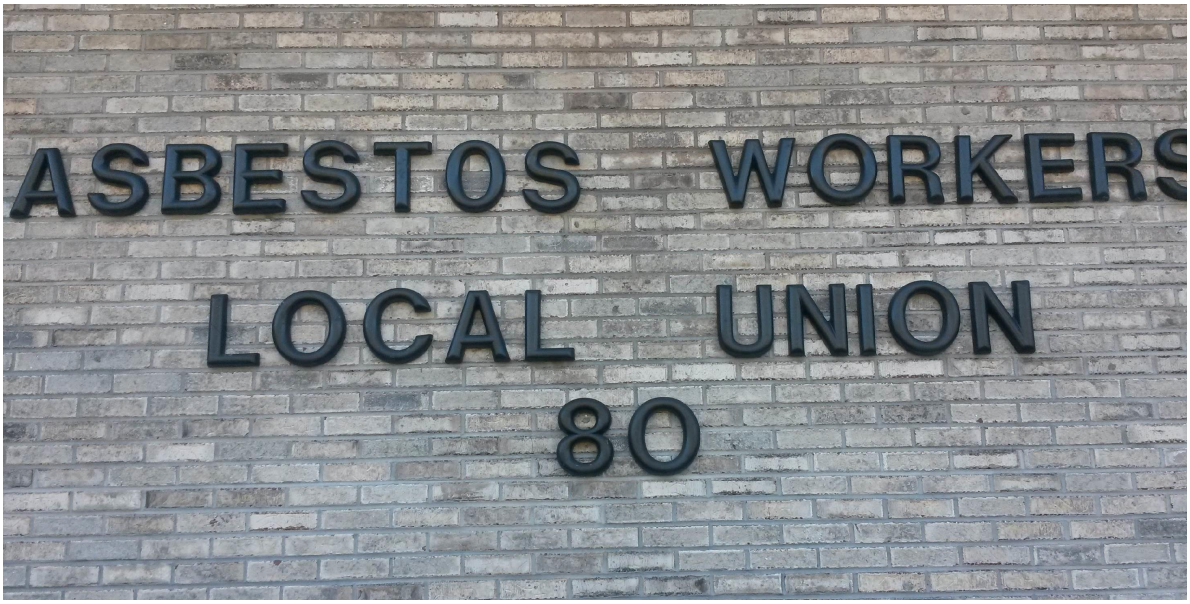
ASBESTOS WORKERS LOCAL UNION NO. 80
SUPPLEMENTAL MEDICAL FUND

SUMMARY PLAN DESCRIPTION



July, 2015

Asbestos Workers Local Union No. 80
Supplemental Medical Fund

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

January 1, 2015

Dear Member:

We are pleased to present the Summary Plan Description outlining the rules of the Asbestos Workers Local Union No. 80 Supplemental Medical Fund as of January 1, 2015.

We urge each of you to become familiar with the contents of this Summary Plan Description so that you may use these supplemental benefits when they become available to you.

If you have any questions or desire any additional information, please feel free to contact the Fund Office.

Sincerely yours,

THE BOARD OF TRUSTEES

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These are the parts and pages where you will find answers to your questions about the Fund and your benefits.

ASBESTOS WORKERS LOCAL UNION NO. 80 SUPPLEMENTAL MEDICAL FUND

General Information
PART I

Enrollment Form

When you have met the initial eligibility requirements, you must fill out an 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.

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

- Changes in marital status
- Names and birth dates of newborn children
- Adoption of child
- Any change of address
- Change in beneficiary
- Death or change in status of Dependent

If a Dependent is not listed on the most current 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.

All enrollment cards can be obtained from the Fund Office. Be sure to complete all information required in order to avoid delay in becoming eligible for benefits.

Summary Plan Description

This Summary Plan Description will serve as your official record of participation in the Fund.

Payment of Benefits

Once benefits become effective, all claims should be reported to the Fund Office as soon as possible. The necessary claim forms and instructions will be mailed to you upon your request. Benefits will be paid by the Fund Office upon receipt of the completed claim forms. File your claim immediately. Any claim reaching the Fund Office later than one year after the medical expenses are incurred cannot be honored.

Eligibility Rules
PART II

Who Can Become Eligible

Employees

All individuals for whom the Fund has received Employer contributions for hours worked may become eligible for benefits in accordance with the Plan rules. The individual must satisfy certain eligibility requirements relating to contributions for hours of work which are described on the following pages.

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

An "Employee" is an individual who is covered by a collective bargaining agreement or a Participation Agreement that requires his Employer to make contributions to this Fund on his behalf. Contributions on an Employee's behalf are made for hours paid or worked in accordance with the applicable Collective Bargaining Agreement at an hourly rate established by the Trustees.

Non-collectively Bargained Employees of an Employer bound to a collective bargaining agreement with Local 80 may participate in the Plan in accordance with the terms of a Participation Agreement between their Employer and the Trustees. There are special rules for these Employees.

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

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

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

A "Retiree" is an Employee who has qualified for and is receiving Retiree benefits from the National Asbestos Workers Medical Fund. An Employee is a Retiree on the effective date of his Retiree coverage.

Dependents

Once the covered Employee becomes eligible, certain of his or her Dependents may also become eligible for benefits through the Fund. Covered Dependents include:

1. Your spouse.

2. Your Dependent child or Dependent children, as defined below:

As used in the Plan, the term ñDependent childò or ñDependent childrenò means ï

Child or Children 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 the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Proof of Status as a Dependent Child:

Dependency. Proof of the individualôs status as a child, as determined satisfactory by the Trustees must be furnished upon request, before benefit payments are made.

