Plan Description and the Plan Document under ERISA.

In the event of inconsistency between or omission from the provisions of this Plan and mandatory provisions of applicable law or regulation or their interpretation by any court or regulatory agency with authority over the Plan, such provisions and their interpretation will control. When the provisions of this Plan are different from those mandated by applicable law or regulation, but are nonetheless permitted by such law or regulation as interpreted by courts or agencies, the provisions of this Plan will control.

Should any provision of the Plan be held to be unlawful, or unlawful as to any person or instance, such holding will not, to the extent possible, adversely affect the other provisions contained in the Plan or the application of said provisions to any other person or instance.

14.10 GOVERNING LAW

The terms of the Plan are governed by and construed in accordance with federal law to the extent federal law applies. To the extent federal law does not apply, the terms of the Plan will be governed by and construed in accordance with the laws of the State of Maryland. The Trustees have the exclusive discretionary authority to interpret the Plan and render all decisions with respect to the Plan.

14.11 EXPENSES NOT COVERED

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 Plan:

- Injury, illness or disease for which benefits are payable in accordance with the provisions of any Worker's Compensation or similar law.
- Charges for treatment of intentionally self-inflicted injury or injury sustained in the act of committing a crime, unless if due to domestic violence or mental illness.
- 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.

Chapter 15 – General Information and Your ERISA Rights

15.01 NAME OF THE PLAN

The name of the Plan is the National Asbestos Workers Medical Fund.

15.02 PLAN ADMINISTRATION

The Fund is a collectively bargained trust fund administered by a joint Board of Trustees. The Trustees have delegated responsibility for managing all aspects of the Fund and interpreting the Plan to an Executive Committee of the Trustees. The Executive Committee is the Plan Administrator as defined by ERISA.

The following Trustees serve on the **Executive Committee**: (1) Ron Piersol, Chairman; (2) Tim Blalock, Co-Chairman; (3) Terry Burke; (4) R. Dean Burows; (5) Richard Chamberlain; (6) Glenn Crouse; (7) Dale Cullum; (8) Tony Green; (9) James Gribbins; (10) Dan Patterson; and (11) Kenneth Slaven.

The Executive Committee has retained an Administrative Agent to carry out its instructions and conduct the day-to-operations of the Plan. **The Administrative Agent is:**

National Employee Benefits Administrators, Inc. (NEBA)
2010 N. W. 150th Avenue, Suite 200
Pembroke Pines, FL 33028

The names and business addresses of the Trustees are:

UNION TRUSTEES

Terry Burke
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Donald Stanley
Heat and Frost Insulators Local 13
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Samuel Schultz
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Breeding Insulation
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Jared Goodsite
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Oklahoma City, OK 73105

Vacancy
Asbestos Workers Local 96
3244 US Highway 80
Bloomingdale, GA 31302

Vacancy

John Gray
Asbestos Workers Local 114
PO Box 641
Brandon, MS 39043

Vacancy

15.03 NAME OF PLAN SPONSOR

The Plan Sponsor is the Board of Trustees of the National Asbestos Workers Medical Fund.

15.04 AGENT FOR SERVICE OF LEGAL PROCESS

The Administrative Agent has been designated as the agent for the service of legal process. In addition, service of legal process may be made upon a member of the Executive Committee.

15.05 PLAN NUMBER AND EMPLOYER IDENTIFICATION NUMBER (EIN)

Plan Number: 501

EIN: 52-6038498

15.06 TYPE OF PLAN

The Plan is an employee welfare benefit plan providing medical, prescription drug, dental, vision, death, accident and dismemberment, disability, and other related benefits. The Plan is a self-insured multiemployer plan governed by ERISA and the Labor Management Relations Act of 1947 (The Taft-Hartley Act).

15.07 PLAN YEAR

August 1 through July 31.

15.08 SOURCE OF FINANCING

The Plan is funded by contributions made by individual Employers under the provisions of Collective Bargaining Agreements, by self-payments by Employees and Retirees in accordance with the provisions of this Plan, and any income earned from investment of such contributions and payments. All monies are used exclusively to provide benefits to Participants, and to pay all expenses incurred with respect to the operation of the Plan. The Trustees periodically review the funding status of the Plan.

Participants may receive from the Fund Office, upon written request, information as to whether or not a particular Employer is a contributing Employer and any applicable Collective Bargaining Agreement.

15.09 COMPLIANCE WITH PRIVACY STANDARDS

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Plan will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected Health Information ("PHI") will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the Plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law.

You may authorize the disclosure of your PHI to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided Participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Plan's use and disclosure of PHI or your rights with regard to this information, you may request a copy of the Notice from the Fund Office.