Disabled Dependent Child. Your dependent child may be covered beyond age 26 if the child 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 Plan Administrator. Proof of physical or mental incapacity must be received by the Plan prior to the end of the calendar year in which the child attains age 26. Additional proof may be required from time to time. A child, who has already attained age 26 at the time you become eligible, is not eligible under the Plan under any circumstances.

Child does not include an adult child, age 19 up to age 26, who is eligible to enroll in another employer-sponsored health plan, other than a group-health plan of a parent. This exception to the coverage of children up to age 26 will be eliminated effective August 1, 2014. Participants and dependents will be required to provide to the Fund Office written certification that a child is not eligible to enroll in another employer-sponsored health plan, other than a group health plan of a parent.

If you have a change in marital status, you are responsible for notifying the Fund Office immediately and in writing. Any benefits paid on behalf of a legally separated or divorced spouse after the date specified in the legal document is the responsibility of the Employee.

Each covered dependent must be listed on a ñBenefit Enrollment Formò signed by the Employee and filed with the Fund Office. Each change in Dependent enrollment after the initial enrollment must be submitted with proof of dependent status satisfactory to the Trustees.

Coverage will be provided as required by a Qualified Medical Child Support order (QMSCOò) as defined on page 15 of the Summary Plan Description. However, if your child who is the subject of the QMCSO is not your ñdependentò as defined in Internal Revenue Code § 152, you may be subject to income tax on the fair market value of the coverage provided to that child by the Plan under the terms of the QMCSO.

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.

An Employee may not remove a Dependent who continues to qualify as a Dependent under the Plan.

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.

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

Qualified Medical Child Support Orders

The Fund will honor all Qualified Medical Child Support Orders (ñQMSCOò). Participants and beneficiaries may receive from the Administrative Agent of the Fund, upon request and free of charge, a copy of the procedures governing QMCSO determinations.

Disabled Employees, Retirees, and Surviving Dependents

Under certain conditions, disabled Employees, Retirees and surviving Dependents may also be eligible for benefits through the Fund. For more information, see the sections on pages 12 through 13.

Rules for Non-Collectively Bargained Employees

Employers who are bound to a collective bargaining agreement with Local 80 and who are participating in this Plan on behalf of their collectively bargained employees may participate in this Plan on behalf of their non-collectively bargained employees. The total number of non-collectively bargained employees participating in this Plan may not exceed 10% or such percentage as permitted by Internal Revenue Service regulations for a collectively bargained plan under Sections 419 and 419A of the Internal Revenue Code. Employers participating on behalf of non-collectively bargained employees must sign a Participation Agreement approved by the Trustees and must satisfy all other conditions established by the Trustees.

The additional rules for participation of non-collectively bargained employees will be adopted by the Trustees.

Rules for Collectively Bargained Employees

How You Become Eligible for Benefits

Generally, a collectively bargained employee will become eligible for benefits from this Fund by meeting two (2) conditions:

1. The employee must be currently eligible for benefits from the National Asbestos Workers Medical Fund; and

2. The employee must meet the requirements described below for work within the jurisdiction of Asbestos Workers Local Union No. 80.

A copy of the eligibility rules of the National Asbestos Workers Medical Fund is attached as Appendix 1.

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

- Work Quarters; and
- Eligibility Quarters

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

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

How Eligibility Quarters Are Earned

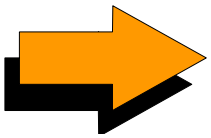
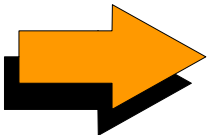
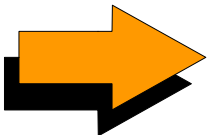
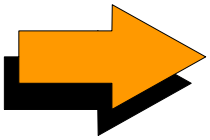
You earn credit for an Eligibility Quarter when:

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

Once you are eligible for benefits in a Work Quarter, you can continue to earn credit for hours in this Plan if you are receiving Loss-of-Time benefits from the National Asbestos Workers Medical Fund or if you verify to the Administrative Agent in writing that you are receiving Worker's Compensation benefits. In these cases you receive credit for up to 31 hours of

contributions each week you are disabled up to a maximum period of 24 months per period of disability, so long as you continue to furnish medical evidence of your continued disability.

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

The Work Quarters...	**Determine Your 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

Initial Eligibility

The hours worked in the jurisdiction of Local 80 will be used to meet the eligibility requirements of both the National Asbestos Workers Medical Fund and the Asbestos Workers Local Union No. 80 Supplemental Medical Fund. Therefore, if you continue to work in the jurisdiction of Local 80, you will become eligible under both Funds at the same time.

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 remain eligible in the National Asbestos Workers Medical Fund and work at least 400 hours in the jurisdiction of Local 80 per Work Quarter and the Fund receives Employer contributions for those hours.

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:

- You lose your eligibility under the National Asbestos Workers Medical Fund (see appendix "1"); or
- Fewer than 400 hours of Employer contributions are received by the Fund for a Work Quarter on your behalf for work within the jurisdiction of Local 80; or
- 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; or
- You fail to make self-payments on time; or
- You are inducted into the Armed Forces; or
- There is a Plan amendment that affects eligibility.

Lost Your Eligibility? How To Get It Back

If for any reason you lose your eligibility for benefits, you can get it back again on the first day of an Eligibility Quarter following completion of any Work Quarter for which your Employer reported and paid a minimum of 400 hours on your behalf for work within the jurisdiction of Local 80. 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. If you return within 90 days of discharge, you would regain your status in the Fund.

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

If you have less than 400 hours reported and paid to the Fund for you by your Employer for a Work Quarter for work within the jurisdiction of Local 80, *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 may make self-payments to continue your eligibility if there is no work available in the jurisdiction of Local 80 and you are immediately available for such work as an Asbestos Worker for a participating Employer within the jurisdiction of Local 80. 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.