The Plan is will also comply with HIPAA's Security Standards. In doing so, the Plan will

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it creases, receives, maintains, or transmits.

(b) Use PHI only for Plan administration activities and not for any employment-related actions or for any purpose unrelated to Plan administration.

(c) Take appropriate action related to any security incident of which it becomes aware.

(d) Ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information.

15.10 YOUR RIGHTS UNDER ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants shall be entitled to:

(a) Receive Information About Your Plan and Benefits

Examine, without charge, at the 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.

Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and the updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

(b) Continue Group Health Coverage

Continue health care coverage for yourself, spouse, or other Eligible Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. This document includes the rules governing your COBRA rights.

(c) Prudent Action by Plan Fiduciaries

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.

(d) Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation for the reason for the denial. You have the right to have the Fund review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Fund 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 Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Fund'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 Administrator.

(e) Assistance with Your Questions

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1730 K Street, N.W., Washington, D.C. 20006, (866) 444-EBSA (3272) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

15.11 NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT | WOMEN'S HEALTH & CANCER RIGHTS ACT

(a) Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Also, under federal law, plans may not set the level of benefits or out-of-pocket expenses so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket expenses, you may be required to obtain pre-certification.

(b) Women's Health and Cancer Rights Act of 1998

Pursuant to the Women's Health and Cancer Rights Act of 1998, surgical expenses shall include reconstructive surgery and post-surgical scar correction following a mastectomy. Reconstructive surgery following a mastectomy includes reconstruction of the breast in which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses. Coverage is also provided for physical complications at all states of mastectomy, including lymphedemas.

ADDENDUM # 1
EMPLOYEES IN NEWLY ORGANIZED GROUPS AND NEWLY INDENTURED APPRENTICES

Which Employees Qualify for These Special Rules?

The National Asbestos Workers Medical Fund has established special eligibility rules for "Employees in Newly Organized Groups and Newly Indentured Apprentices". These 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 who signs a Collective Bargaining Agreement with a participating Local Union or newly organized employees represented by a participating Local Union 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 a Local Union which participates in the Fund, 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 Asbestos Workers Local Union or other regular applicants for representation by the Local Union.

To What Period Do These Special Rules Apply?

This Addendum 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 Plan with a similar title. All other provisions of the Plan 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, all of the rules and benefits of the Plan apply as described therein 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 as described in the Plan within nine (9) months of employment or loses eligibility under the special Continuing Eligibility Rules described in this Addendum, 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.

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.

Examples of Initial Eligibility for Benefits

Assume Mike's employer signed a Collective Bargaining Agreement with a participating Local Union on March 10. Mike has been employed by this employer for several years but the employer was not obligated to contribute to the Fund for any of his employees. Mike will become eligible for benefits from the Fund on May 1, if Mike works at least 135 Hours for which contributions are owed to the Fund during the month of April and the Fund receives those contributions (and all other contributions due from the effective date of the Collective Bargaining Agreement) and a list of the Employees in this Newly Organized Group that includes Mike before May 1st.

Assume Bob is part of a new group of employees represented by a participating Local Union hired by an Employer under a Collective Bargaining Agreement covering this new group of employees. He started

working for the Employer under the Collective Bargaining Agreement on March 10. Although he remained employed by the employer, he did not work at least 135 Hours for which contributions were owed to the Fund in April. He did work 135 hours for which contributions were owed in May. Bob will become eligible for benefits from the Fund on June 1st provided the Fund receives contributions for May hours (and all contributions due for prior months) and a list of Employees in this Newly Organized Group that includes Bob before June 1st.

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, or have an accumulation of hours as shown in the chart below, and the Fund receives contributions for those hours. Each month for which you work at least 135 hours per month (or have the required accumulated hours) 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.

Work Month	Hours Required in the Month	Required Accumulated Hours
Month 1	135	135
Month 2	135 or	270 in months 1-2
Month 3	135 or	405 in months 1-3
Month 4	135 or	540 in months 1-4
Month 5	135 or	675 in months 1-5
Month 6	135 or	810 in months 1-6

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 Asbestos 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 inducted into the Armed Forces.
- There is a Plan amendment that affects eligibility.
- Your Local Union withdraws from this Fund.

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 Addendum, you can then become eligible for benefits only by meeting the regular Initial Eligibility Rules of the Plan as described in Chapter 1 of this Plan. The only exception is if you lose eligibility because of induction into the Armed Forces. In this case, notify the Fund Office, in writing, and your status will be frozen for the length of your service or four years.

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

If you lose your eligibility for benefits during the limited period covered by the special rules described in this Addendum, the Plan's Self-Payment Rules do not apply. However, the Alternative Self-Payment Rules (COBRA) described in the Plan do apply to you.