Alternative Self-Payment Rules (COBRA)

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. 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 these alternative COBRA rules. You may not switch back and forth. The rules 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 may continue coverage under the COBRA rules after your death and after you and your spouse are divorced.
COBRA coverage does not include weekly accident and sickness benefits.

Rules concerning COBRA Continuation Coverage have changed, effective January 1, 2004. The new rules governing COBRA Continuation Coverage follow:

General Notice of COBRA Continuation Coverage Rights

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (ñCOBRAò). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The Plan Administrator is Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046. The Plan Administratorôs phone number is (410) 872-9500. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a ñqualifying event.ò Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a ñqualified beneficiary.ò A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

(1) your hours of employment are reduced, or

(2) your employment ends for any reason other than your gross misconduct.

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

(1) your spouse dies;

(2) your spouseôs hours of employment are reduced;

(3) your spouseôs employment ends for any reason other than his or her gross misconduct;

(4) your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) you become divorced or legally separated from your spouse.

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

(1) the parent-employee dies;

(2) the parent employeeôs hours of employment are reduced;

(3) the parent-employeeôs employment ends for any reason other than his or her gross misconduct;

(4) the parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) the parents become divorced or legally separated; or

(6) the child stops being eligible for coverage under the plan as a ñdependent child.ò

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employeeôs spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), your employer must notify the Plan Administrator of the qualifying event within 60 days of the date your employer becomes aware of your changed circumstances.

For the other qualifying events (divorce legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send notice to ASBESTOS WORKERS LOCAL NO. 80 SUPPLEMENTAL MEDICAL FUND c/o Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts up to 36 months.

When the qualifying event is the end of employment or reduction of the employeeôs hours of employment, COBRA continuation of coverage lasts for up to 18 months. There are two ways in which this 18-month COBRA continuation coverage can be extended.

Disability extension of 18-month period for continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administrationôs determination within 60 days of the date of the determination and before the end of the 18-month period for COBRA continuation coverage. This notice

should be sent to The Asbestos Workers Local Union No. 80 Supplemental Medical Fund, c/o Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.**

Termination of COBRA Coverage

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

- All health benefits offered by the Fund terminate;
- You do not make the required payments to the Fund on time;
- You become covered by another group health plan unless that replacement plan limits coverage due to pre-existing conditions; or
- You become entitled to benefits under Medicare.

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

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact **ASBESTOS WORKERS LOCAL NO. 80 SUPPLEMENTAL MEDICAL FUND, c/o Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046,** or you may contact the nearest Regional or District Office of the U.S. Department of Laborôs Employee Benefits Security Administration (PWBA). Addresses and phone numbers of Regional and District PWBA Offices are available through PWBAôs website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your familyôs rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.

THE ELECTION PERIODS FOR THE PLANS 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.

Continuing Your Eligibility While Totally Disabled

Periods of proven disability that commence 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 you will be credited with up to thirty-one (31) hours of employment for each week disabled, so long as you furnish medical evidence of your continued disability, (including Worker's Compensation) to the satisfaction of the Trustees.

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

Eligibility will be determined in accordance with the Fund rules.

Continuing Your Eligibility While Retired

To continue eligibility while retired, you must be receiving a pension from the National Asbestos Workers Pension Fund, pay the cost of retiree coverage established by the Trustees and meet the following requirements:

- You must have pension eligibility from Local 80;
- You must have ten (10) years of participation in this plan;
- You must have seven (7) years of eligibility in this plan;
- Contributions must have been made on the Employeeôs behalf into this Fund for thirty-six (36) out of sixty (60) months immediately preceding the Employeeôs pension effective date.

Retiree Benefits will be available to eligible Retirees who meet the conditions described above and to eligible Dependents of such Retirees and to a widow(er) to whom such a Retiree has been married for at least one year prior to the death of the Retiree, provided there is no group coverage on the widow(er). The eligibility of the widow(er) will terminate upon remarriage.

Retiree Benefits will also be available to the widow(er) and eligible Dependents of an Active Eligible Employee who dies while the Employee 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 other Pension Fund of an Employer participating in this Plan on behalf of non-collectively bargained employees.

The cost for Retiree coverage is established by the Board of Trustees of the National Asbestos Workers Medical Fund. The amount of the retiree premium payment rules for Retiree coverage may be changed at any time by the Trustees of the Asbestos Workers Local Union No. 80 Supplemental Medical Fund.

Continuing Your Eligibility During Family and Medical Leave

The Family and Medical Leave Act ("FMLA") of 1993 entitles employees eligible under the Act to take up to 12 weeks of unpaid job-protected leave each year for the employee's own illness, or to care for a seriously ill child, spouse or parent. In addition, the FMLA provides leave for the birth or placement of a child with the employee in the case of adoption or foster care. 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 1250 hours of service to the employer. An employee at a work site at which there are less than 50 employees is not eligible for FMLA leave unless the total number of employees within a 75 mile radius of that employee equals or is greater than 50.

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

Change of Eligibility Rules And Benefits

Over time, it may be necessary to change the eligibility rules and the benefits provided by the Supplemental Medical Fund. *The Trustees, in their discretion, have the authority to change, modify or discontinue all or part of the eligibility rules or benefits provided, at any time.* Whenever the eligibility rules provide that certain policies (such as self-payment rates, benefits provided, etc.) are set by the Trustees, these policies will be on file at the Fund Office. If you have any questions about these policies, contact the Fund Office.

Description of Benefits
PART III

The Board of Trustees will at all times recognize that a primary purpose of this Fund will be to provide financial assistance to those Fund Participants who are Retirees and whose Home Local Union is Asbestos Workers Local Union No. 80, in receiving health coverage from the National Asbestos Workers Medical Fund through its Retired Employees Separate Account. The Board of Trustees can adopt no program of benefits which would adversely affect the Fundôs ability to provide this program of financial assistance, and any such benefit which would be adopted would be deemed to violate Article II, Section 3 of the Agreement and Declaration of Trust.

Deductible Supplement

The Plan will pay a $50.00 per family supplement annually to the deductible of the National Asbestos Workers Medical Fund or other insurance arrangement for non-collectively bargained employees.

The deductible supplement will apply to the first dollars covered by the other Plan and disallowed under the other Plan's deductible. If a family incurs less than $50.00 in expenses which would be subject to the deductible of the other plan, the Local 80 Supplemental Plan will pay up to that amount.

Weekly Accident and Sickness Benefits
for Active Eligible Employees – off the Job Illness or Injury

A weekly accident and sickness benefit is payable to Active Eligible Employees only while 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 Workerôs Compensation Law.

If you are eligible to receive the weekly accident and sickness benefit provided through the National Asbestos Workers Medical Fund, you will automatically be entitled to receive this additional weekly accident and sickness benefit under the Asbestos Workers Local Union No. 80 Supplemental Medical 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.

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.

Period of Coverage

Your Weekly Accident and Sickness Benefit will begin on the first day if your disability resulted from an accident, or on the eighth day if your disability resulted from an illness. Benefits are payable for a maximum of twenty-six (26) weeks of disability in the amount of $200 per week.

Payment will be made for as many separate and distinct periods of disability as may occur.

Period of Disability

Successive periods of disability separated by less than two 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.

Retired Employees' Premium Benefit

The Plan will pay 100% of the retiree premiums for eligible Retirees and their eligible Dependents for medical, dental and vision coverage in the National Asbestos Workers Medical Fund. You must be eligible for Retiree coverage in the National Asbestos Workers Medical Fund and satisfy the rules for eligibility in this Plan to have premiums paid on your and your Dependentsô behalf.

The following are the guidelines for eligibility for the Retired Employeesô Premium Benefit:

1. The Employee must be eligible for Retiree benefits from the National Asbestos Workers Medical Fund.

2. The Employeeôs home local must be Local 80 of the International Association of Heat & Frost Insulators and Asbestos Workers, and he must be a member in good standing of Local 80.

3. The Employee must have pension eligibility from Local 80 in the National Asbestos Workers Pension Fund. An Employee with Ownership Interests in an Employer satisfies the requirements of this paragraph if the Employee:

    a. Is covered by a Special Participation Agreement for Employees with Ownership Interests;

    b. Has pension eligibility from Local 80 in the National Asbestos Workers Pension Fund, the pension plan of an Employer signatory to Local 80's Collective Bargaining Agreement or for a retirement benefit from the Social Security Administration; and

    c. Was actively working and participating in the Fund immediately prior to retirement.

4. For an Employee who does not have an Ownership Interest in a Employer, and who is not covered by a Collective Bargaining Agreement, he will satisfy the requirement for pension eligibility from Local 80 if he is covered by a Special Participation Agreement entered into by an Employer.

5. The Employee must have ten (10) years of participation in the National Asbestos Workers Medical Fund in the Local 80 area.

6. The Employee must have seven (7) years of eligibility in the National Asbestos Workers Medical Fund in the Local 80 area.

7. Contributions must have been made on the Employee's behalf into this Fund for thirty-six (36) out of the sixty (60) months immediately preceding the Employee's pension effective date.

8. The Fund will pay 100% of the cost of the retiree premium to the National Asbestos Workers Medical Fund for:

    a. Retirees
    b. Spouses
    c. Dependents
    d. Widow(er)s
    e. Surviving dependents
    f. an Eligible Employee who is totally and permanently disabled and receiving a Social Security Disability Benefit even though that Employee does not meet the requirements of other eligibility guidelines indicated herein.

    The Retired Employees' Premium Benefit does not provide premium payments for spouses or dependents that are acquired AFTER an employee retires. Only those spouses and dependents who are eligible at the time the employee retires are eligible for this Benefit. If an employee retires and later marries and/or acquires dependents, the total cost of coverage under the National Asbestos Workers Medical Fund for the spouse and/or dependents must be paid by the retiree.

9. If you meet the guidelines for this Fund based on your employment with Local 80 but you are not working out of Local 80 at the time of your retirement, or do not elect retiree coverage when you retire, you may still be eligible to participate in the this Fund when you retire or elect coverage. 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 the National Asbestos Workers Medical Fund until retirement or you elect retiree coverage.

10. *The Trustees may change the percentage paid by this benefit, change the eligibility rules for this benefit or discontinue this benefit at any time.*

11. Satisfaction of the requirements numbered 2-10 (above) will not guarantee any Employeeôs eligibility for benefits from the National Asbestos Workers Medical Fund.

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

Self-Pay for Dependents of Deceased Active, Eligible Employees

The Plan will pay 100% of the self-payment for Widow(er)s or Dependents of Active, Eligible Employees for medical coverage in the National Asbestos Workers Medical Fund. The Widow(er) or Dependent must be eligible for coverage as a Widow(er) or Dependent in the National Asbestos Workers Medical Fund and satisfy the rules for eligibility to self-pay.

Self-Pay for Unemployed Participants

For Employees whose eligibility for coverage under the Planôs basic eligibility provisions has terminated due to insufficient work hours, the Fund will pay the self-payment to the National Asbestos Workers Medical Fund for an Unemployed Participant, up to $1,000 at 100% and any remaining amount up to 50%, *once in a calendar year* and contingent upon final approval by the Chairman and Co-Chairman of the Board of Trustees. The Unemployed Participant must timely pay the remaining balance of the self-payment for self-payments in excess of $1,000.

Use of the Self-payment for Unemployed Participants benefit is limited to Employees whose loss of coverage is due to a layoff due to lack of work, a directive from the Union, or firing without just cause.