Continuing Your Eligibility While Totally Disabled

If you become Totally Disabled during the limited period covered by the special rules described in this Addendum, the coverage continuation rules described in the Plan do not apply. However, the Alternative Self-Payment Rules (COBRA) described in the Plan do apply to you.

Continuing Eligibility for Your Dependents After Your Death

If you should die while you are an Eligible Employee during the limited period covered by the special rules described in this Addendum, the coverage continuation rules for your Dependents described on the Plan do not apply. However, the Alternative Self-Payment Rules (COBRA) described in the Plan do apply to you.

Conclusion

These special rules for Newly Organized Employees or Newly Indentured Apprentices are available at the option of that employee or apprentice's home local.

Medical Benefits are set forth in Chapter 4.

Prescription Drug Benefits are set forth in Chapter 6.

Vision Benefits may be added to any option for an additional contribution.

Dental Benefits may be added to any option for an additional contribution.

The Weekly Accident and Sickness Benefits, Annual Physical Benefits and the Death Benefits and Accidental Death and Dismemberment Benefits describe elsewhere in the Plan do not apply during the limited period covered by the special rules described in this Addendum. You will become eligible for these benefits and the Active medical benefits described in the Plan when you meet the regular Initial Eligibility Rules of the Plan.

ADDENDUM # 2
CLAIM FORMS

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.

Filing Claim Forms

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 Worker's Compensation 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 Worker's Compensation.

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.

Filing Medical 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:

First Step . . . Get claim form

Second Step . . . Fill out Employee's portion of the form

Third Step . . . Have the doctor fill out the back side of the form. If more than one doctor treated you, have each doctor complete a separate form.

Fourth Step . . . Mail the completed form to the Fund Office within 90 days of care received, along with an itemized bill, if any.

Filing Direct Reimbursement Claims

If you want payment made directly to you:

First Step . . . Get claim form.

Second Step . . . Fill out form in detail including diagnosis and all doctor's bills.

Third Step . . . Attach original itemized bills, paid receipts or canceled checks.

Fourth Step. . . Mail completed form to the Fund Office and payment will be made directly to you.

Filing Weekly Accident and Sickness Claims

First Step . . . Get claim form.

Second Step . . . Fill out front side of the form.

Third Step . . . If you are disabled and unable to work, be sure the doctor fills out lines 17 and 18 of Side 2 of the form. The doctor should be as specific as possible about when you will be able to return to work. "Indefinite" is too vague an answer to item 17. We need this information to know when your disability began and when it is expected to end.

Fourth Step . . . Send the form to the Fund Office.

Weekly Accident and Sickness . . . Continuation of Benefits

Weekly Accident and Sickness Benefits are paid based on your doctor's estimate of when you can return to work. Approximately two weeks before that date, the Fund Office will mail you a "Supplementary Certificate of Attending Physician" form. If you will not be able to return to work until after the initial estimated return date, you must have the supplementary report completed and send it to the Fund Office.

Filing Dental Claims

First Step . . . Get claim form.

Second Step . . . Complete the Sections of the Form that covered persons must complete.

Third Step . . . If the series of treatments is expected to cost more than $100, it may be to your advantage to submit an estimate from your dentist. This will ensure that you will know which services and materials are covered and how much will be paid.

Fourth Step . . . Give the form to your dentist to complete the portions of the form that dentists must complete. An itemized statement from the dentist can be included in place of the Description of Services section. The dentist should sign the form.

Fifth Step . . . Review the dentist's charges. If they are accurate, sign the form and send it to the Fund Office. Do this within 90 days of receiving dental services. Also sign the applicable section of the form if you want the dentist paid directly; otherwise, the Fund will pay benefits to you.

Filing Vision Claims

First Step . . . Get claim form.

Second Step . . . Complete the top portion of the form.

Third Step . . . After the optometrist has completed the form, sign the claim form and request that it be mailed to the Fund Office. Payment will be made directly to the Employee. Ask the optometrist to itemize the charges so that you will know what amount of charges not covered by the Fund you will have to pay.

Filing Death or Dismemberment Claims

First Step . . . Call or write the Fund Office and explain the type of claim you are filing. The Fund Office will send you the proper claim form.

Second Step . . . Fill out the claim form and send it back to the Fund Office. For death claims you will also have to include a certified copy of the death certificate.

Claim 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 Worker's 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 Worker's 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 Executive Committee, if it denies the appeal, will again recommend that the Employee or Dependent take steps to protect his rights under the appropriate Worker's Compensation statute or similar law.

Step 4. If the Employee or Dependent files his claim under the appropriate Worker's Compensation statute or similar law and the claim is finally denied, the Executive Committee, 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 Worker's Compensation case, even if Worker's 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 Worker's 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 reimbursement and subrogation provisions of the Plan.