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 the Union. The Self-Payment for Unemployed Participants 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 pay.

The Application for Self-Payment for Unemployed Participants can be obtained from the Fund Office or at the Offices of Insulators and Allied Workers Local 80.

Authority to Amend Benefit Provisions

In accordance with the provisions of the Trust Agreement, the Board of Trustees has full discretion and authority to add or eliminate benefits provided by the Fund, and to increase or decrease the amount of all such benefits.

Basic Plan Information
PART IV

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

Summary Plan Description

(A) The name of the Plan is the Asbestos Workers Local Union No. 80 Supplemental Medical Fund.

(B) This Plan is maintained by:

Board of Trustees
Asbestos Workers Local Union No. 80 Supplemental Medical Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

(C) The Employer identification number assigned by the Internal Revenue Service is: 53-0196381. The Plan number assigned by the Board of Trustees is: 501.

(D) This Medical Plan provides a weekly Accident and Sickness supplement, deductible reimbursement, and retire premium assistance to/for benefits provided under the National Asbestos Workers Medical Fund.

(E) The day-to-day administration of the Plan is carried out by a contract administrator, Carday Associates, Inc. Carday Associates is referred to as the Administrative Agent.

(F) The Plan Administrator is:

Board of Trustees
Asbestos Workers Local Union No. 80 Supplemental Medical Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

(G) The name and address of the person designated as agent for the service of legal process is:

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

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

(H) The name, title and address of the principal place of business of each Trustee of the Plan is as follows:

UNION TRUSTEES

Steve Keller, Co-Chairman
Asbestos Workers Local Union No. 80
7901 State Route 34, Box 806
Winfield, WV 25213

Mark Thomas
Asbestos Workers Local Union No. 80
7901 State Route 34, Box 806
Winfield, WV 25213

EMPLOYER TRUSTEES

Dan Patterson, Chairman
EPI Insulation Company
PO Box 1794
Parkersburg, WV 26102

Mark Artrip
Thermal Solutions
9329 County Road 107
Proctorville, OH 45669

(I) The Plan's requirements respecting eligibility for participation and for benefits are set forth in earlier pages which explain in detail the rules for becoming eligible for benefits as well as continuing eligibility for benefits.

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

(1) Failure to satisfy eligibility requirements stipulated in the Plan because of:
(a) insufficient employment under jurisdiction of Plan,

(b) disability for periods of time prior to or following periods during which credit is available,

(c) failure to pay on a timely basis amounts that may be required to continue eligibility during periods of disability or when employment not available.

(2) Non-covered employment.

(3) Failure to file necessary forms required in support of a claim.

(4) Failure to file claims within time limit specified in Plan.

(K) Contributions to the Plan are made by participating Employers for work performed by their active employees. The basis on which Employers make contributions is stated in a collective bargaining agreements covering collectively bargained employees and in participation agreements covering non-collectively bargained employees.

(L) The Plan is financed by contributions to the Trust and any income earned from investment of contributions. All monies are used exclusively to provide benefits to eligible employees or their dependents, and to pay all expenses incurred with respect to the operation of the Plan.

(M) The Plan's annual year-end date is: June 30

(N) Claims and Appeals Procedure

All participants requesting benefits under the Plan are required to file a written claim for benefits with the Administrative Agent at the Plan's Administrative Agent. The Board of Trustees make forms available for claims applications with the Plan's Administrative Agent.

Filing the prescribed claim form is the normal manner of applying for Plan benefits. However, any form of written claim for benefits filed with the Plan's Administrative Agent and reasonably calculated to notify the Administrative Agent of the claim and to provide all the necessary information required in order for the Administrative Agent to determine the eligibility of the applicant to receive Plan benefits will satisfy the requirement of filing a written claim.

In order for a claim to be considered, it must be received by the Administrative Agent within one year of the date that the claim first became legally enforceable under the Plan. Failure to make a claim within this one-year period will be an absolute waiver of the claim in question and will be grounds for denial of the claim.

The Administrative Agent will examine all written claims for benefits filed with it. The Administrative Agent has the right to require submission of all necessary information needed to determine the participant's eligibility for any benefit claimed in addition to that filed with the claim application. No benefit payments will be made under the Plan until an application or written claim is made for the benefit to the Administrative Agent and all additional information required by the Administrative Agent to substantiate the claim has been submitted.

A participant may file a claim under this procedure through an attorney or any other authorized representative acting on the participant's behalf.

Upon receipt of a claim, the Administrative Agent will, within a reasonable length of time but no later than 30 days after its submission, determine the eligibility of the participant for Plan benefits and will notify the participant of its determination and the amount of any benefit payable. If the decision on the claim cannot be made within this 30-day period, the Administrative Agent will notify the participant before the period expires and explain why more time is needed. After giving notice, the Administrative Agent may take up to another 15 days to make the decision.

If a claim is wholly or partially denied, the Administrative Agent will provide a written notice to the applicant setting forth:

1. The specific reason or reasons for denial;

2. Specified reference to pertinent Plan provisions, claims procedures or other evidence on which the denial is based;

3. A description of any additional material or information necessary for the participant to perfect the claim and any explanation of why such material or information is necessary;

4. An explanation of the Plan's claim review procedures, the time limits under the procedures and a statement regarding the Participantôs right to bring a legal action under Section 502 (a) of ERISA following an adverse benefit determination on appeal.

Every participant whose application for benefits has been denied in whole or in part will have the opportunity to appeal the denial to the Board of Trustees. An appeal may be made by the participant directly or through an attorney or any other authorized representative acting on the participant's behalf.

In the event a participant desires to take advantage of his opportunity to appeal, he will be required to file a written request for review with the Board of Trustees. Any form of written request for review filed with the Board of Trustees and reasonably calculated to notify the Board of Trustees of the request for review shall satisfy the requirement of filing a written request for review.

The written request for review must be received by the Board of Trustees within 180 days of the participant's receipt of the Administrative Agent's notification of denial of claim. Failure to request in writing a review of the denial of a claim within the foregoing 180 days shall constitute a waiver of further review of the claim in question and the denial of the claim shall be binding and conclusive on all questions of fact or law, unless consideration of the claim is permitted in the discretion of the Board of Trustees. A request for review shall be considered "received" by the Board of Trustees at the time it is delivered to the Administrative Agent.

The Board of Trustees will consider all appeals from denials of claims. In the written request for review, a participant should submit in writing every issue, comment, argument and all other evidence in support of the appeal.

The Board of Trustees will make its determination after examination of the evidence presented by the appealing participant. The decision of the Board will be final and binding on all parties.

The Board of Trustees, or a committee of the Board, will make its decision on the appeal in writing within 60 days at the first meeting after the request is filed. Any notices required by these claims and appeals procedures will be in writing and signed by the person sending the notice. The notice may be sent by first-class mail or hand-delivered. Notices to a participant will be sent to him or her at the last known address, as indicated by the file at the Administrative Agent. The notices which are required of a participant will be sent or hand-delivered, to the appropriate office as designated by these procedures.

If an appeal is wholly or partially denied, the Administrative Agent will provide a written notice to the applicant setting forth:

1. The specific reason or reasons for denial;

2. Specified reference to pertinent Plan provisions on which the denial is based;

3. A statement that the participant is entitled to receive, Upon request and free of charge, access to and copies of all documents, records and other information relevant to the participantôs claim.

4. An explanation of the Participantôs right to bring a legal action under Section 502 (a) of ERISA following an adverse benefit determination on appeal.

The Administrative Agent for this Plan is:

Administrative Agent
Asbestos Workers Local Union No. 80 Supplemental Medical Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

(O) As a participant in the Asbestos Workers Local Union No. 80 Supplemental Medical Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan administratorôs office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called ñfiduciariesò of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(P) The Trustees shall have the right to terminate, suspend, amend or modify the terms of the Summary Plan Description in whole or in part at any time. The Trustees further have authority to terminate the Summary Plan Description upon termination of the Asbestos Workers Local Union No. 80 Supplemental Medical Fund (ñFundò).

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 Employers 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.

Appendix 1
PART V

Eligibility Rules for the National Asbestos Workers Medical Fund

How You Become Eligible for Benefits

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

- Work Quarters; and
- Eligibility Quarters

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

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

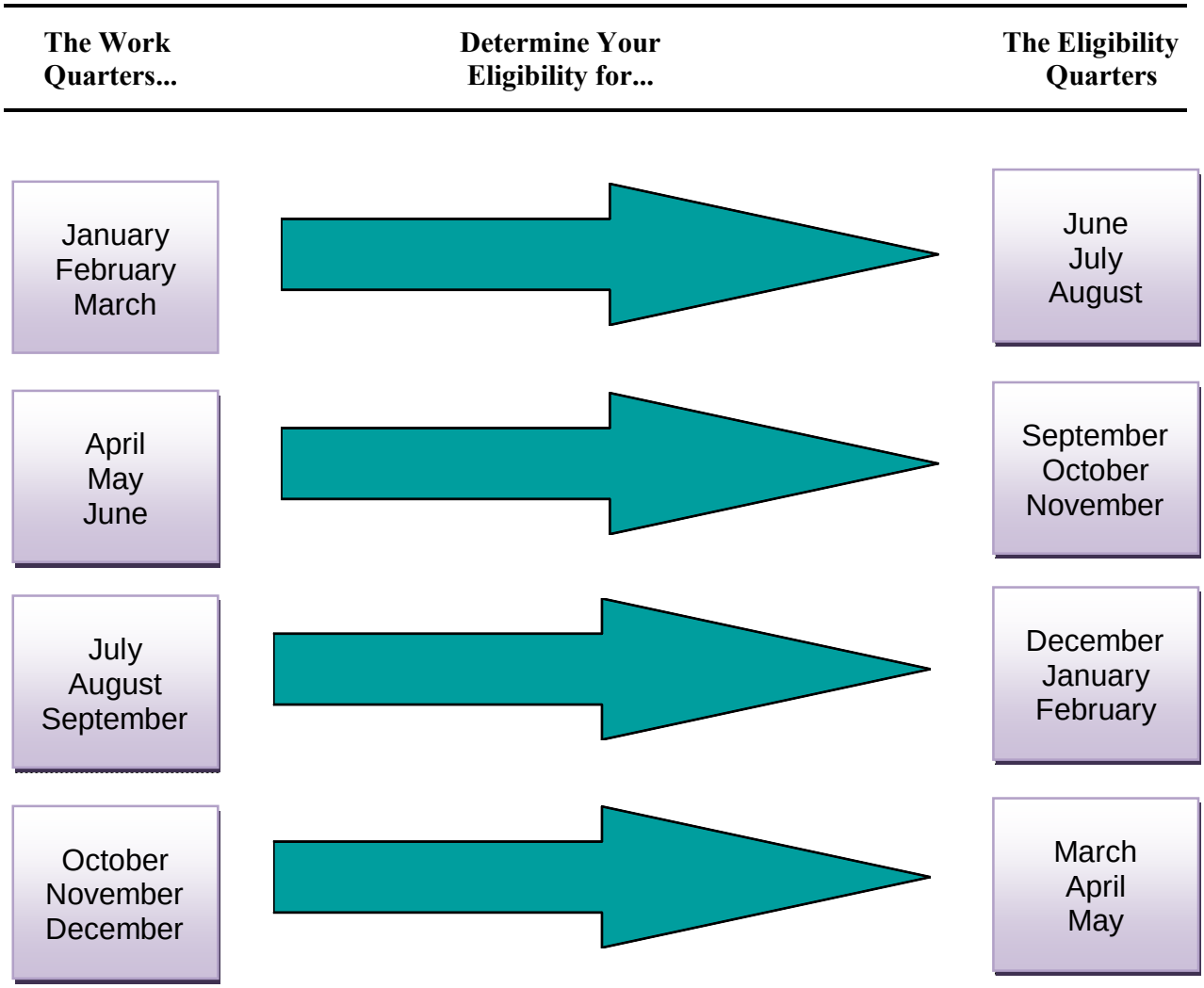
How Eligibility Quarters Are Earned

You earn credit for an Eligibility Quarter when:

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

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

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



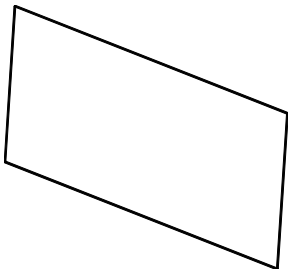
Initial Eligibility

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

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

Example of Initial Eligibility for Benefits

Assume Mike started working as an 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.

	Reported Hours	Work Quarters	Earn	Initial Eligibility
Initial Eligibility For New Employee April 1	800 Hours	April May June July August September		October November December January February

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.

Appendix 2
PART VI

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
(Effective April 14, 2004)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The U.S. Department of Health and Human Services has issued regulations establishing strict standards on how health funds, like the Asbestos Workers Local Union No. 80 Supplemental Medical Fund, may use and disclose your medical records. These regulations, formally known as the ñStandards for Privacy of Individually Identifiable Health Informationò are required by Health Insurance Portability and Accountability Act of 1996 and are effective April 14, 2004.

The Fund 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 (ñPrivacy Rulesò). Under these standards, the Fund 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 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. To the extent protect health information is used or disclosed, the Fund will use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

The Fund has adopted a written Privacy Policy setting forth the rules and procedures the Fund has established to protect your personal health information as required by applicable law. This Privacy Policy is hereby incorporated as part of the Summary Plan Description of the Fund.

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

Use or Disclosure of PHI

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

   · ñPaymentò generally means the activities of a Fund to collect premiums, to fulfill its coverage responsibilities, and to provide benefits under the Plan, and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing and collection, making claims for stop-loss insurance, determining medical necessity and performing utilization review. For example, the Fund will disclose the minimum necessary PHI to medical service providers for the purposes of payment.

   · ñHealth Care Operationsò are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run its business and to support the core functions of treatment and payment. For example, the Fund may disclose the minimum necessary PHI to the Fundôs attorney, auditor, actuary, and consultant(s) when these professionals perform services for the Fund that requires them to use PHI. Persons who perform services for the Fund are called ñbusiness associates.ò Federal law requires the Fund to have written contracts with its business associates before it shares PHI with them, and the disclosure of your PHI must be consistent with the Fundôs contract with them. Other examples of business associates are the Fundôs stop-loss insurance carrier, claims repricing services, utilization review companies, prescription benefit managers, PPOs and HMOs.

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

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

   · The Fund will use or disclose your PHI to the extent it is required by law to do so.

   · The Fund may disclose your PHI to a public health authority for certain public health activities, such as: (1) reporting of a disease or injury, or births and deaths, (2) conducting public health surveillance, investigations, or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality, safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an

employer about a member of its workforce, for the purpose of workplace medical surveillance or the evaluation of work-related illness and injuries, but only to the extent the employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or State law requirements having a similar purpose.

- The Fund may disclose your PHI to the appropriate government authority if the Fund reasonably believes that you are a victim of abuse, neglect or domestic violence.

- The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law, including: (1) audits; (2) civil, administrative, or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative, or criminal proceedings or actions; and (6) other activities.

- The Fund may disclose your PHI in the course of any judicial or administrative proceeding in response to an order by a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process.

- The Fund may disclose your PHI for a law enforcement purpose to law enforcement officials. Such purposes include disclosures required by law, or in compliance with a court order or subpoena, grand jury subpoena, or administrative request.

- The Fund may disclose your PHI in response to a law enforcement official's request, for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

- The Fund may disclose your PHI if you are the victim of a crime and you agree to the disclosure or, if the Fund is unable to obtain your consent because of incapacity or emergency, and law enforcement demonstrates a need for the disclosure and/or the Fund determines in its professional judgment that such disclosure is in your best interest.

- The Fund may disclose your PHI to law enforcement officials to inform them of your death, if the Fund believes your death may have resulted from criminal conduct.

- The Fund may disclose PHI to law enforcement officials that it believes is evidence that a crime occurred on the premises of the Fund.

- The Fund may disclose your PHI to a coroner or medical examiner for identification purposes. The Fund may disclose your PHI to a funeral director to carry out his or her duties upon your death or before and in reasonable anticipation of your death.

- The Fund may disclose your PHI to organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.

- The Fund may use or disclose your PHI for research purposes, if the Fund obtains one of the following: (1) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.

- The Fund may use or disclose your PHI to avoid a serious threat to the health or safety to you or others.

- The Fund may disclose your PHI if you are in the Armed Forces and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities.

- The Fund may disclose your PHI to a correctional institution where you are being held.

- The Fund may disclose your PHI in emergencies or after you provide verbal consent under certain circumstances.

- The Fund may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workersô compensation or other similar programs.

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

- The Fund will provide you with access to your PHI.

- The Fund may provide your Personal Representative or Attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your Personal Representative or lawyer has authority under applicable law to act on your behalf.

- Unless otherwise permitted by law, the Fund will not use or disclose your PHI to someone other than you unless you sign and execute an ñAuthorization Form.ò You can revoke an Authorization Form at any time by submitting a ñCancellation of Authorization Formò to the Fund. The Cancellation of Authorization Form revokes the Authorization Form on the date it is received by the Fund. Attached to this Notice is a sample Authorization Form and a sample Cancellation Form.

- The Fund will disclose your PHI to the Fundôs Board of Trustees only in accordance with the provisions of the Fundôs Privacy Policy and the provisions of the Plan.

Individual Rights

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

- You have a right to request that the Fund restrict use or disclosure of your PHI to carry out payment or health care operations. The Fund is not required to agree to a requested restriction.

- You have a right to receive confidential communications about your PHI from the Fund by alternative means or at alternative locations, if you submit a written request to the Fund in which you clearly state that the disclosure of all or part of that information could endanger you.

- You have a right of access to inspect and copy your PHI that is maintained by the Fund in a ñdesignated record set.ò A ñdesignated record setò consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Fund in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Fund, or (2) decisions that the Fund makes about you.

- You have a right to amend your PHI that was created by the Fund and that is maintained by the Fund in a designated record set, if you submit a written request to the Fund in which you provide reasons for the amendment.

- You have a right to receive an accounting of disclosures of your PHI, with certain exceptions, if you submit a written request to the Fund. The Fund need not account for disclosures that were made more than six years before the date on which you submit your request, nor any disclosures that were made for treatment, payment or health care operations.

Duties of the Fund

The Fund has the following obligations:

- The Fund is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. To obtain a copy of the Fundôs entire Privacy Policy, you should contact the Fundôs Privacy Officer, identified below.

- The Fund is required to abide by the terms of the Notice that is currently in effect.

- The Fund will provide a paper copy of this Notice to you upon request.

Changes to Notice

- The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains, regardless of whether the PHI was created or received by the Fund prior to issuing the revised Notice.

- Whenever there is a material change to the Fundôs uses and disclosures of PHI, individual rights, the duties of the Fund, or other privacy practices stated in this Notice, the Fund will promptly revise and distribute the new Notice to participants and beneficiaries.

Contacts and Complaints

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

Claims Manager
Asbestos Workers Local Union No. 80 Supplemental Medical Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

You may also file a complaint with the U. S. Secretary of Health and Human Services in Washington, DC. The Fund will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for filing a complaint.

For More Information About Privacy

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

ASBESTOS WORKERS LOCAL UNION NO. 80
SUPPLEMENTAL MEDICAL FUND

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

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

SUMMARY OF MATERIAL MODIFICATIONS #1

Important Change to the Rules for Retirees Effective January 1, 2017

December 2016

Dear Participant:

This notice, referred to as a Summary of Material Modifications (SMM), describes an important change to the rules of the Asbestos Workers Local Union No. 80 Supplemental Medical Fund. We encourage you to read this notice carefully and keep it with your Summary Plan Description (SPD). As always, feel free to contact the Fund Office if you have any questions.

Disqualifying Employment / Loss of Eligibility for the Retired Employees' Premium Benefit

As you know, the Retired Employees' Premium Benefit offered by the Supplemental Medical Fund covers 100% of the retiree premiums charged by the National Asbestos Workers Medical Fund. This benefit is intended to alleviate the burden of paying for health coverage for eligible Retirees who no longer receive a steady paycheck. However, the Retired Employees' Premium Benefit is not intended to provide health coverage to Retirees who continue to work and receive wages throughout their retirement.

With that in mind, effective **January 1, 2017**, the Trustees have amended Part III of your SPD to add the following paragraph under the section entitled *Retired Employees' Premium Benefit*: "Eligible Retirees who perform work for which no contributions are made to the Fund ("disqualifying employment") will lose eligibility for the Retired Employees' Premium Benefit. Loss of eligibility will be effective with the next Eligibility Quarter for which retiree premiums have yet to be paid by this Fund to the National Asbestos Workers Medical Fund. Retirees who work in disqualifying employment and consequently become ineligible for the Retired Employees' Premium Benefit may reapply for the premium benefit after leaving disqualifying employment. After you reapply, a decision will be made regarding your eligibility for the premium benefit."

In short, eligible Retirees who work in disqualifying employment will no longer have their premiums payable to the National Asbestos Workers Medical Fund covered by this Fund. Consequently, in order to continue their retiree coverage under the National Asbestos Workers Medical Fund, Retirees impacted by this rule must pay the full amount of the premiums charged by the National Asbestos Workers Medical Fund in a timely fashion. If they fail to pay the full amount of such premiums in a timely fashion, and fail to receive a waiver for making a late payment, their retiree coverage under the National Asbestos Workers Medical Fund will also terminate and they will be unable to reinstate such coverage. Alternatively, Retirees may file an opt-out form to suspend Retiree coverage under the National Asbestos Workers Medical Fund so long as they maintain continuous coverage during the opt-out period.

Conclusion

The Trustees will continue to monitor the Fund's resources to ensure that it is able to provide high-quality supplemental health coverage to members and their families for many years to come. As always, if you have any questions about the change summarized in this notice, or the Fund in general, please contact the Fund Office.

The Board of Trustees of the Asbestos Workers Local Union No. 80 Supplemental Medical Fund is:

UNION TRUSTEES

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EPI Insulation Company
P.O. Box 1794
Parkersburg, WV 26102

Mark Artrip
Thermal Solutions
9329 County Road 107
Proctorville, OH 45669

Vacancy

Sincerely,

BOARD OF TRUSTEES

Please keep this in your Summary Plan Description for handy reference and safekeeping. If you do not have a Summary Plan Description, you may obtain a copy by making a written request to the Fund Office, to the attention of the Membership Services Department.

SMM#1 SPD 7/2015